MEDICAID PROVIDER MANUAL OVERVIEW

SECTION 1 – INTRODUCTION

The following documents comprise the Michigan Medicaid Provider Manual, and address all health insurance programs administered by the Michigan Department of Community Health (MDCH). MDCH also issues periodic bulletins as changes are implemented to the policies and/or processes described in the manual. An inventory of these bulletins is maintained in the Supplemental Bulletin List located on the MDCH website. Bulletins are incorporated into the online version of the manual on a quarterly basis. (Refer to the Directory Appendix for website information.)

1.1 ORGANIZATION

The following table identifies each chapter and appendix in the manual, indicates what providers are affected, and provides a brief overview of each.

Chapter Title	Affected Providers	Chapter Content
General Provider Chapters		
Medicaid Provider Manual Overview	All Providers	Brief discussion of the organization of the manual and effectively using the document.
General Information for Providers	All Providers	Policies and general information regarding provider enrollment and participation, prior authorization, record retention, billing the beneficiary, fraud and abuse, etc.
Beneficiary Eligibility	All Providers	Policies and information regarding how to verify beneficiary eligibility, information on various eligibility categories, enrollment in contracted health plans, beneficiary utilization control, etc.
Coordination of Benefits	All Providers	Policies and information regarding coordination of benefits, Medicaid's payment liability, etc.
Billing & Reimbursement for Dental Providers	Providers billing the ADA-2000 or 837 Dental claim formats.	Policies and instructions for billing dental services.
Billing & Reimbursement for Institutional Providers	Providers billing the UB-92 or 837 Institutional claim formats.	Policies and instructions for billing institutional services.

Chapter Title	Affected Providers	Chapter Content
Billing & Reimbursement for Professionals	Providers billing the CMS-1500 or 837 Professional claim formats.	Policies and instructions for billing professional services.
Provider/Service Specific Chapters		
Adult Benefits Waiver	All Providers	Information regarding program eligibility, benefit package, County Health Plans, billing instructions, etc. There is currently an enrollment freeze for this program.
Ambulance	Ambulance (PT 18)	Coverage policy related to emergency and non-emergency transports by ground, water or air ambulance.
Children's Special Health Care Services	All Providers	Information regarding program eligibility, benefit package, etc.
Chiropractor	Chiropractor (PT 14)	Coverage policy related to chiropractic services.
Dental	Dentists/Dental Clinics (PT 12, 74)	Coverage policy related to dental services and information on the Healthy Kids Dental Program.
Emergency Services Only Medicaid	All Providers	Information regarding program eligibility, benefit package, etc.
Family Planning Clinics	Title X clinics (PT 23)	Coverage policy related to family planning services provided through Title X clinics.
Federally Qualified Health Centers	Clinics designated by HHS as FQHCs	Coverage and reimbursement policies applicable to FQHCs.
Hearing Aid Dealers	Hearing Aid Dealers (PT 90)	Coverage policy related to the dispensing of hearing aids and alternative listening devices, and related supplies.
Hearing Services	Hearing & Speech Centers, Outpatient Therapy Providers (PT 40, 80)	Coverage policy related to hearing evaluations and speech/language services.

Chapter Title	Affected Providers	Chapter Content
Home Health	Home Health (PT 15)	Coverage policy related to services provided by home health agencies.
Hospice	Hospice (PT 15)	Coverage policy related to hospice services.
Hospital	Inpatient & outpatient hospitals (PT 22, 30, 40)	Coverage policy for inpatient and outpatient hospital services. Also includes cost reporting requirements, Graduate Medical Education and disproportionate share payment methodologies, appeals, etc.
Laboratory	Independent Clinical Labs (PT 16)	Coverage policy for laboratory services.
Local Health Departments	Local Health Departments	Coverage policy, cost reporting requirements, interim payments, and appeals for local health departments.
Maternal Infant Health Program	Certified MIHP providers (PT 77)	Provider certification requirements, beneficiary eligibility criteria, and covered services.
Maternity Outpatient Medical Services	Providers of Maternity Related Services	Program eligibility requirements, benefit package, and billing instructions.
Medicaid Health Plans	Contracted HMOs (PT 17)	Health plan participation and coverage policies.
Medical Supplier	Medical Suppliers/Durable Medical Equipment, Orthotists/Prosthetists (PTs 85, 87)	Coverage policies and parameters for medical supplies, durable medical equipment, orthotics, and prosthetics.
Mental Health/Substance Abuse	Mental Health and Substance Abuse providers (PT 77, 21)	Coverage policies and reporting requirements for services provided through Prepaid Inpatient Health Plans. Includes Children's Home and Community Based Services Waiver, Substance Abuse and Habilitation/Supports Waiver information.
Nursing Facility	Nursing Facilities (PTs 60, 61, 62, 63, 64, 72)	Coverage policy; certification, survey and enforcement policy; reimbursement methodology; and appeals related to nursing facilities.
Outpatient Therapies	Outpatient Therapy Providers (PT 40)	Outpatient therapy provider participation requirements and coverage policy.

Chapter Title	Affected Providers	Chapter Content
Pharmacy	Pharmacies (PT 50)	Coverage policy related to pharmacy services.
Practitioner	MD, DO, Oral Surgeons, DPM, NP, CRNA, CNM, Physical Therapists (PTs 10, 11, 13, 77)	Coverage policy for services rendered by physicians, advanced practice nurses, oral surgeons, and podiatrists.
Private Duty Nursing	Independent & PDN Agency (PTs 10, 15)	Coverage policy related to private duty nursing services provided through an agency or by an independent nurse.
Program of All Inclusive Care for the Elderly (PACE)	Contracted PACE providers	Information regarding program eligibility, benefit package, etc.
Rural Health Clinics	Rural Health Clinics	Coverage policy related to Rural Health Clinics.
School Based Services	Enrolled Intermediate School Districts	Coverage policy for medical services provided to students eligible under the IDEA of 1990.
School Based Services – Administrative Outreach	Enrolled Intermediate School Districts	Coverage, claiming, and billing policies related to the SBS Administrative Outreach Program.
Special Programs	All Providers	General information about MDCH health insurance programs that are not addressed elsewhere in this manual.
Tribal Health Centers	Tribal Health Centers	Coverage policy for Tribal Health Centers, defined under the Indian Self-Determination and Education Assistance Act (Public Law 93-638 as those owned and operated by American Indian/Alaska Native tribes and tribal organizations under contract or compact with the Indian Health Service (IHS).
Vision	Ophthalmologists, Optometrists, Vision suppliers (PTs 10, 86, 94, 95)	Coverage policy for vision services and hardware.
Appendices		
Acronyms	All Providers	
Directory	All Providers	

Chapter Title	Affected Providers	Chapter Content
Glossary	All Providers	
Forms	All Providers	Provides samples of forms identified in the manual and instructions for form completion, when appropriate. Providers may also download forms directly from the MDCH website.

1.2 PRINTING

MDCH will not provide a printed copy of the Provider Manual but will provide the information via compact disc (CD) to all enrolled providers and subscribers on an annual basis. (Refer to the Manual Updates Section of this chapter for additional information.)

Should the user elect to print portions of the manual for his use, please note the following:

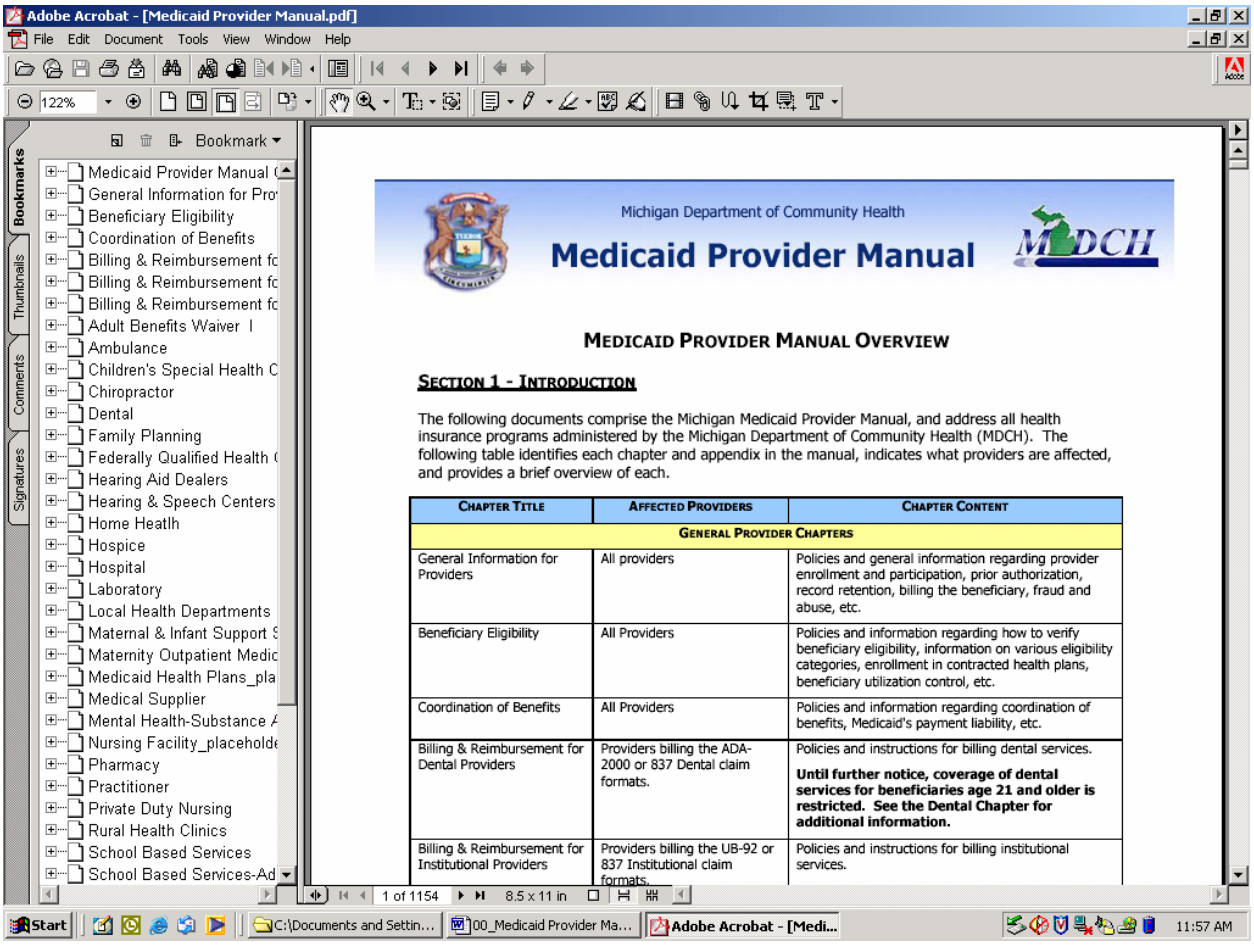
- The version date is noted at the bottom of each page on the left hand side. When researching policy, it is imperative that the most current version be used.
- The page number at the bottom right hand side of each page represents the page number within that chapter, not within the whole document.
- The name of the chapter is on the bottom of each page.
- It is recommended that any printing be done in black and white, not color, as printing in color can be very expensive. The features on each page are adequately effective in black and white.

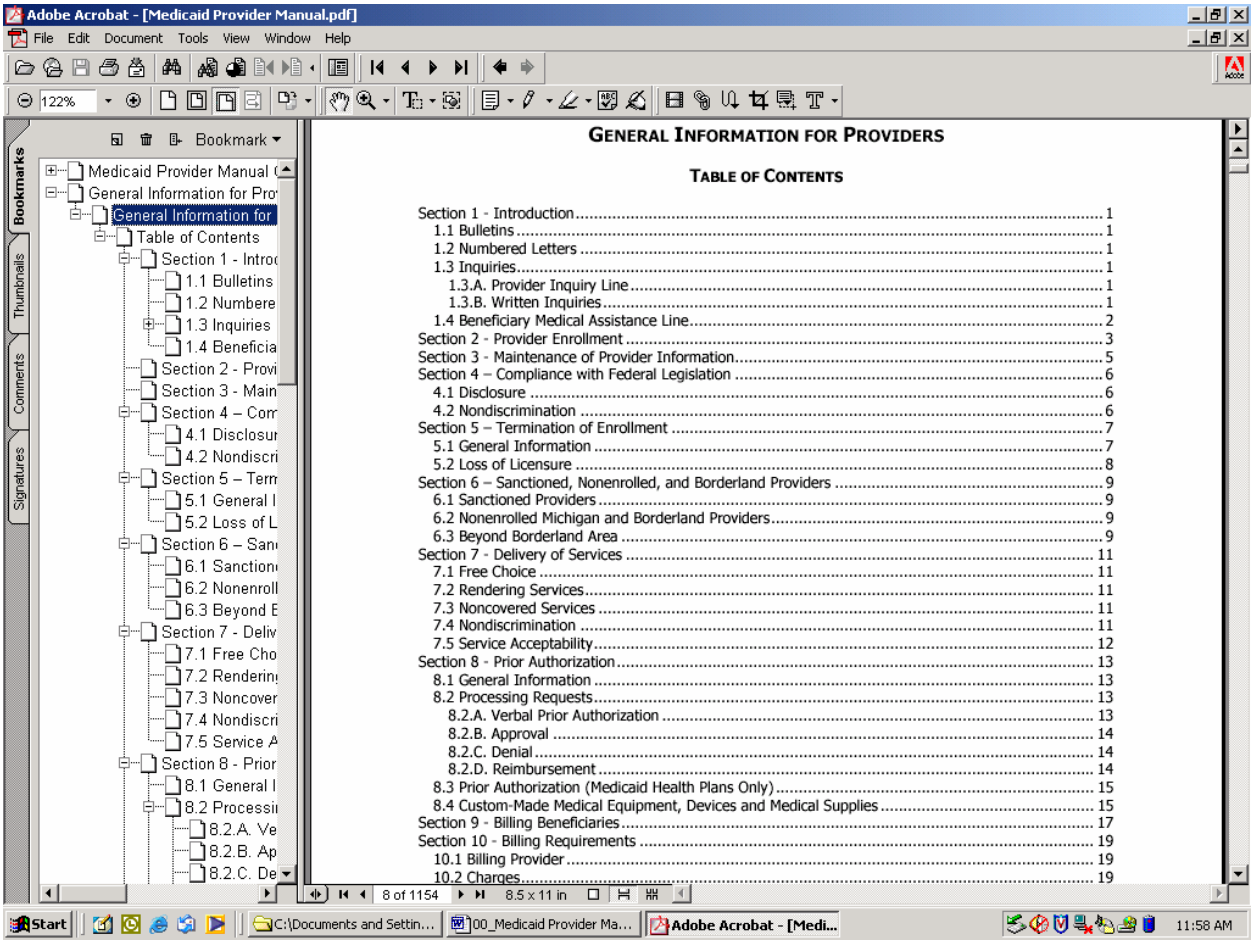
SECTION 2 - NAVIGATION THROUGH THE MANUAL

2.1 BROWSE CAPABILITIES

Each chapter within the manual is linked with all other manual chapters and appendices. Users can easily navigate from chapter to chapter by clicking on the bookmark navigation keys located on a palette on the left side of the screen. (See the following illustrations.) To jump to a topic using its bookmark, click the bookmark icon or text in the palette that represents that topic. The bookmarks in the manual correspond to chapter titles, section titles, subsections and appendices.

Bookmarks can be expanded or collapsed to easily link to the desired information. Primary headings, such as chapter titles, display as the first level of bookmarks. If a primary heading has secondary headings (i.e., section titles, subsections), they are displayed underneath the primary heading. Primary headings can be collapsed to hide the secondary headings. When a primary heading is collapsed, it has a plus (+) sign next to it. Click on the plus (+) sign to expand the bookmarks to display secondary headings. When all headings are displayed, a minus (-) sign appears next to the heading. (See the illustrations below.)





Users can also navigate from section to section within each chapter by clicking on the Section Titles within the Table of Contents.

2.2 Search Capabilities

Users can also access the powerful online search capabilities of Adobe Acrobat to quickly locate information within the manual. There are two search methods:

- Click on Edit, Find on the tool bar and enter a keyword in the Find dialog box, or
- Click on the Binoculars on the toolbar and enter a keyword in the dialog box.

Always use the most specific term or acronym for the search, rather than a general term. (Refer to the Acronym Appendix for a list of all those used in the manual.) Start the search on the first page of the manual to assure that all relevant information is located.

In order to locate all of the information pertinent to a subject, search by the acronym if the word or term has one.

SECTION 3 – MANUAL UPDATES

3.1 QUARTERLY UPDATES

The Medicaid Provider Manual located on the MDCH website is updated quarterly to reflect information that has been added, deleted or changed via policy bulletins and other communications during the previous quarter. The contact information contained in the Directory Appendix is also updated quarterly. Policy Bulletins, Databases, Numbered Letters and other important information are also located on the website.

A CD containing quarterly updates is not issued; therefore, the providers must pay close attention to written correspondence from MDCH and visit the MDCH website frequently to obtain the most recent information.

3.2 YEARLY UPDATES

A complete manual, incorporating changes issued during the previous year, is produced on CD annually and sent to all enrolled providers. The entire manual replacement is also available on the MDCH website for quick, online access. Providers are able to access the most recent manual on the MDCH website as well as previous manuals that may be needed for historical purposes. Manuals that were produced prior to January 2004 are not available online.

GENERAL INFORMATION FOR PROVIDERS

TABLE OF CONTENTS

SECTION 1 - INTRODUCTION

This chapter applies to all providers.

The Michigan Department of Community Health (MDCH) acts as the fiscal intermediary for several health insurance programs including Medicaid, Adult Benefits Waiver (ABW), Children's Special Health Care Services (CSHCS), the Refugee Assistance Program (RAP), Maternity Outpatient Medical Services (MOMS), and the Repatriate Program. Although coverage, limitations, and administration may differ, billing procedures and reimbursement methods are essentially the same.

This chapter is used for all health insurance programs administered by MDCH. Any reference to Medicaid in the manual and bulletins pertains to all programs administered by MDCH unless specifically stated otherwise. Reference to the state mental health facilities includes only those facilities owned and operated by MDCH. It does not include proprietary facilities for the mentally ill or developmentally disabled.

1.1 BULLETINS

This manual is the provider's primary source of information. Revisions to the manual regarding policy and procedural changes are sent to the provider via Policy Bulletins. Bulletins should be kept until the information is incorporated into the manual. Bulletins are numbered for the provider's reference. The first two digits of the bulletin number refer to the year. The next two digits refer to the specific sequence number assigned to the bulletin (e.g., 03-04).

Bulletins are sent to affected providers and are posted on the MDCH website. (Refer to the Directory Appendix for website and contact information.)

1.2 NUMBERED LETTERS

The purpose of a numbered letter is to educate, inform, and/or clarify issues related to MDCH policies, procedures, and/or decisions that affect multiple providers.

1.3 INQUIRIES

MDCH has several methods of resolving inquiries. Questions regarding policies and procedures should be directed to Provider Inquiry. (Refer to the Directory Appendix for contact information.)

1.3.A. PROVIDER INQUIRY LINE

If billing assistance is required, the Provider Inquiry Line is available for immediate resolution of inquiries. (Refer to the Directory Appendix for contact information.)

1.3.B. WRITTEN INQUIRIES

Complex problems may require research and analysis. The problem should be clearly explained, in writing, with complete documentation (e.g., RA) attached and sent to Provider Inquiry.

1.4 Beneficiary Medical Assistance Line

If assistance to the beneficiary is required, the Beneficiary Helpline is available to assist them. (Refer to the Directory Appendix for contact information.) Beneficiaries enrolled in a Medicaid Health Plan (MHP) should be referred to their plan for assistance. Plan member services contact information is included on the beneficiary's plan membership card.

Within the limits of Medicaid, MDCH does not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, political beliefs, or source of payment.

1.5 Reporting Fraud and Abuse

Any provider, beneficiary, or employee who suspects Medicaid fraud or abuse is encouraged to report that information to MDCH. Information about fraud and abuse reporting requirements is located on the MDCH website. (Refer to the Directory Appendix for website and contact information.)

1.6 Provider Liaison Meetings

MDCH routinely schedules meetings to meet with provider specialty groups (e.g., physicians, hospitals, pharmacies, etc.) to discuss issues of interest/concern. The meetings are arranged through the various provider professional associations, though all affected providers and interested parties are welcome to attend. A calendar of provider liaison meetings is posted on the MDCH website, along with contact information. (Refer to the Directory Appendix for website and contact information.)

SECTION 2 - PROVIDER ENROLLMENT

An eligible provider who complies with all licensing and regulation laws applicable to the provider's practice or business in Michigan, who is not currently excluded from participating in Medicaid by state or federal sanction, and whose services are directly reimbursable per MDCH policy, may enroll as a Medicaid provider. Borderland providers and, under certain circumstances, beyond-borderland providers must be licensed and/or certified by the appropriate standard-setting authority in their home state. (Refer to the Beyond-Borderland Area subsection of this chapter for more information.) In addition, some providers must also be certified as meeting Medicare or other standards as specified by MDCH.

Providers must have a completed and signed Medical Assistance Provider Enrollment & Trading Partner Agreement (DCH-1625) on file with the Provider Enrollment Unit to be reimbursed for covered services rendered to eligible Medicaid beneficiaries.

A provider's participation in Medicaid is effective on the date the provider signs the DCH-1625 if the Provider Enrollment Unit receives the application within 30 calendar days of the signature date. If the application/agreement is not received within 30 calendar days of the signature date, the provider's enrollment is effective on the date it is received and date-stamped by the Provider Enrollment Unit.

Providers may request, in writing, that enrollment be retroactive. The request should be addressed to the Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

Retroactive enrollment is not considered prior to the effective date of licensure/certification or provider reinstatement. Enrollment may be retroactive one year from the date the request is received if the provider's licensure/certification or reinstatement is effective for that entire period. Retroactive enrollment eligibility is not a waiver for claims/services that do not meet established Medicaid billing criteria.

Once enrolled, providers are sent the MDCH Provider Confirmation Form. This is a computer printout of data on file with the Provider Enrollment Unit. Corrections to the data should be directed to the Provider Enrollment Unit. The form is not to be returned to MDCH.

The Provider Enrollment Unit does not issue a group or corporate provider identification (ID) number for multiple provider practices or multi-site or agency entities. Each provider (e.g., physician, dentist, etc.) within a group must enroll as a Medicaid provider. Each service rendered by a provider in a group must be billed using that provider's individual ID number. If a provider renders services at several service office locations/sites, the provider must have a separate ID number identifying each individual service location/site. A service office location/site is defined as a physical facility where a provider conducts business operations. The facility and its operations would include:

- Seeing patients;
- Maintaining staff;
- Having established hours; and
- Storage of medical records.

If a provider does not normally practice in an office (e.g., anesthesiologist), then separate ID numbers are not required.

For information regarding substitute physician or a locum tenens arrangement, refer to the Practitioner Chapter of this manual.

A Medicaid Health Plan (MHP) is responsible for reimbursing a contracted provider or subcontractor for its services according to the conditions stated in the subcontract. The MHP must also reimburse noncontracted providers for properly authorized, medically necessary covered services.

SECTION 3 - MAINTENANCE OF PROVIDER INFORMATION

Providers must notify the MDCH Provider Enrollment Unit immediately, in writing, of changes affecting their enrollment information. (Refer to the Directory Appendix for contact information.)

Examples of such changes include:

- A change in the provider's Federal Employer ID Number (or Tax ID Number).
- Moving to a new office.
- Adding another office or location.
- Leaving the current employer/partnership.
- Changing the billing address to which warrants and RAs only are sent.
- Retiring from practice.
- Closing a business.
- Provider files Chapter 11, Reorganization.
- Provider files Chapter 7, Bankruptcy.
- Any action taken by a licensing authority or hospital that affects health care privileges.
- Any criminal conviction.
- Addition/change of a specialty (a copy of the Letter of Congratulations or a certificate is required).
- Employer/partnership additions or changes.
- Change/loss of licensure status.
- New employees/providers.
- New contractual obligations to a clinic, employer, contractor, or other entity.
- Clinical Laboratory Improvement Act (CLIA) changes.
- A change in ownership.

Nursing Facility providers should refer to the Nursing Facility Chapter for additional instructions.

Some of these changes may result in termination or a change in the provider ID number. Failure to notify MDCH of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services.

The Provider Enrollment Unit disenrolls providers if mail is returned as nondeliverable.

SECTION 4 – COMPLIANCE WITH FEDERAL LEGISLATION

4.1 DISCLOSURE

Providers must notify the state-licensing agency and MDCH Provider Enrollment of any person(s) with an ownership or controlling interest in a facility that has been convicted of a criminal offense related to their involvement in any programs under Medicare, Medicaid, or Social Services Block Grants since the inception of these programs.

4.2 NONDISCRIMINATION

Federal regulations require that all programs receiving federal assistance through Health and Human Services (HHS) comply fully with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Providers are prohibited from denying services or otherwise discriminating against any medical assistance recipient on the grounds of race, color, national origin or handicap. For complaints of noncompliance, contact the Michigan Department of Civil Rights or the Office of Civil Rights within the U.S. Department of Justice. (Refer to the Directory Appendix for contact information.)

SECTION 5 – TERMINATION OF ENROLLMENT

5.1 GENERAL INFORMATION

The name of any provider or provider organization suspected of fraudulent practices, misuse or abuse of protected health information in relation to Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy requirements or suspected of accepting or soliciting unearned rebates, refunds, receipt of free goods, or other unearned considerations, in the form of money or otherwise, is referred to the Office of Civil Rights, the Department of Attorney General or to the Office of the United States Attorney General for investigation and possible prosecution under applicable state and/or federal statutes. In the event of a disqualifying action (e.g., loss of license or certification, suspension or exclusion), providers are immediately terminated from participation in Medicaid on the effective date of the disqualifying action.

The following are considered grounds for termination or refusal to renew the provider's participation in Medicaid:

- Any actions that threaten the health, safety or welfare, or privacy of protected health information of Medicaid beneficiaries.
- Any actions that threaten the fiscal integrity of Medicaid.
- Violation of contractual obligations.
- Continued failure to correct cited inappropriate services or billing actions.
- Failure to comply with the conditions of participation.
- Abuse of patient trust funds (Nursing Facilities only).
- Failure to meet certification standards.
- A pattern of providing inappropriate or unnecessary services to a beneficiary.
- Termination or exclusion from the Medicare Program.
- Conviction under Medicaid or Health Care False Claim Act or similar state/federal statute.

Summary suspension prevents further payment after a specified date, regardless of the date of service (DOS.)

If an indication of fraud or Medicaid misuse/abuse is discovered during any of the following, MDCH considers it as a basis for summary suspension:

- An evaluation of billing practices.
- The prior authorization (PA) process.
- An on-site review of financial and medical records and a written report of this review is filed.
- The construction of a profile to evaluate patterns of utilization of Medicaid beneficiaries served by the provider.
- A peer review of services or practices.

- A hearing or conference between MDCH and the provider (and counsel, if so requested).
- Indictment or bindover on charges under the Medicaid or Health Care False Claim Act or similar state/federal statute.

5.2 Loss of Licensure

For providers who must be licensed to practice their profession, continued enrollment in Medicaid is dependent upon maintaining licensure. Failure to renew a provider's license results in disenrollment from Medicaid effective the date of final lapse of the provider's license.

Suspension or revocation of a provider's license by the appropriate standard setting authority results in termination of Medicaid participation effective on the date the provider is no longer licensed. In the case of a provider not located in Michigan, suspension or revocation would be administered by the appropriate state licensing board.

If a provider is no longer licensed to practice (e.g., the license was suspended, lapsed, or revoked), MDCH does not reimburse for services rendered or ordered by that provider after the termination of the license. Medicaid payments obtained for services rendered during a period when the provider was unlicensed must be refunded to the State.

A provider may contact the Provider Enrollment Unit, in writing, to request re-enrollment as a Medicaid provider when his license is reinstated.

SECTION 6 – SANCTIONED, NONENROLLED, AND BORDERLAND PROVIDERS

6.1 SANCTIONED PROVIDERS

Medicaid does not reimburse providers for any services rendered that were ordered/prescribed by sanctioned (suspended, terminated or excluded) providers. If a provider is presented with an order/prescription from a sanctioned provider, that provider should inform the beneficiary that the order/prescription cannot be filled because the ordering/prescribing provider has been suspended from Medicaid. The beneficiary may purchase the service if he understands why the service is not covered by Medicaid and agrees, in writing, to pay for the service**.**

Notice of a provider's sanction is issued in Medicaid Bulletins. In order to ensure providers receive timely notification regarding sanctioned providers, a notifying bulletin, including a cumulative list of sanctioned providers, is printed twice a year. Other qualifying bulletins showing additions and deletions to the sanctioned provider list are issued on a monthly basis. A copy of the cumulative list is also available on the MDCH website at the address noted in the Directory Appendix.

Providers should check each name on the list closely to avoid accepting orders/prescriptions for Medicaid beneficiaries from these sanctioned providers. The list is also distributed to providers and to the Department of Human Services (DHS) county offices each time a provider is sanctioned as a result of Medicaid initiating the sanction.

The Bulletin also includes providers who have been sanctioned by other programs (e.g., Medicare). If the source has suspended, terminated, or excluded a provider from participation, that action remains applicable to Medicaid even if that provider has not been included on Medicaid's list of sanctioned providers. Any payments that may be unintentionally made to a provider acting on an order/prescription from a sanctioned provider for dates of service on or after the dates indicated on the list must be refunded to Medicaid.

6.2 NONENROLLED MICHIGAN AND BORDERLAND PROVIDERS

Medicaid pays nonenrolled Michigan and nonenrolled borderland providers for emergency services and for the first claim for nonemergency services that were provided in compliance with Michigan Medicaid coverage policies.

All nonenrolled Michigan and borderland providers rendering services to Michigan Medicaid beneficiaries must have a signed DCH-1625, Medical Assistance Provider Enrollment & Trading Partner Agreement on file with the MDCH in order to receive reimbursement. Providers that choose not to enroll as a Michigan Medicaid provider may enter into a "trading partner only" arrangement with the MDCH by including that statement on the DCH-1625. If selecting this option, providers must contact MDCH Provider Inquiry for billing instructions. (Refer to the Directory Appendix for contact information.) Claims submitted through Provider Inquiry will experience significant delays in processing. Providers should contact the MDCH Provider Enrollment Unit to obtain a copy of the DCH-1625. (Refer to the Directory Appendix for contact information.)

When a nonenrolled Michigan and borderland provider submits a claim for nonemergency services, Provider Inquiry will process the claim and sends a letter to the provider with an enrollment application inviting him to enroll in Medicaid. If the provider elects not to enroll in Medicaid and submits another

claim(s) for nonemergency services for payment, Provider Inquiry returns the claim(s) with another application for enrollment. This second invitation to enroll states that if the provider chooses not to enroll, the claim(s) will not be paid. The provider and the beneficiary must then make their own payment arrangements for the service(s).

6.3 Beyond Borderland Area

Reimbursement for services rendered to beneficiaries is normally limited to Medicaid-enrolled providers. MDCH reimburses providers who are beyond the borderland area if the service meets one of the following criteria:

- Emergency services as defined by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the Balanced Budget Act of 1997 and its regulations; or
- Medicare has paid a portion of the service and the provider is billing MDCH for the coinsurance and/or deductible amounts; or
- The service is prior authorized by MDCH.

Providers must be licensed and/or certified by the appropriate standard-setting authority.

All providers rendering services to Michigan Medicaid beneficiaries must have a signed DCH-1625 (Medical Assistance Provider Enrollment & Trading Partner Agreement) on file with the MDCH in order to receive reimbursement. Out of state providers should contact the MDCH Provider Enrollment Unit to obtain a copy of the DCH-1625. (Refer to the Directory Appendix for contact information.)

Out of state providers enrolled with the Michigan Medicaid program may submit their claims directly to the MDCH billing system. Providers should refer to the appropriate Billing and Reimbursement chapter of this manual for billing instructions.

Providers that choose not to enroll as a Michigan Medicaid provider may enter into a "trading partner only" arrangement with the MDCH by including that statement on the DCH-1625. If selecting this option, providers must contact MDCH Provider Inquiry for billing instructions. (Refer to the Directory Appendix for contact information.) Claims submitted through Provider Inquiry will experience significant delays in processing.

Nonenrolled providers have a responsibility to follow Michigan Medicaid policies, including obtaining PA for those services that require PA by enrolled Michigan providers.

All nonemergency services rendered by providers require the referring physician to obtain written PA from MDCH as indicated in the Prior Authorization Section of this chapter.

When a Michigan provider has referred a Medicaid beneficiary to a provider beyond the borderland area, the referring provider should instruct the provider to contact the Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

Borderland is defined as a county that is contiguous to the Michigan border. It also includes the five major cities beyond the contiguous county lines. The borderland area includes:

Indiana	Fort Wayne (city); Elkhart, LaGrange, LaPorte, St. Joseph, and Steuben (counties)
Ohio	Fulton, Lucas, and Williams (counties)
Wisconsin	Ashland, Green Bay, and Rhinelander (cities); Florence, Iron, Marinette, Forest, and Vilas (counties)
Minnesota	Duluth (city)

SECTION 7 - DELIVERY OF SERVICES

7.1 FREE CHOICE

Beneficiaries are assured free choice in selecting an enrolled licensed/certified provider to render services, unless they are patients in a state-owned and-operated psychiatric facility or enrolled in a Medicaid Health Plan (MHP) or County Health Plan (CHP) (including PLUS CARE).

7.2 RENDERING SERVICES

Enrollment in Medicaid does not legally require a provider to render services to every Medicaid beneficiary seeking care, except as noted below. Providers may accept Medicaid beneficiaries on a selective basis. However, a Medicare participating provider must accept assignment for Medicare and Medicaid dual eligibles.

Hospitals must provide emergency services as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42USC 1395dd.

If a Medicaid-only beneficiary is told and understands that a provider is not accepting them as a Medicaid patient and asks to be private pay, the provider may charge the patient for services rendered. The beneficiary must be advised prior to services being rendered that their **mihealth** card is not accepted and that they are responsible for payment.

All such services rendered must be in compliance with the provider enrollment agreement; contracts (when appropriate); Medicaid policies; and applicable county, state, and federal laws and regulations governing the delivery of health care services. (Refer to the Billing Beneficiaries Section of this chapter for more information.)

7.3 NONCOVERED SERVICES

When the beneficiary needs a medical service recognized under State Law, but not covered by Medicaid, the service provider and the beneficiary must make their own payment arrangements for that noncovered service. The beneficiary must be informed, prior to rendering of service, that Medicaid does not cover the service. A Medicaid beneficiary in a nursing facility can use his patient-pay funds to purchase noncovered services subject to MDCH verification of medical necessity and the provider's usual and customary charge. (Refer to the Nursing Facility Chapter for additional information.)

7.4 NONDISCRIMINATION

Providers must render covered services to a beneficiary in the same scope, quality, and manner as provided to the general public. Within the limits of Medicaid, providers shall not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political beliefs, or source of payment.

7.5 Service Acceptability

MDCH may determine that a provider did not render services within the scope of currently accepted medical/dental practice or the service was not provided within Medicaid limitations. In such cases, MDCH reviews the situation and may:

- Refuse to reimburse for the service.
- Require the provider to repeat or correct the service at no additional charge to Medicaid or the beneficiary (e.g., an inaccurate vision prescription was written).
- Recover any monies paid to the provider for the service.
- Require the service to be done immediately (e.g., provide services to complete an incomplete examination or treatment).

Failure to comply with any of the last three items may result in the provider's disenrollment from Medicaid.

SECTION 8 - PRIOR AUTHORIZATION

8.1 GENERAL INFORMATION

There may be occasions when a beneficiary requires services beyond those ordinarily covered by Medicaid or needs a service that requires prior authorization (PA). In order for Medicaid to reimburse the provider in this situation, MDCH requires that the provider obtain authorization for these services before the service is rendered. Providers should refer to their provider-specific chapter for PA requirements. (Refer to the Directory Appendix for contact information for PA.)

Requests for PA may be submitted in writing, or electronically (utilizing the ANSI X12N 278 version 4010A1 Health Care Services Review/Request transaction) if the provider is an MDCH-approved EDI submitter. Providers wishing to submit a 278 transaction should refer to the Electronic Submission Manual and the MDCH Companion Guide for the HIPAA 278 Health Care Services Review/Request transaction for further information. Both documents are available on the MDCH website. (Refer to the Directory Appendix for website information.)

PA requirements for MHP enrollees may differ from those described in this manual. Providers should contact the individual plans regarding their authorization requirements.

PA may not be required if the beneficiary has Medicare or other insurance coverage. (Refer to the Coordination of Benefits Chapter for additional information.)

8.2 PROCESSING REQUESTS

Based on documentation submitted, the PA request is approved, disapproved, or returned for more information. Results of the request are returned to the provider via a letter or a copy of the PA form, whichever is applicable. Providers must immediately notify the beneficiary of the approval or denial of the PA request.

Approval of a PA request does not verify beneficiary eligibility. It is the provider's responsibility to verify the beneficiary's eligibility for the date a service is actually rendered.

8.2.A. VERBAL PRIOR AUTHORIZATION

If a service requires PA but the situation requires immediate action to diagnose or correct a medical condition or avoid further damage, the provider may request PA by calling the MDCH Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

If the service is required at a time when MDCH cannot be contacted, the provider may perform the service and call MDCH by the end of the next working day.

After verbal authorization is obtained, the provider must submit a written PA request (with supporting documentation) to MDCH. If the supporting documentation matches the information relayed for verbal authorization, MDCH sends an approval to the provider.

8.2.B. Approval

Payment is made only for services provided during the period of time the PA is valid and the beneficiary is eligible for Medicaid. Providers should carefully review the approval as it is for specific services and may be for only a specific period of time.

The prior authorized service must be the service that is rendered and billed. If there are changes in the plan of treatment or if the approved service does not accurately reflect the service to be provided, the Prior Authorization Division should be contacted prior to rendering the service.

If a beneficiary elects to accept a service other than the service that was authorized, and that service also requires PA which was not obtained or is not covered by Medicaid, the beneficiary is responsible for payment of the entire service. In this situation, the provider must notify the beneficiary prior to rendering the service that Medicaid does not cover the service and the beneficiary is financially responsible for the entire service. It is suggested the beneficiary acknowledge this responsibility in writing.

8.2.C. Denial

If PA for the service is denied, it must not be billed to Medicaid. The beneficiary will be sent a copy of the denial with an explanation of his appeal rights. Once notified of the denial, the beneficiary may still wish to receive the service. The provider must reiterate to the beneficiary prior to rendering the service that Medicaid does not cover the service and the beneficiary is financially responsible for the entire service. It is suggested the beneficiary acknowledge this responsibility in writing.

8.2.D. Reimbursement

For most providers, procedure codes that do not have an MDCH established fee screen, or need special pricing, require documentation to be sent with the claim. For some types of services, the special pricing review is completed through the PA process. If a PA is returned with an approved fee, no documentation is required with the claim. If the PA is returned without an approved fee and instructions to bill under a not otherwise classified (NOC) code, documentation must be submitted with the claim.

Medicaid does not provide reimbursement if:

- The beneficiary was not eligible for Medicaid on the DOS. Reimbursement is denied on this basis even if the service has been prior authorized. **Exception:** For customized equipment and devices, the beneficiary must be eligible for Medicaid on the date the item/service was ordered to be eligible for reimbursement.
- A service that is prior authorized is rendered in conjunction with a service that is not a separately reimbursable service and is not a Medicaid benefit.
- A service that is prior authorized and rendered in conjunction with another service that requires PA, and PA for the second service was not obtained.
- PA was required but was not obtained.

- The beneficiary has other insurance and the rules for coverage for other insurance were not followed.
- It was determined that PA was obtained after the service was rendered. (The provider should refer to the Verbal Prior Authorization subsection above for an exception to this situation.)
- The service/product was ordered or prescribed by a provider who has been sanctioned from Medicaid, and the sanction was effective before PA was granted.

Providers cannot charge the beneficiary or beneficiary's representative for the provider's failure to obtain PA. If the provider failed to obtain PA for a service and the service was rendered, he cannot apply his fee for that service in calculating other reimbursement due to him from Medicaid.

8.3 Prior Authorization (Medicaid Health Plans Only)

Medicaid Health Plans (MHPs) are responsible for authorizing all Medicaid-covered services in the Comprehensive Health Care Program (CHCP) benefit package for enrolled Medicaid beneficiaries, with certain exceptions such as emergency services. Providers must contact the MHPs before rendering services to MHP enrollees to obtain PA. Each MHP is responsible for establishing procedures for PA.

8.4 Custom-Made Medical Equipment, Devices and Medical Supplies

Medicaid is responsible for payment of custom equipment or devices, hearing aids, eyeglasses, dentures, prosthetics and orthotics authorized and ordered before the last date of Medicaid eligibility and delivered within 30 days after loss of eligibility. This policy also applies to enrollment changes that signify a change in payment responsibility similar to the loss of eligibility.

Medicaid or the MHP that authorizes and orders the equipment or item is responsible for paying for the item even though it is delivered after the beneficiary loses eligibility or has an enrollment change (fee-for-service [FFS] to MHP, MHP to FFS or MHP to MHP). The order must be placed before the change in enrollment status, and the service should be delivered within 30 days after the change in enrollment status.

If a provider determines that a beneficiary needs a durable medical equipment (DME) item that is authorized by either MDCH or the current MHP and is ordered before a change in enrollment status, the party that authorized the service is responsible for payment.

If a custom-made item, medical device, or equipment (e.g., prosthetic limb, custom-made medical equipment such as a brace, custom motorized wheelchair, orthotics) is ordered for a beneficiary during a hospital stay but is not delivered until after discharge and enrollment status changes, payment must be made by the party responsible for the hospital stay.

This policy does not apply to mass-produced, readily available items that can be used by a person other than for whom it was ordered. It also excludes all rental items, all expendable/disposable medical supply items (e.g., diapers, dressings, ostomy supplies, IV infusion supplies) or any item that does not require a length of time (days or weeks) to special order for a specific person.

SECTION 9 - BILLING BENEFICIARIES

Providers cannot bill beneficiaries for services except in the following situations:

- A co-payment for chiropractic, dental, hearing aid, pharmacy, podiatric, or vision services is required. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required co-payment on the date of service.
- A monthly patient-pay amount for inpatient hospital or nursing facility services. The local DHS determines the patient-pay amount. Noncovered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Refer to the Nursing Facility Chapter for additional information.)
- For nursing facility (NF), state-owned and -operated facilities or CMHSP-operated facilities determine a financial liability or ability-to-pay amount separate from the DHS patient-pay amount. The state-owned and -operated facilities or CMHSP-operated facilities liability may be an individual, spouse, or parental responsibility. This responsibility is determined at initiation of services and is reviewed periodically. The beneficiary or his authorized representative is responsible for the state-owned and -operated facilities or CMHSP ability to pay amount, even if the patient-pay amount is greater.
- The provider has been notified by DHS that the beneficiary has an obligation to pay for part of, or all of, a service because services were applied to the beneficiary's Medicaid deductible amount.
- If the beneficiary is enrolled in a MHP and the health plan did not authorize a service, and the beneficiary had prior knowledge that he was liable for the service. (It is the provider's responsibility to determine eligibility/enrollment status of each beneficiary at the time of treatment and to obtain the appropriate authorization for payment. Failure of the provider to obtain authorization does not create a payment liability for the beneficiary.)
- Medicaid does not cover the service. If the beneficiary requests a service not covered by Medicaid, the provider may charge the beneficiary for the service if the beneficiary has been told prior to rendering the service that it was not covered by Medicaid. If the beneficiary is not informed of Medicaid noncoverage until after the services have been rendered, the provider cannot bill the beneficiary.
- The beneficiary refuses Medicare Part A or B.
- Beneficiaries may be billed the amount other insurance paid to the policyholder if the beneficiary is the policyholder.
- The beneficiary is the policyholder of the other insurance and the beneficiary did not follow the rules of the other insurance (e.g., utilizing network providers).
- The provider chooses not to accept the beneficiary as a Medicaid beneficiary and the beneficiary had prior knowledge of the situation. The beneficiary is responsible for payment.

It is recommended that providers obtain the beneficiary's written acknowledgement of payment responsibility prior to rendering any nonauthorized or noncovered service the beneficiary elects to receive.

Some services are rendered over a period of time (e.g., maternity care). Since Medicaid does not normally cover services when a beneficiary is not eligible for Medicaid, the provider is encouraged to advise the beneficiary prior to the onset of services that the beneficiary is responsible for any services rendered during any periods of ineligibility. Exceptions to this policy are services/equipment (e.g., root canal therapy, dentures, customized seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific chapters of this manual for additional information regarding exceptions.)

When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for:

- Medicaid-covered services. Providers must inform the beneficiary before the service is provided if Medicaid does not cover the service.
- Medicaid-covered services for which the provider has been denied payment because of improper billing, failure to obtain PA, or the claim is over one year old and has never been billed to Medicaid, etc.
- The difference between the provider's charge and the Medicaid payment for a service.
- Missed appointments.
- Copying of medical records for the purpose of supplying them to another health care provider.

If a provider is not enrolled in Medicaid, they do not have to follow Medicaid guidelines about reimbursement, even if the beneficiary has Medicare as primary.

If a Medicaid-only beneficiary understands that a provider is not accepting him as a Medicaid patient and asks to be private pay, the provider may charge the beneficiary its usual and customary charges for services rendered. The beneficiary must be advised prior to services being rendered that his mihealth card is not accepted and that he is responsible for payment. It is recommended that the provider obtain the beneficiary's acknowledgement of payment responsibility in writing for the specific services to be provided.

SECTION 10 - BILLING REQUIREMENTS

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the manual.

10.1 BILLING PROVIDER

Providers must not bill MDCH for services that have not been completed at the time of the billing.

The provider who renders the service must bill for the service on the appropriate claim form using his own provider ID number for the location where the service was actually rendered.

Providers rendering services to the residents of the ICF/MR facility (Mt. Pleasant Regional Center) may not bill Medicaid directly. All covered services (e.g., laboratory, x-rays, medical surgical supplies including incontinent supplies, hospital emergency rooms, clinics, optometrists, dentists, physicians, and pharmacy) are included in the per diem rate.

10.2 CHARGES

Providers cannot charge Medicaid a higher rate for a service rendered to a beneficiary than the lowest charge that would be made to others for the same or similar service. This includes advertised discounts, special promotions, or other programs to initiate reduced prices made available to the general public or a similar portion of the population. In cases where a beneficiary has private insurance and the provider is participating with the other insurance, refer to the Coordination of Benefits Chapter of this manual for additional information.

10.3 BILLING LIMITATION

Each claim received by MDCH receives a unique identifier called a Claim Reference Number (CRN). This is a ten-digit number found in the Remittance Advice (RA) that indicates the date the claim was entered into the MDCH Claims Processing (CP) System. The CRN is used when determining active review of a claim. (Refer to the Billing & Reimbursement Chapters for additional information.)

A claim must be initially received and acknowledged (i.e., assigned a CRN) by MDCH within twelve months from the date of service (DOS).* DOS has several meanings:

- For inpatient hospitals, nursing facilities, and MHPs, it is the "From" or "Through" date indicated on the claim.
- For all other providers, it is the date the service was actually rendered or delivered.

Claims over one year old must have continuous active review to be considered for Medicaid reimbursement. Claim replacement can be resubmitted within 12 months of the latest RA date or other activity.

* Initial pharmacy claims (provider type 50) must be received within 180 days.

Active review means the claim was received and acknowledged by MDCH within twelve months from the DOS. In addition, claims with DOS over one year old must be billed within 120 days from the date of the last rejection. For most claims, MDCH reviews the claims history file for verification of active review.

Only the following types of claims require documentation of previous activity in the Remarks section of the claim:

- Claim replacements;
- Claims previously billed under a different provider ID number;
- Claims previously billed under a different beneficiary ID number; and
- Claims previously billed using a different DOS "statement covers period" for nursing facilities and inpatient hospitals.

There are occasions when providers are not able to bill within the established time frames (e.g., awaiting notification of retroactive beneficiary eligibility). In these situations, the provider should submit a claim to Medicaid, knowing the claim will be rejected. This gives the provider a CRN to document continuous active review.

Exceptions may be made to the billing limitation policy in the following circumstances.

- Department administrative error occurred, including:
  - The provider received erroneous written instructions from MDCH staff;
  - MDCH staff failed to enter (or entered erroneous) authorization, level of care, or restriction in the system;
  - MDCH contractor issued an erroneous PA; and
  - Other administrative errors by MDCH or its contractors that can be documented.

  Retroactive provider enrollment is not considered an exception to the billing limitation.
- Medicaid beneficiary eligibility/authorization was established retroactively:
  - Beneficiary eligibility/authorization was established more than twelve months after the DOS; and
  - The provider submitted the initial invoice within twelve months of the establishment of beneficiary eligibility/authorization.
- Judicial Action/Mandate: A court or MDCH administrative law judge ordered payment of the claim.
- Medicare processing was delayed: The claim was submitted to Medicare within 120 days of the DOS and Medicare submitted the claim to Medicaid within 120 days of the subsequent resolution. (Refer to the Coordination of Benefits Chapter in this manual for further information.)

Providers who have claims meeting either of the first two exception criteria must contact their local DHS office to initiate the following exception process:

- The DHS caseworker completes and submits the Request for Exception to the Twelve-Month Billing Limitation for Medical Services form (MSA-1038) to MDCH.
- DHS informs the provider when the MSA-1038 has been approved by MDCH.
- Once informed of the approval, the provider prepares claims related to the exception, indicating "MSA-1038 approval on file" in the comment section.
- The provider submits claims to MDCH through the normal submission process.

Refer to the Billing & Reimbursement chapters of this manual for additional information on claim submission. Questions regarding claims submitted under this exception should be directed to MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

10.4 Professional Corporation

For services involving multiple visits billed with a single procedure code (e.g., surgery and pre- and post-operative care, prenatal care) or initial or new services, the code/service may be billed only once by a professional corporation. Other members of the corporation may not bill separately any procedures related to the service. This policy includes services rendered in a partnership, employer-employee, or contractor relationships.

10.5 Invoice Completion Fee

A fee for completing the Medicaid claim cannot be charged to Medicaid, the beneficiary, or the beneficiary's representative.

10.6 Claim Documentation

In some cases, MDCH may require specific information with the claim (e.g., indication of medical necessity). Providers should refer to the provider-specific and Billing & Reimbursement Chapters of this manual for the information that may be needed on the claim.

A claim without the requested information may be reviewed:

- Prior to payment. (The claim may be rejected for missing, incorrect or insufficient information.)
- Subsequent to payment. (A post-payment audit/review may indicate that the information was insufficient or missing and a gross adjustment would be initiated to recover the payment.)

10.7 Claim Certification

Providers certify by signature that a claim is true, accurate, and contains no false or erroneous information. The provider's signature or that of the provider's authorized representative may be handwritten, typed, or rubber-stamped on a paper claim.

When a provider's warrant is endorsed or deposited, it is certification that the services billed were actually provided. It further certifies that the claims (paper or electronic) paid by the warrant accurately document that the health care services provided were within the limitation of Medicaid (or compliance

with a contract). The warrant's certification applies to original claims as well as resubmitted claims and claim adjustments.

This does not apply to state-owned and -operated facilities, as they do not receive a warrant.

Providers are held responsible for any errors, omissions, or resulting liabilities that may arise from any claim for medical services submitted to MDCH under the provider's name or ID number. Contractual arrangements (verbal or written) with employers, employees, contractors, etc. do not release the provider of the responsibility for services billed or signed under the provider's ID Number.

Providers are responsible for the supervision of a subordinate, officer, employee, or contracted billing agent who prepares or submits the provider's claims.

10.8 Billing Agents

A billing agent who submits Medicaid claims via electronic media must be authorized by MDCH before submitting claims. The provider must then authorize the billing agent to submit his claims. The authorization for submitting claims via electronic media must be submitted even if the provider is acting as his own billing agent. The provider must submit a completed Medicaid Billing Agent Authorization (DCH-1343) to the MDCH Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

After processing the DCH-1343, the Provider Enrollment Unit mails a confirmation letter, along with the DCH Provider Confirmation Form, to the provider. The provider must then notify the billing agent that he may begin submitting claims on the provider's behalf.

MDCH notifies providers of changes by means of bulletins and letters. If the provider has a contract with a billing service, it is the provider's responsibility to notify the billing service of any changes that may affect claims submitted on his behalf. Providers are responsible for the claims submitted by the billing agent, including improper billings, duplicate payments, etc.

In the case of a billing agent who submits electronic claims, DCH-1343 represents the provider's signature. For the billing agent who submits paper claims, the billing agent's name should appear in the certification area of the claim. If the provider wishes to have his name appear in the certification area as well, it should precede the billing agent's name.

The MDCH Electronic Submission Manual contains additional detailed information. (Refer to the Directory Appendix for website information.)

SECTION 11 - THIRD PARTY LIABILITY

Federal regulations require that all identifiable financial resources available for payment, including Medicare, be billed prior to billing Medicaid. (Refer to the Coordination of Benefits Chapter of this manual for additional information.)

Medicaid does not reimburse for services provided to individuals being held in a detention facility against their will except for those directly related to an inpatient hospital stay (medical/surgical/psychiatric) provided in a nonstate owned facility. All other services must be billed to the detention facility. The Eligibility Verification System (EVS) shows Level of Care 32 for these individuals.

SECTION 12 - REIMBURSEMENT

12.1 PAYMENT IN FULL

Providers must accept Medicaid's payment as payment in full for services rendered, except when authorized by Medicaid (e.g., co-payments, patient-pay amounts, other cost sharing arrangements authorized by the State). Providers must not seek nor accept additional or supplemental payment from the beneficiary, the family, or representative in addition to the amount paid by Medicaid, even when a beneficiary has signed an agreement to do so. This policy also applies to payments made by MHPs, CHPs, and PIHPs/CMHSPs/CAs for their Medicaid enrollees.

Contractors or nursing facility (including ICF/MR) operators must not seek nor accept additional or supplemental payment beyond the patient-pay or MDCH ability-to-pay amount.

12.2 PRE- AND POST-PAYMENT REVIEW / AUDIT

Providers are subject to pre- and post-payment review/audit or an adjustment to the reimbursement rate.

- In pre-payment review, MDCH may deny reimbursement for a service until it is satisfied the service meets Medicaid guidelines.
- In post-payment review/audit, MDCH may initiate an adjustment to obtain monies paid for services that do not comply with Medicaid coverage, billing and/or reimbursement policies or that suspends or disenrolls the provider from Medicaid.

12.3 EMERGENCY SERVICES (MHPS ONLY)

Emergency services to the point of stabilization (as required to be provided under the Emergency Medical Treatment and Active Labor Act [EMTALA]), provided to a MHP enrollee inside or outside the MHP's service area, must be reimbursed by the MHP to the provider of services.

12.4 FACTORING

Factoring of Medicaid accounts by any provider is prohibited. A factor is defined in federal regulations as "an organization, that is, a collection agency or service bureau which advances money to a provider for his accounts receivable which have been assigned or sold, or otherwise transferred to this organization for an added fee or a deduction of the accounts receivable." Power of attorney arrangements, under which a check is payable to the provider but can be cashed by a factor, are prohibited. However, payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order.

Factor does not include a business representative, such as a billing agent or an accounting firm, which renders statements and receives payments in the name of the individual provider as long as the business representative's compensation for this service is:

- Reasonably related to the cost of processing the claim;
- Not related, in any way, to the dollar amount to be billed or collected; and
- Not dependent upon the actual collection of payment.

This policy is not applicable to State-owned and -operated facilities.

SECTION 13 – RECORD KEEPING

13.1 RECORD RETENTION

Providers must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries. Necessary records include fiscal and clinical records as discussed below. Appointment books and any logs are also considered a necessary record if the provider renders a service that is time-specific according to the procedure code billed. Examples of services that are time-specific are psychological testing (per hour), medical psychotherapy (20-30 minutes), and vision orthoptic treatment (30 minutes). The records are to be retained for a period of not less than six years from the DOS, regardless of change in ownership or termination of participation in Medicaid for any reason. This requirement is also extended to any subcontracted provider with which the provider has a business relationship.

13.2 PROVIDER'S ORDERS

Providers rendering or arranging services upon the written order of another provider (e.g., physician) must maintain that order for a period of six years.

13.3 BENEFICIARY IDENTIFICATION INFORMATION

Providers must retain the following beneficiary identification information in their records:

- Name
- Medicaid ID number
- Medical record number
- Address, including zip code
- Birth date
- Telephone number, if available
- Any private health insurance information for the beneficiary, if available

13.4 AVAILABILITY OF RECORDS

Providers are required to permit MDCH personnel, or authorized agents, access to all information concerning any services that may be covered by Medicaid. This access does not require an authorization from the beneficiary as it is considered part of the treatment, payment and operations processes that do not require authorization under the HIPAA Privacy rule. Health plans contracting with the MDCH must be permitted access to all information relating to services reimbursed by the health plan.

Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying any record that must be maintained. (Failure to make requested copies available may result in the provider's suspension from Medicaid.) Records (exclusive of billings or charges) may only be released to other individuals if they have a release signed by the beneficiary authorizing access to his records.

If the beneficiary or his representative requests charges, payments, or copies of claims billed to or paid by Medicaid, the beneficiary's request (including Medicaid ID number) should be directed to the MDCH Third Party Liability (TPL) Section. (Refer to the Directory Appendix for contact information.)

13.5 Confidentiality

MDCH complies with HIPAA Privacy requirements and recognizes the concern for the confidential relationship between the provider and the beneficiary and protects this relationship using records and information only for purposes directly related to the administration of Medicaid.

All records are of a confidential nature and should not be released, other than to a beneficiary or his representative, unless the provider has a signed release from the beneficiary. Providers are bound to all HIPAA privacy and security requirements as federally mandated.

If the provider receives a court order or a subpoena for medical bills, the bills should be released. At the same time, copies of the court order or subpoena, released bills, and any additional information should be sent to the MDCH TPL Section. (Refer to the Directory Appendix for contact information.)

If there is a reason to suspect a duplicate payment has been or will be made, but the payment is not assigned, the provider should contact the TPL Section. TPL will make the necessary arrangements to collect the duplicate payment from the third-party source.

If the provider questions the appropriateness of releasing beneficiary records, he is encouraged to seek legal counsel before doing so.

13.6 Fiscal Records

The following fiscal records must be maintained:

- Copies of Remittance Advices (RA);
- PA requests and approvals for services and supplies (including managed care authorizations);
- Verification of medical necessity and the provider's usual and customary charge for the noncovered service;
- Record of third-party payments; and
- Copies of purchase invoices for items offered or supplied to the beneficiary.

13.7 Clinical Records

The following table contains general guidelines for clinical documentation that must be maintained by all providers except nursing facilities. Clinical records other than those listed may also be needed to clearly document all information pertinent to services that are rendered to beneficiaries. All providers must refer to their specific coverage policy in this manual for additional documentation requirements. The clinical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed. All documentation for services provided must be signed and dated by the rendering health care professional.

For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin time and end time of the particular service. For example, some Physical Medicine procedure codes specify per 15 minutes. If the procedure started at 3:00 p.m. and ended at 3:15 p.m., the begin time and end time must be recorded in the medical record.

The medical record must indicate the specific findings or results of diagnostic or therapeutic procedures. If an abbreviation, symbol, or other mark is used, it must be standard, widely accepted health care terminology. Symbols, marks, etc. unique to that provider must not be used.

Examples**:**

- When a test is performed, at a minimum, the test value for that beneficiary for that test must be noted. Additionally, the normal range of values for the testing methodology should be annotated in the record.
- When an x-ray is taken, the results or findings must be indicated. For example, a chest x-ray may indicate "no pulmonary edema present" or "no consolidation."
- When a physical examination is performed, pertinent results or readings must appear.
- If blood pressure is taken, the actual reading must appear.
- If heart, lungs, eyes, etc. are checked, the results or findings must be detailed.
- Medical/surgical procedures performed must be sufficiently documented to allow another professional to reconstruct what transpired (e.g., "I-D" is not sufficient documentation).
- When a complete physical exam is rendered, the level of service must be fully documented.
- If private duty nursing is provided, the care provided during each hour must be fully detailed.

Hospitals must retain any clinical information required to comply with 42 CFR 482.24. A nursing facility must retain any clinical information required to comply with 42 CFR 483.75(n) and the plan of care must comply with 42 CFR 483.20(d). These regulations are available from MDCH or Centers for Medicare and Medicaid Services (CMS). (Hospitals and nursing facilities should refer to the Reimbursement Appendix of their chapters in this manual for additional record keeping requirements.)

Clinical Documentation Requirements

	Ambulance	CMHSP	Dentist	Family Planning	Hearing Aid Dealer	Hearing/Speech Center	Home Health	Hospice	Hospital	Lab	Medical Supplier	MI Choice	MIHP	Pharmacy	Practitioner *	Private Duty Nursing Agency/RN & LPN	School Based Services	Vision
Date of Each Visit	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖
Begin Time & End Time if Service is Time-Specific According to Procedure/Revenue Code Billed	✖	✖	✖			✖	✖	✖	✖	✖		✖			✖	✖	✖	
Presenting Symptom, Condition	✖	✖	✖	✖	✖	✖	✖	✖	✖			✖	✖		✖	✖	✖	
Diagnosis	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖
Patient Histories, Plans of Care, Progress Notes, Consultation Reports	✖	✖	✖	✖		✖	✖	✖	✖		✖	✖	✖		✖	✖	✖	
Result of Exams		✖	✖	✖		✖		✖	✖						✖		✖	
Records of Medications, Drugs, Assistive Devices or Appliances, Therapies, Tests, and Treatments that are Prescribed, Ordered, or Rendered	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖		✖	✖	✖	✖	
Physical Assessments and/or nursing activities that pertain to care provided & support the services rendered and billed	✖	✖	✖	✖			✖	✖	✖			✖	✖		✖	✖	✖	
Orders for Tests & Test Results		✖	✖	✖	✖	✖	✖	✖	✖	✖		✖		✖	✖	✖	✖	
Pictorial Records or Graphs & Written Interpretations of Tests	✖	✖	✖	✖		✖			✖	✖					✖		✖	
Identification of Specimen, Type & Source				✖			✖		✖	✖		✖			✖	✖		
Test Methodology		✖	✖	✖					✖	✖					✖			✖

	Ambulance	CMHSP	Dentist	Family Planning	Hearing Aid Dealer	Hearing/Speech Center	Home Health	Hospice	Hospital	Lab	Medical Supplier	MI Choice	MIHP	Pharmacy	Practitioner *	Private Duty Nursing Agency/RN & LPN	School Based Services	Vision
Name, Strength, Dosage, Quantity & Route of Drug, and Time Administered	✖	✖	✖	✖			✖	✖	✖			✖		✖	✖	✖	✖	
Ambulance Requestor's Name, Origination/ Terminating Location, Level & Type of Service	✖								✖						✖		✖	
Prescribing/Referring Physician		✖	✖	✖		✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖
Transportation Information other than Ambulance		✖							✖				✖				✖	

***** Includes MD, DO, DPM, DC, OD, Certified Nurse Midwife, Certified Nurse Anesthetist, Nurse Practitioner, Physical Therapist, Oral Surgeon, Medical Clinics (e.g., FQHCs, Public Health Clinics).

SECTION 14 – POST-PAYMENT REVIEW AND FRAUD / ABUSE

All Medicaid-reimbursed services are subject to review for conformity with accepted medical practice and Medicaid coverage and limitations. Post-payment reviews of paid claims may be conducted to assure that the services, as well as the rendering provider and setting, were appropriate, necessary, and comply with Medicaid policy. Post-payment review also verifies that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities, etc.), and that third party resources were utilized to the fullest extent available.

14.1 MDCH PROGRAM INVESTIGATION SECTION

The Program Investigation Section, as a federal mandate (42 CFR 455.14), is responsible for investigating all suspected Medicaid provider (FFS or managed care) fraud and/or abuse. To report suspected fraudulent activities to MDCH, contact the Program Investigation Section. (Refer to the Directory Appendix for contact information.) Suspected fraud and/or abuse is referred by the Program Investigation Section to the Michigan Department of the Attorney General, Medicaid Fraud Control Unit.

14.2 STATE LAW

The Michigan Department of Attorney General uses the following State laws for investigating provider fraud and abuse:

- Medicaid False Claim Act (MCLA 400.601 et. seq.) An individual, whether a provider, an employee, or an accomplice, convicted of such an activity is subject to a fine of up to $50,000 and a prison sentence of four to ten years for each count, as well as full restitution to Medicaid of all funds fraudulently obtained. The provider may be suspended from participating in Medicaid for a period of time and, in some instances, his license to practice his profession may be suspended or revoked.

  Examples of Medicaid fraud are:

  - Billing for Services Not Rendered: A provider bills Medicaid for a treatment or procedure that was not actually performed (e.g., laboratory tests or x-rays that were not taken, full dentures were prior authorized and billed for when a partial denture was actually supplied).
  - Billing Without Reporting Other Resources: A provider bills Medicaid the full charge for a service without reporting the amount billed and received from another source (e.g., a private insurance company) or charging the patient for the service or a co-pay for a covered benefit.
  - Billing for a Brand Name Drug Not Dispensed: A pharmacy bills Medicaid for a brand name drug when a generic substitute (at a lower cost) was actually dispensed to the beneficiary.
  - Billing for Unnecessary Services: A provider misrepresents the diagnosis and symptoms on a beneficiary's record in order to provide and bill for unnecessary tests and procedures.

- Billing a DOS Other Than the Actual Date the Service was Rendered: A provider indicates a DOS other than the actual DOS that was during a time of beneficiary ineligibility or service noncoverage.
- Receiving Kickbacks: An ancillary provider (e.g., physical therapist, laboratory, pharmacy) may agree to pay a physician, nursing facility, or hospital administrator or owner a portion of his Medicaid reimbursement for services rendered to the physician's patient or a beneficiary residing in the facility. Payments to a physician or facility administrator or owner may be a cash payment, a vacation trip, a leased vehicle, inflated rental for space, etc. Often a kickback arrangement results in unnecessary tests or services being provided to the beneficiary in order to generate additional reimbursement.
- Fraudulent Cost Reports: A nursing facility or hospital including nonallowable costs or false information (e.g., understate patient census days) or including nonpatient care expenses (e.g., landscaping, interior design, or remodeling at the owner's or administrator's personal residence) in its cost report to justify a higher per diem or reimbursement rate from Medicaid.

- Social Welfare Act (MCLA 400.111d): A conviction may result in a denial, suspension, or termination of the provider's license or similar action from Medicaid.
- Public Health Code (MCLA 333.16226): A conviction may result in a fine or probation from Medicaid or the denial, suspension, or revocation of a provider's license.

MDCH encourages provider assistance in reducing and reporting provider fraud and abuse in Medicaid and violation of HIPAA Privacy regulations. Any provider or employee suspecting that a fraudulent activity is occurring should contact the Michigan Department of Attorney General. (Refer to the Directory Appendix for contact information.)

14.3 Federal Law

The Office of Inspector General of the United States Department of Health and Human Services (HHS) investigates provider fraud, abuse and violation of HIPAA Privacy and Security regulations under federal laws.

The following federal laws are primarily used:

- Social Security Act (Section 1909). A conviction resulting in a penalty of up to five years imprisonment and/or a $10,000 fine.
- Civil Monetary Penalties Law of 1981 (Section 1128A of the Social Security Act). A conviction may result in a civil monetary penalty of not more than $2,000 for each item or service, and an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the federal or state agency because of the fraudulent claim.

To report fraudulent activities to the federal investigators, contact the Office of Inspector General. Complaints regarding Michigan health facilities may be reported to the Michigan Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)

14.4 Patient Abuse

Under federal law, the Department of Attorney General, Health Care Fraud Division (Medicaid Fraud Control Unit) is mandated to investigate and prosecute instances of patient abuse occurring in any Michigan facility receiving Medicaid funds.

Examples of patient abuse are:

- Physical abuse, involving assaulting, striking, or sexually abusing a patient.
- Threat or perceived threat of physical or sexual abuse.
- Neglect resulting from inadequate medical or custodial care or other situations that create health risks to the patient.
- Financial abuse, including misappropriation of patient's personal funds, co-mingling of patient and facility funds.
- Use of patient funds to pay for facility operations, or theft of patient's property.

The above examples are not all inclusive.

Complaints involving suspected abuse of patients within any Michigan facility receiving Medicaid funds should be reported to the Michigan Department of Attorney General's 24-hour toll-free hotline. Complaints may also be mailed to the Attorney General's Medicaid Fraud Unit. (Refer to the Directory Appendix for contact information.)

Pursuant to Section 111b of the Social Welfare Act of 1939 (PA 280, as amended, MCLA 400.111b[7]), a provider is required to make available, to authorized agents of the Department of Attorney General, any record required that must be maintained as a condition of participation in Medicaid.

The Michigan Department of Attorney General is also empowered to investigate and prosecute any complaint involving patient abuse by a provider that receives Medicaid funds. It does not matter whether or not the abused patient is receiving Medicaid benefits. (Patient abuse is defined as harm or threat of harm to a patient's health or welfare by a person responsible for the patient's health or welfare that occurs through nonaccidental physical or mental injury, sexual abuse, or maltreatment.)

14.5 Beneficiary Fraud / Abuse

A provider can contact the local DHS in the beneficiary's county of residence to report beneficiary fraud, or contact the Office of Inspector General's Recipient Fraud Unit Hotline. (Refer to the Directory Appendix for contact information.)

The provider can also report beneficiary over-utilization of services by contacting the local DHS worker or the Beneficiary Monitoring Program. (Refer to the Directory Appendix for contact information.)

SECTION 15 - PROVIDER APPEAL PROCESS

Any provider participating in, or applicant wishing to participate in, Medicaid has the right to appeal any adverse action taken by MDCH unless the adverse action resulted from an action that MDCH had no control over (e.g., Medicare termination, license revocation). The method of appeal depends upon the provider type. Most providers are informed of the steps to be taken to appeal the action via the notice of adverse action. (Hospital providers may appeal at the time of adverse action, prior to the notice.) Institutional providers should refer to their respective chapters of this manual for the appropriate steps and time frames for appeal.

Any questions regarding this appeal process should be directed to MDCH Administrative Tribunal and Appeals Division. (Refer to the Directory Appendix for contact information.)

SECTION 16 - REVIEW OF PROPOSED CHANGES

The following guidelines for the development of policies, procedures, forms, and instructions apply to the Medicaid, Children's Special Health Care Services, Adult Benefits Waiver, and other health insurance programs administered by MDCH.

MDCH consults with affected providers and other interested parties on those proposed changes in Medicaid policies, procedures, forms, and instructions which are determined significant enough to be communicated to providers by means of a provider bulletin. This consultation process involves a notification of the proposed change and the reasons for the change. MDCH includes the distribution of draft policy to those parties who have expressed interest in reviewing and commenting on the changes.

Affected provider means any enrolled provider or provider association/organization that is impacted by the proposed changes. Any affected provider or other interested party who would like an opportunity to comment on any proposed changes in his area of interest (e.g., podiatry, hospital, vision) may do so.

Visit the MDCH website to review draft policies or to request draft policies be sent to you for comment. You may also contact MDCH directly to request to participate in the policy promulgation process. (Refer to the Directory Appendix for contact information.)

Your request to receive draft policies must include:

- Provider's/Individual's name;
- Telephone number;
- Mailing address (and E-mail address, if requesting electronic distribution);
- Involvement with Medicaid (e.g., Medicaid provider, drug manufacturer, interested party);
- Association/organization represented (if applicable); and
- Specific area(s) of interest to review and comment on (e.g., physician, ambulance, hospital, Maternal Infant Health Program (MIHP), dental, nursing facilities).

Copies of draft bulletins are sent to interested parties via e-mail or US mail, and are posted on the MDCH website for a minimum of 30 days. Anyone wishing to comment on proposed changes may submit comments electronically, by fax or by US mail within the comment period.

Comments received are considered and suggestions may be incorporated in the final policy if determined appropriate. Upon completion of the consultation process, a provider bulletin serves as final notice of the change. A summary of the comments made, MDCH's response, and a copy of the final bulletin are sent to those who submitted comments. Proposed changes may have to be implemented before comments are considered if specific action is ordered by governmental entities having authority over MDCH with time frames that do not allow full compliance with the consultation process. In these cases, comments are requested from affected providers and are considered for incorporation after the implementation of the change.

MDCH consults with the Medical Care Advisory Council (composed of consumers, providers, and government officials) in the review of proposed policies and procedures prior to implementation. Numerous provider associations and organizations are also involved in the review process. A provider who feels that his association or the Medical Care Advisory Council adequately represents him may not wish to be included on the provider consultation list.

BENEFICIARY ELIGIBILITY

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SECTION 1 – DETERMINATION OF ELIGIBILITY

This chapter applies to all providers.

1.1 LOCAL DEPARTMENT OF HUMAN SERVICES OFFICE DETERMINATION

Eligibility for Medicaid and most other health programs is determined at the local Department of Human Services (DHS) office. The DHS worker reviews the beneficiary's financial and nonfinancial (e.g., disability, age) factors and determines the types of assistance for which the beneficiary is eligible. Once eligibility is established, the data is entered on the electronic Eligibility Verification System (EVS) and a **mihealth** card is issued.

MDCH determines eligibility for Children's Special Health Care Services (CSHCS).

Some Medicaid beneficiaries are in a deductible situation. This means the beneficiary has met all Medicaid eligibility criteria except he has excess income. (Refer to the Medicaid Deductible Beneficiaries Section of this chapter for additional information.)

Migrant agricultural workers may also be eligible for health care benefits. However, due to the transient nature of the migrant population, they might not receive their **mihealth** card. The provider must call EVS to verify eligibility when a beneficiary indicates he is a health care program beneficiary and does not have a **mihealth** card. (Refer to the Verifying Beneficiary Eligibility Section of this chapter for additional information.)

1.2 ELIGIBILITY BEGIN DATE

Coverage is usually effective the first day of the month that the beneficiary becomes eligible.

- Not all beneficiaries, however, are eligible beginning the first day of the month. Coverage may become effective the actual day the beneficiary becomes eligible.
- In some instances, the beneficiary's eligibility may be retroactive up to three months prior to the month of application. This may occur if, during the retroactive period:
  - All eligibility requirements for the specific health care program were met; and
  - Medical services were rendered.

The provider may submit claims to MDCH for payment of any covered services rendered during the beneficiary's eligibility period. If the beneficiary has previously paid for services and the provider has billed MDCH for the same services, the provider must refund to the beneficiary the portion of payment the beneficiary is responsible for, regardless of the amount MDCH pays. (Refer to the Medicaid Deductible Beneficiaries Section of this chapter for additional information.)

1.3 Redeterminations

Beneficiary eligibility is redetermined annually but may occur more often as case circumstances dictate. Beneficiaries are notified of the need to have their cases redetermined and the process to be followed to accomplish this.

1.4 Beneficiary Appeals

Beneficiaries may appeal their eligibility determination/redetermination by contacting their DHS worker at the local DHS office.

1.5 Corrective Action

Beneficiaries that have been denied Medicaid eligibility and have filed a hearing request may be entitled to a reimbursement if they paid for Medicaid covered services during a corrective action period. The corrective action period begins on the date the hearing request is received by the Department of Human Services (DHS) and ends on the date that eligibility is established. The services received must have been provided during the established eligibility period, including any months of established retroactive eligibility.

The provider has the option to reimburse the beneficiary in full and bill Medicaid for services rendered. MDCH encourages the provider to return the amount the beneficiary paid and bill Medicaid for the service. If the provider chooses not to reimburse the beneficiary, the beneficiary can request a direct reimbursement from the State.

In order to be eligible for a direct reimbursement from the State, the beneficiary, or someone legally responsible for the beneficiary's bills, must have paid for a Medicaid covered service during the corrective action period. The beneficiary cannot receive reimbursement for any required copays, patient pay amounts, amounts used to meet a Medicaid deductible, or care or services paid for through private insurance, Medicare, or any other form of government-sponsored or private health care coverage.

To request a refund of medical expenses, the beneficiary must provide a copy of all bills for medical services received on or after February 2, 2004 for which the beneficiary, or someone legally responsible for the beneficiary's bills, paid during the corrective action period to MDCH.

Bills must include or contain:

- Beneficiary name;
- Date the care or service was received;
- Amount charged for the care or service;
- Amount paid by the beneficiary or legally responsible party;
- Date the bill was paid;

- Procedure code(s) for the care or service;
- Description of each care or service, e.g., office visit, physical therapy, etc. The drug name, quantity dispensed, and the name of the prescribing physician must be included for prescriptions; and
- Proof of any payment made by a third party, such as an insurance company.

SECTION 2 – MIHEALTH CARD

The provider must verify beneficiary eligibility on the EVS prior to rendering services for:

- Medicaid
- CSHCS
- Transitional Medical Assistance-Plus (TMA-Plus)
- Maternity Outpatient Medical Services (MOMS) programs
- Adult Benefits Waiver (ABW)

(Refer to the Verifying Beneficiary Eligibility Section of this chapter for additional information.)

The **mihealth** card is a plastic, magnetic strip identification card issued once to each beneficiary. The front of the card contains the beneficiary's name and beneficiary ID number. When a family is determined eligible for a health program, a **mihealth** card is issued to each eligible person in the household. All cards for a household are mailed to the head of the household. The **mihealth** card does not contain eligibility information and does not guarantee eligibility until verified through EVS that the person is covered.

The provider can use the **mihealth** card to access a beneficiary's eligibility information on the EVS by entering the Medicaid ID number or swiping the card using a magnetic strip reader. Contact the MDCH EVS vendor who can provide additional information on magnetic strip readers and software. (Refer to the Directory Appendix for contact information.)

The eight-digit beneficiary identification (ID) number obtained from the EVS must be used when billing Medicaid.

The provider should request the beneficiary present a **mihealth** card to access a beneficiary's information on the EVS to verify health program eligibility before rendering any service. If the beneficiary does not have a **mihealth** card, the provider can also access the beneficiary's eligibility information on the EVS with the following additional search methods:

- Beneficiary ID number.
- Beneficiary social security number (SSN) and date of birth (DOB).
- Beneficiary name and SSN (or DOB).

If the beneficiary has lost his **mihealth** card, a replacement card may be issued by contacting the Beneficiary Helpline. (Refer to the Directory Appendix for contact information.) The provider is encouraged to verify a beneficiary's identity by requesting additional identification (e.g., driver's license, State Police ID, Social Security Card).

If the provider suspects fraud, the case should be reported to the Office of Inspector General. (Refer to the Directory Appendix for contact information.)

Suspected cases of beneficiary program abuse should be sent to the MDCH Program Investigation Section. (Refer to the Directory Appendix for contact information.)

Occasionally, the provider may see a Statement of Medical Services Paid (MSA-110-EOB). This statement is for the beneficiary's information only and indicates services received and paid on his behalf by MDCH.

2.1 Scope / Coverage Codes

The provider must always note the beneficiary's scope/coverage code, which indicates the extent of Medicaid coverage. The scope/coverage code is two characters. The first character (numeric) indicates the scope of eligibility. This code is used for administrative purposes only.

Scope Code	Program	Qualifying Information
1	Medicaid	When used in conjunction with Coverage Codes E, F, P, Q, T, U, or V
2	Medicaid	When used in conjunction with Coverage Codes B, C, E, F, J, H, T, V, or 0 (zero)
3	Adult Benefits Waiver (ABW)	When used in conjunction with Coverage Codes G, M, or R
4	Refugees and Repatriates	When used in conjunction with Coverage Code F

The second character (alpha) indicates the coverage available for this beneficiary. It is this part of the scope/coverage code that the provider should be aware of prior to rendering the service.

Coverage Code	Qualifying Information
0 (zero)	No Medicaid eligibility/coverage (refer to the Medicaid Deductible Beneficiaries Section of this chapter for additional information)
B	Qualified Medicare Beneficiary (QMB) (pays Medicare Parts A & B premiums, coinsurances, and deductibles)
C	Specified Low Income Medicare Beneficiary (SLMB) (pays Medicare Part B premium)
D	Freedom to Work Beneficiary (full Medicaid coverage)
E	Emergency or urgent Medicaid coverage only
F	Full Medicaid coverage
G	Adult Benefits Waiver (ABW) (full ABW coverage)

Coverage Code	Qualifying Information
H	Additional Low Income Medicare Beneficiary (ALMB) (pays Medicare Part B premium)
J	Additional Low Income Medicare Beneficiary (ALMB) (pays part of Medicare Part B premium)
K	Freedom to Work Beneficiary (full Medicaid coverage)
M	PLUS CARE (Wayne County) (full PLUS CARE coverage)
P	Transitional Medical Assistance-Plus (TMA-Plus) (full Medicaid coverage)
Q	Medicare Qualified Disabled Working Individual
R	Resident County Hospitalization only (administered by the local DHS office)
T	Healthy Kids (full Medicaid coverage)
U	Transitional Medical Assistance-Plus (TMA-Plus) (emergency services only)
V	Healthy Kids (emergency services only)
Y	Family Planning Waiver (family planning services only)

2.2 Patient Pay Information

Patient pay is the beneficiary's financial liability. It is shown in whole dollars only (e.g., 00050 is $50.00, not 50 cents). This amount applies to inpatient hospitals, nursing facilities (including ICF/MR facilities), and hospice while in a nursing facility. (Refer to Patient Pay Amount Section of this chapter for more information.)

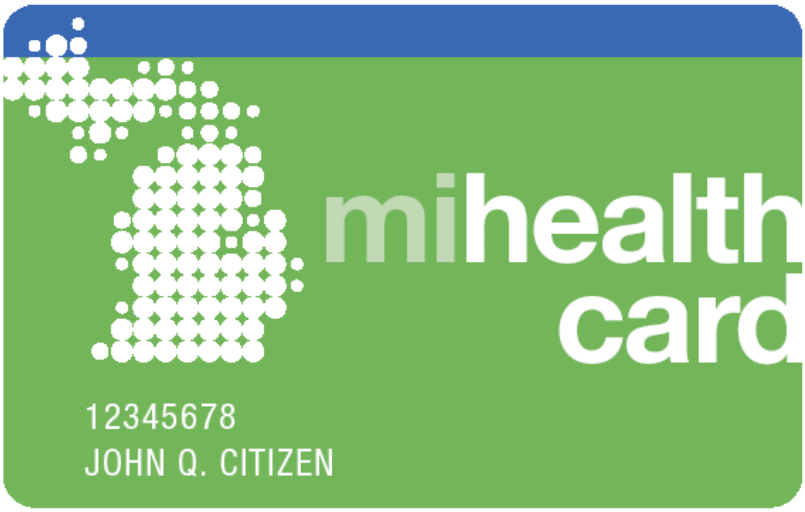
2.3 Level of Care Codes

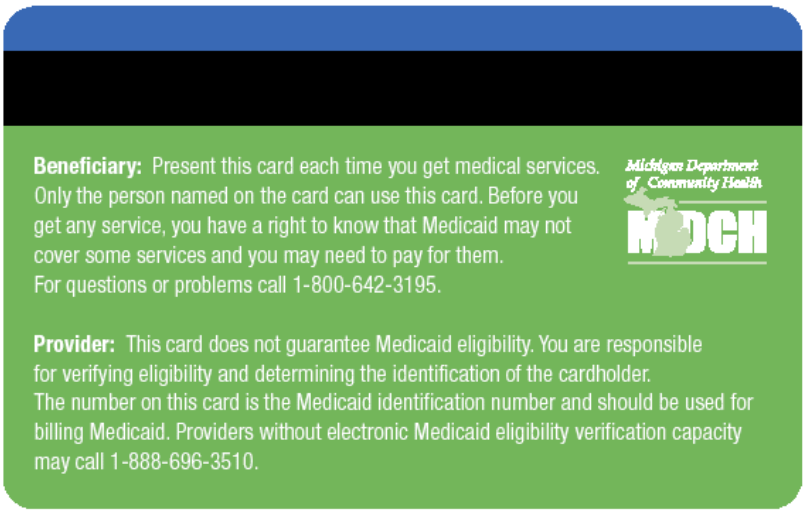
The EVS indicates one of the following codes:

Level of Care Code	Description
Blank	No LOC code. Beneficiary is considered to be fee-for-service (FFS).
02	Beneficiary of nursing facility services (e.g., nursing home, medical care facility, hospital long-term care unit).
11	Beneficiary in Adult Benefits Waiver Program – County Health Plan.
07	Beneficiary is enrolled in a Medicaid Health Plan (MHP) or Program of All-Inclusive Care for the Elderly (PACE). (Refer to the Medicaid Health Plans Section of this chapter for additional information.)
08	Developmentally disabled beneficiary in an intermediate care facility for the mentally retarded (ICF/MR and Mt. Pleasant Regional Center only).
10	The beneficiary has a patient pay amount for inpatient hospital acute care.
13	Beneficiary is on the Beneficiary Monitoring Program Pharmaceutical Lock-In. (Refer to the Beneficiary Monitoring Program Section of this chapter for additional information.)
14	Beneficiary is on the Beneficiary Monitoring Program Restricted Primary Provider Control. (Refer to the Beneficiary Monitoring Program Section of this chapter for additional information.)
16	Beneficiary is in a hospice program.
22	Beneficiary is enrolled in MI Choice, the Home and Community-Based Services Waiver for the Elderly and Disabled.
32	Beneficiary is involuntarily residing in a detention facility. Medicaid coverage limited to inpatient hospital related services only.
55	The need for long term care has been disapproved by the agency responsible for certifying the need for nursing care.
56	Services provided/billed by a long term care facility or waiver are not covered. Services provided by the facility may be billed to the beneficiary. Services provided/billed by other providers are covered if Medicaid guidelines are met.

Level of Care Code	Description
88	Administrative purposes. Medical exception to managed care enrollment. The beneficiary should be treated as if the LOC code was blank.

2.4 MIHEALTH CARD SAMPLE





2.5 Special Programs – Beneficiary Identification

Program/Eligibility Type	Level of Care	Scope/ Coverage	Message
Health Plan	07	1F, 2F, 4F	HMO ENROLLEE, Health Plan Name and Phone Number
Wayne County PLUS CARE – Also need County Code 82 and Coverage Code G or H to identify a PLUS CARE beneficiary	11	3M	PLUS CARE contractor's name and telephone number - ID Card is issued by Plus Care
Adult Benefits Waiver (ABW) – County Health Plan	11	3G	
ABW – Emergency Services Only	Blank	3E	
Beneficiary Monitoring Program – Pharmaceutical Control	13	1F, 2F, or 4F	Pharmaceutical Lock-in
Beneficiary Monitoring Program – Restricted Primary Provider Control	14	1F, 2F, or 4F	Restricted Provider Control, Provider Name and ID number
Qualified Medicare Beneficiary (QMB) – Medicaid pays Medicare Part B premiums, coinsurance, and deductibles	Blank	2B	Medicare Coinsurance/Deductible Only
Additional Low-Income Medicare Beneficiary (ALMB)			
Type 1 or Q1 – Medicaid pays the entire Medicare Part B premium	Blank	2H	No **mihealth** card is issued. No Medicaid coverage exists.
Type 2 or Q2 – Medicaid pays a portion of the annual Medicare Part B premium to the beneficiary	Blank	2J	No **mihealth** card is issued. No Medicaid coverage exists.
Qualified Disabled Working Individual (QDWI) - Medicaid pays the Medicare Part A premium.	--	1Q	No **mihealth** card is issued. No Medicaid coverage exists.
Specified Low Income Medicare Beneficiary (SLMB) – Medicaid pays the Medicare Part B premium	--	2C	No **mihealth** card is issued. No Medicaid coverage exists.

Program/Eligibility Type	Level of Care	Scope/ Coverage	Message
Limited Medicaid Coverage (Medicaid only covers urgent/emergent services)	Blank	1E or 2E	Urgent/Emergent Services Only
Medicaid Deductible – Scope/Coverage code 2F or 2E is added when the beneficiary provides documentation of meeting the deductible amount to the DHS worker	Blank	20 (zero)	No Medicaid coverage exists until beneficiary incurs sufficient medical expenses to meet the deductible amount.
Medicaid Deductible and QMB – Medicaid pays Medicare Part B premiums, coinsurance, and deductibles for the entire month	Blank	2B or 2C	No Medicaid coverage for Medicaid-covered services exists until beneficiary incurs sufficient medical expenses to meet the deductible amount.

SECTION 3 – VERIFYING BENEFICIARY ELIGIBILITY

The **mihealth** card does not contain eligibility information and does not guarantee eligibility. The provider can use the **mihealth** card to access a beneficiary's eligibility information on the EVS.

3.1 ELIGIBILITY VERIFICATION SYSTEM

Beneficiary information obtained from EVS is confidential under federal guidelines. EVS information must be used only for verifying beneficiary eligibility. If the beneficiary is eligible, the following information is available from the EVS:

- Beneficiary name, beneficiary ID number, gender, DOB.
- Eligibility information for the date of service (DOS) for:
  - Medicaid
  - ABW
  - CSHCS
  - TMA-Plus
  - MOMS
  - MIChild
- Program code, scope/coverage code, and patient-pay amount. (MOMS, CSHCS, and MIChild program beneficiaries are identified separately and do not use scope/coverage codes.)
- Current county of residence, DHS case number, DHS worker load number, and DHS local office phone number.
- Verification of whether or not the provider is authorized by the CSHCS program to render services to this beneficiary on a particular DOS or period of time.
- Dental program information
- Third-party liability (TPL), other insurance information, carrier ID or other insurance code, policy number, contract number, and services code (if applicable) and employer name and policyholder name.
- Level of care (LOC) information, such as health plan enrollment or Beneficiary Monitoring Program.

No additional information is provided by the EVS.

3.2 ACCESSING EVS

Providers may enter the EVS in one of two ways:

- By using a touch-tone telephone (or rotary telephone with a tone dialer), the provider receives information through a voice response system. This method is free to the provider. (Refer to the Directory Appendix for contact information.)

- Other methods for verifying eligibility are available that feature batch capabilities, quicker response time and offer printed verification of eligibility. These methods may involve a charge to the provider. For more information, contact the EVS vendors. (Refer to the Directory Appendix for contact information.)

The **mihealth** card uses magnetic swipe technology that allows providers to access beneficiary eligibility information quicker and easier with the use of a magnetic strip reader. For more information on magnetic strip readers and software, contact the EVS vendor. (Refer to the Directory Appendix for contact information.)

3.3 Eligibility Verification for Dates of Service Over 12 Months Old

MDCH follows CMS guidelines regarding release of eligibility information. Requests for information over 12 months from the date of request are only provided to hospitals. To obtain this information, hospitals should contact the MDCH EVS vendor during normal business hours. (Refer to the Directory Appendix for contact information.) There is a transaction fee to the requester.

SECTION 4 –MEDICAID DEDUCTIBLE BENEFICIARIES

4.1 ELIGIBILITY

There are cases when beneficiaries have the medical need for Medicaid coverage but they have excess income. These beneficiaries are known as Medicaid deductible beneficiaries**.** Medicaid deductible means that the beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by the local DHS worker to qualify for Medicaid. Once his deductible amount has been met, he becomes eligible for Medicaid benefits (Scope/Coverage Code 2F or 2E). Providers must verify Medicaid coverage using the Scope/Coverage Code available from the EVS.

The process for a Medicaid deductible beneficiary to become Medicaid eligible is as follows:

- The beneficiary presents proof of any medical expenses incurred (e.g., insurance premiums, bills for prescriptions and/or office visits) to the DHS worker. Providers may estimate any other insurance or Medicare payment that may be applied to the incurred bill. If the exact charge is not immediately known, providers should estimate the charge on the incurred bill. This expedites the eligibility process.
- The local DHS worker reviews the medical bills incurred and determines if the amount of beneficiary liability is met and the first date of Medicaid eligibility.
  - It is fraud to provide beneficiaries with a notice of a bill incurred if no service has been rendered.
  - Bills for services rendered prior to the effective date of Medicaid eligibility are the beneficiary's responsibility.
- For the first date of eligibility, the DHS worker sends letters to those providers whose services are:
  - Entirely the beneficiary's responsibility.
  - Partly the beneficiary's responsibility and partly Medicaid's responsibility.
- A letter is also sent to the beneficiary indicating which services are the beneficiary's responsibilities for that first date of Medicaid eligibility.
- The beneficiary's Scope/Coverage Code is changed to 2F or 2E to indicate the Medicaid eligibility period. The provider must verify eligibility on EVS when the beneficiary becomes eligible. Once the deductible amount is met, eligibility is established through the end of the month.

Providers may bill Medicaid for any covered services rendered during that eligible period**.**

Before billing, providers should verify through the EVS that Scope/Coverage Code 2F or 2E has been entered into the system. This will assure that the claims will not be rejected for lack of eligibility.

4.2 Retroactive Eligibility

Providers should be aware that, since bills have to be incurred before the deductible amount is met, there is always a period of retroactive eligibility. This may be several days or up to a period of three months from the current month. In this situation, the local DHS office may apply these old bills to the past three months or may prospectively apply them to the next several months, depending on the DOS and the date the bill was presented to the DHS worker.

It is the provider's option to bill Medicaid if the beneficiary has paid the provider for services rendered. MDCH encourages the provider to return the amount the beneficiary paid and bill Medicaid for the service. If the provider decides to bill Medicaid, he must return all money the beneficiary paid over and above the amount identified as the beneficiary's responsibility on the Medicaid deductible letter. If the beneficiary is accepted as a Medicaid beneficiary, he cannot be charged more than indicated on the letter from the local DHS office (plus applicable co-payment amounts).

4.3 Billing Instructions

There may be services that are partly the beneficiary's liability and partly Medicaid's liability. If the provider chooses to bill Medicaid for this service, he should refer to the Billing & Reimbursement Chapters of this manual for instructions for submitting claims.

Beneficiaries are responsible for payment of expenses that were incurred to meet the deductible amount. Payment does not have to be made before Medicaid eligibility is approved.

(Refer to the Qualified Medicare Beneficiary Section of this chapter for information on Medicaid deductible beneficiaries and Scope/Coverage Code 2B.)

SECTION 5 - CONTRACTUAL CARE ARRANGEMENTS FOR LONG TERM CARE

A **life care contract** is created when an individual enters into an agreement with a continuing care retirement community to provide for all the individual's needs, including health care, for the rest of his life. The individual pays a one-time entrance fee and monthly payments thereafter. The continuing care retirement community assumes full financial responsibility if the individual is unable to make his monthly payments at a later date. An individual with a life care contract is not eligible for Medicaid.

A **continuing care contract** is created when an individual enters into an agreement with a continuing care retirement community to provide or pay for all, or some of, the individual's medical care for the rest of his life. The individual pays a one-time entrance fee and monthly payments thereafter. An individual with a continuing care contract may be eligible for some Medicaid services.

SECTION 6 – QUALIFIED MEDICARE BENEFICIARY

6.1 GENERAL INFORMATION

Federal regulations require that Medicaid purchase Medicare coverage for some beneficiaries and reimburse providers for the Medicare coinsurance and deductible amounts. If these beneficiaries are not also eligible for Medicaid, they have Scope/Coverage Code 2B, Qualified Medicare Beneficiary (QMB). Medicaid only reimburses providers for the Medicare coinsurance and deductible amounts up to the Medicaid maximum amount. Medicaid does not reimburse services not covered by Medicare.

6.2 MEDICAID DEDUCTIBLE BENEFICIARIES AND QMB

Beneficiaries may be a QMB and also a Medicaid deductible beneficiary. Until the deductible amount has been met, the EVS shows Scope/Coverage Code 2B. Once the deductible amount is met, the Scope/Coverage Code is changed to 2F (full Medicaid benefits) and EVS is updated. For this Medicaid eligibility period, Medicaid reimburses the provider for Medicaid-covered services, as well as the Medicare coinsurance and deductible amounts up to the Medicaid allowable.

If Medicare covers the service, the provider may bill Medicaid for the coinsurance and deductible amounts only. For any Medicare noncovered services, the beneficiary should obtain proof of the incurred medical expense to present to the DHS worker so the amount may be applied toward the beneficiary's Medicaid deductible amount.

SECTION 7 – NEWBORN CHILD ELIGIBILITY

A newborn is defined as a child aged 0 (birth) to 1 year old. Generally, Medicaid automatically covers a child born to a woman eligible for and receiving Medicaid at the time of the birth. The mother is required to notify the local DHS office of the birth of the newborn within ten days of the birth.

If the mother is enrolled in a Medicaid Health Plan (MHP) at the time of delivery, the newborn's services are also the responsibility of the health plan unless the child is placed in foster care or enrolled in CSHCS.

7.1 FACILITY ADMISSION NOTICE

In the few cases where this process may be delayed, any provider may notify the local DHS office of the newborn's birth by submitting a Facility Admission Notice form (MSA-2565-C). (Refer to the Forms Appendix for a sample.) The form is to be completed for the newborn and must include the following information:

- Item 6 must state the name of the mother.
- Item 20 must state "newborn."
- A copy of the mother's EVS information should be attached to the form, or Item 22 must contain the County, District, Unit, Worker, case number data from EVS separated by slashes (e.g., 33/01/01/08/K3300772A).

The local DHS office enters the newborn's data on EVS and returns the MSA-2565-C to the provider with the necessary billing information.

Eligibility information must be obtained from EVS using the newborn ID number provided by MDCH. When an EVS query does not locate the newborn, inquiries should be directed to the MDCH Enrollment Services Section. (Refer to the Directory Appendix for contact information.) All inquiries must include the following information to assist MDCH in locating newborn ID numbers:

- Newborn's name (last, first, middle initial);
- Newborn's gender;
- Newborn's DOB;
- Mother's name (last, first, middle initial);
- Mother's Medicaid ID number; and
- Requesting person's name and telephone number.

7.2 BILLING

When billing MDCH for medical services rendered to the newborn, providers must use the newborn's Medicaid ID number. The mother's number cannot be used except when the delivering physician performs the newborn's care and circumcision during the mother's inpatient stay. In that situation, the delivering physician may bill for the newborn care and circumcision on the same claim as the delivery under the mother's Medicaid ID number.

SECTION 8 – BENEFICIARY MONITORING PROGRAM

State and federal regulations require MDCH to conduct surveillance and utilization review of Medicaid benefits to ensure the appropriate amount, scope, and duration of medically necessary services are being provided to Medicaid beneficiaries. The objectives of the Beneficiary Monitoring Program (BMP) are to reduce overuse and/or misuse of Medicaid services (including prescription medications), improve the quality of health care for Medicaid beneficiaries, and reduce costs to the Medicaid program. To accomplish these objectives, MDCH:

- Identifies FFS beneficiaries who appear to be overusing and/or misusing Medicaid services.
- Evaluates the Medicaid services to determine whether the services are appropriate to a FFS beneficiary's medical condition(s).
- If it is determined that a Medicaid FFS beneficiary is overusing and/or abusing Medicaid services, the beneficiary may be subject to a utilization control (lock-in) mechanism. There are two types of utilization control mechanisms for BMP:
  - Pharmaceutical Lock-In is used for beneficiaries who are abusing and/or misusing drugs listed in the Drug Categories subsection below.
  - Restricted Primary Provider Control is used for beneficiaries who are misusing and/or abusing Medicaid services other than pharmaceuticals.
- Monitors FFS beneficiaries in the control mechanism to determine whether control is effective and, if not effective, makes appropriate changes.

A beneficiary who is subject to the BMP Pharmaceutical Control mechanism is identified by LOC code 13 with the message "Pharmaceutical Lock-In".

A beneficiary who is subject to the BMP Restricted Primary Provider Control mechanism is identified by LOC code 14 with the message "Restricted Provider Control".

8.1 ENROLLMENT CRITERIA

The following criteria are used to determine whether a beneficiary may be placed in the Pharmaceutical Lock-In or Restricted Primary Provider Control mechanism. The dosage level and frequency of prescriptions, as well as the diagnoses and number of different prescribers, are reviewed when evaluating each individual case.

8.1.A. DISENROLLMENT FROM A MEDICAID HEALTH PLAN

MDCH has disenrolled the Medicaid beneficiary from an MHP for one of the following:

- Noncompliance with physician/drug treatment plan.
- Noncompliance with MHP rules/regulations for pharmacy lock-in.
- Suspected/Alleged fraud for altered prescriptions.
- Suspected/Alleged fraud for stolen prescription pads.

8.1.B. Convicted of Fraud

The beneficiary has been convicted of fraud for one of the following:

- Selling of products/pharmaceuticals obtained through Medicaid.
- Altering prescriptions used to obtain medical products or pharmaceuticals.
- Stealing prescription pads.

8.1.C. Inappropriate Use of Emergency Room Services

- More than three emergency room visits in one quarter.
- Repeated emergency room visits with no follow-up with a primary care physician.
- More than one outpatient hospital emergency room facility used in a quarter.

8.1.D. Inappropriate Use of Physician Services

- Utilized more than three different physicians in one quarter.
- Utilized more than two different physicians to obtain duplicate services for the same health condition or prescriptions for the drug categories defined below.
- Utilized multiple physicians for vague diagnosis (e.g., myalgia, myositis, sinusitis, lumbago, migraine) to obtain drugs from the drugs categories defined below.

8.1.E. Inappropriate Use of Pharmacy Services

- Utilized more than three different pharmacies in one quarter.
- Aberrant utilization patterns for drug categories noted below over a one-year period.
- Obtained more than 11 prescriptions for drugs identified below in one quarter (including emergency prescriptions).

8.2 Drug Categories

MDCH considers the following categories of drugs to be subject to abuse. Beneficiaries obtaining these products and meeting the criteria above may be subject to enrollment in the BMP.

- Narcotic Analgesics
- Barbiturates
- Sedative-Hypnotic, Non-Barbiturates
- Central Nervous System Stimulants/Anti-Narcoleptics
- Anti-Anxieties
- Amphetamines
- Skeletal Muscle Relaxants

8.3 Pharmaceutical Lock-In Control Mechanism

Michigan's Pharmacy Benefits Manager maintains a real-time screen of all point of sale (POS) prescription drug claims for MDCH. Requests for prescriptions (including emergency prescriptions for the therapeutic drug categories listed above) are evaluated against other prescriptions filled for the beneficiary and paid by Medicaid in the last 34 days.

Beneficiaries are not allowed to fill or refill prescribed medications in the drug categories listed above until 95 percent of the medication quantity limits would have been consumed in compliance with the prescribed dose, amount, frequency and time intervals established by the MDCH.

No overrides are allowed for beneficiaries enrolled in the BMP except when authorized by the MDCH Office of Medical Affairs (OMA).

8.4 Restricted Primary Provider Control Mechanism

Beneficiaries are enrolled in the Restricted Primary Provider control mechanism if they are identified as abusing or misusing Medicaid services other than pharmaceuticals. It is the responsibility of the restricted beneficiary's primary care provider to supervise the case management and coordination of all prescribed drugs, specialty care and ancillary services. Reimbursement for any ambulatory service is not made unless the services rendered were provided, referred, prescribed, or ordered by the primary provider.

The primary care provider must complete the Beneficiary Monitoring Primary Provider Referral Notification/Request (MSA-1302) to authorize care by other physicians (MD, DO), medical clinics, and outpatient hospitals. (Refer to the Forms Appendix for a copy of the form and distribution instructions.)

- The MSA-1302 does not authorize prescriptions ordered or written by the referred provider.
- The MSA-1302 does authorize the referred medical provider to render the service. The MSA-1302 is valid for a 60-day period from the date of the first appointment with the referred provider.

A telephone referral is adequate authorization to render the service. However, the primary provider must immediately forward one copy of the MSA-1302 to the referred provider and one copy to the Beneficiary Monitoring Program.

Any authorization by the primary care provider of the restricted beneficiary does not replace any prior authorization (PA) required by MDCH (e.g., vision services, cosmetic surgery).

A monthly case management fee is paid to the Restricted Primary Provider for each beneficiary assigned.

The following services are exempt from the primary care provider beneficiary utilization control mechanism:

- Emergency services
- Dental services
- Services rendered by a nursing facility (NF) provider
- Services rendered in an inpatient hospital

8.5 Referral Services

If a provider receives a referral from a beneficiary's primary care provider and wishes to order any services that will be performed by another provider (e.g., laboratory tests, prescription drugs, physical therapy, outpatient services), the order for such services must be authorized or prescribed by the primary provider. Medicaid reimburses only for those services billed using the primary provider as the referring/prescribing physician.

The referred provider must:

- Receive his copy of the MSA-1302 before billing Medicaid for the services;
- Retain the form in the beneficiary's file as authorization for the service; and
- Use the provider ID number identified in the MSA-1302 for billing.

8.6 Monitoring and Review

Beneficiaries are placed into the BMP for a minimum of 24 months. The utilization of medical services or drugs is routinely monitored and the effectiveness of the current control mechanism evaluated. When the beneficiary's utilization has been reduced to an appropriate level or there is a change in medical status, MDCH may determine that the BMP is no longer required.

8.7 Appeals

Beneficiaries may appeal MDCH's action to place them in pharmaceutical lock-in and/or primary care provider utilization control.

SECTION 9 – MEDICAID HEALTH PLANS

MDCH contracts with health plans in the state. The Medicaid Health Plans (MHPs) are paid a monthly capitation rate to provide specific covered services to enrolled Medicaid beneficiaries. The MHP is responsible for providing, arranging, and reimbursing most medical services.

9.1 ENROLLMENT

Within the Medicaid population, there are groups that:

- Must enroll in a MHP.
- May voluntarily enroll in a MHP.
- Are excluded from enrollment in a MHP.

Mandatory Enrollment	▪ Most people who are receiving full Medicaid benefits. ▪ People receiving Medicaid who participate in the Children's Waiver or the Habilitation/Supports Home and Community Based Waiver. ▪ Supplemental Security Income (SSI) beneficiaries who do not receive Medicare.
Voluntary Enrollment	▪ Pregnant women whose pregnancy is the basis for Medicaid eligibility and pregnant women who are in their third trimester of pregnancy. **If the mother of a newborn child is enrolled in a MHP at the time of the child's birth, the newborn child is automatically enrolled in that health plan. Health plan responsibilities begin at the time of the child's birth. (Refer to Newborn Child Eligibility Section of this chapter for more information.)** ▪ Migrants. ▪ Native Americans.
Excluded Enrollment	▪ People without full Medicaid coverage (they receive emergency services only), or receive ABW. ▪ People in Plus Care. ▪ People who are dually Medicaid/Medicare eligible. ▪ People for whom Medicaid is purchasing Medicare coverage (QMB, SLMB, ALMB). ▪ People with Medicaid who reside in an ICF/MR or state psychiatric hospital. ▪ People in the MDCH Traumatic Brain Injured residential rehabilitation program. ▪ People receiving long term care in a licensed nursing facility. (Refer to the Excluded Health Plan Services subsection of this chapter for additional information.)

- People being served under the MIChoice Waiver (LOC Code 22).
- People enrolled in the CSHCS Program.
- Medicaid Deductible beneficiaries. (Refer to Medicaid Deductible Beneficiaries Section of this chapter for additional information.)
- People with commercial health plan coverage, including Medicare health plan coverage.
- People in PACE (Program of All-Inclusive Care for the Elderly).
- Children in foster care or child caring institutions.
- People in the Refugee Assistance Program.
- People in the Repatriate Assistance Program.
- People who have been disenrolled from a Medicaid health plan due to actions inconsistent with plan membership.

If one member of a family is enrolled in the Children's Special Health Care Services (CSHCS) program, resides in a nursing facility, or loses Medicaid eligibility, this does not exempt the other family members from enrollment in a health plan.

9.2 MICHIGAN ENROLLS

Beneficiaries that are eligible to enroll in a MHP are covered for Medicaid services on a FFS basis until enrolled in a health plan.

Beneficiaries who are required or are eligible to enroll in a health plan have the opportunity to choose their health plan. They are given a pamphlet, "Choosing Your Health Plan", which provides them information on this process. If no selection is made, the beneficiary is automatically enrolled with a health plan in the beneficiary's county of residence. Those beneficiaries automatically enrolled are identified on EVS by the acronym MCEP (Managed Care Enrollment Plan). The beneficiary has 90 days after assignment of or choosing a health plan to change the health plan. After 90 days, the beneficiary is required to remain in the chosen health plan until the next open enrollment period.

The MDCH has contracted with MI Enrolls to:

- Inform beneficiaries which physicians, pharmacies, and hospitals are part of each health plan.
- Provide information to help the beneficiary choose a primary provider (a physician, nurse practitioner (NP), or physician's assistant who manages all of the beneficiary's health care).
- Answer beneficiary questions regarding how to use the health plan.
- Enroll beneficiaries in the health plan they choose, or automatically enroll them in a health plan.

- Change the beneficiary's health plan.
- Provide a Request for an Administrative Hearing and Instructions form (DCH-0092).
- Provide a Medical Exception Request form (MSA-1628) for medical exception from Managed Care.
- Provide a Beneficiary Complaint form (MSA-0300).

(Refer to the Directory Appendix for MI Enrolls contact information.)

9.3 Medical Exceptions to Mandatory Enrollment

The intent of the medical exception process is to preserve continuity of medical care for a beneficiary who is receiving active treatment for a serious medical condition from an attending physician (MD or DO) who would not be available to the beneficiary if the beneficiary is enrolled in a MHP. The medical exception may be granted on a time-limited basis necessary to complete treatment for the serious condition. The medical exception process is only available to a beneficiary who is not yet enrolled in a MHP, or who has been enrolled for less than two months. MHP enrollment would be delayed until one of the following occurs:

- The attending physician completes the current ongoing plan of medical treatment for the patient's serious medical condition, or
- The condition stabilizes and becomes chronic in nature, or
- The physician becomes available to the beneficiary through enrollment in a MHP.

If the treating physician can provide service through a MHP that the beneficiary can be enrolled in, then there is no basis for a medical exception to managed care enrollment.

If a beneficiary is enrolled in a MHP, and develops a serious medical condition after enrollment, the medical exception does not apply. The beneficiary should establish relationships with providers within the plan network who can appropriately treat the serious medical condition.

9.3.A. Definitions

Serious Medical Condition	Grave, complex, or life threatening. Manifests symptoms needing timely intervention to prevent complications or permanent impairment. An acute exacerbation of a chronic condition may be considered serious for the purpose of medical exception.
Chronic Medical Condition	Relatively stable. Requires long term management. Carries little immediate risk to health. Fluctuates over time, but responds to well-known standard medical treatment protocols

Active Treatment	Active treatment is reviewed in regards to intensity of services when: ▪ The beneficiary is seen regularly, (e.g., monthly or more frequently), and ▪ The condition requires timely and ongoing assessment because of the severity of symptoms, and/or the treatment.
Attending/Treating Physician	The physician (MD or DO) may be either a primary care doctor or a specialist whose scope of practice enables the interventions necessary to treat the serious condition.
MHP Participating Physician	A physician is considering participating in a MHP if he is in the MHP provider network or is available on an out-of-network basis with one of the MHPs with which the beneficiary can be enrolled. The physician may not have a contract with a MHP but may have a referral arrangement to treat the plan's enrollees. If the physician can treat the beneficiary and receive payment from the plan, then the beneficiary would be enrolled in that plan and no medical exception would be allowed.

9.3.B. Process for Requesting a Medical Exception

The Medicaid beneficiary must initiate the review process for medical exception by completing Section I of the Medical Exception Request (form MSA-1628). Beneficiaries can obtain forms, discuss managed care options, or ask questions regarding the medical exception process by contacting MI Enrolls. (Refer to the Directory Appendix for contact information.) If the beneficiary has been enrolled in a MHP for more than two months, the medical exception request does not apply.

9.3.C. Physician Responsibility

The physician who is actively treating the beneficiary for the serious medical condition must complete Section II of the MSA-1628. If multiple physicians are involved, each one must complete a separate form. The physician completing the form must be actively treating the beneficiary, and must not be participating with or have any arrangement with a MHP with which the beneficiary can be enrolled. The information provided by the physician must include:

- A detailed description of the serious medical condition that is being treated, including the diagnosis and current active signs and symptoms in adequate detail to justify the degree of seriousness. Diagnosis alone is not sufficient.
- The length of time that the beneficiary has been actively treated for this condition by the physician completing the form.
- The treatment plan in place, including any planned interventions and a list of all current and anticipated medications.
- The frequency of visits.
- The anticipated length of time (in months) that the beneficiary will need this treatment.

A Medical Exception Request cannot be processed without all of the above information. MDCH will verify that the treating physician is not available in any MHP in which the beneficiary can be enrolled. If an exception to managed care enrollment is granted, the MDCH will identify a period of time, up to one year, for which it is approved. At the end of that period, the beneficiary will be eligible for enrollment in a MHP.

9.4 Identified on EVS

EVS indicates the following for a beneficiary in a MHP:

- LOC Code 07.
- The message "HMO ENROLLEE".
- The name of the health plan.
- The telephone number of the health plan.

9.5 Health Plan Membership

Once enrolled in a health plan, that health plan sends member information to the beneficiary. The appropriate LOC code is entered on EVS with the name and toll-free telephone number of the MHP. The beneficiary also receives a membership card from the health plan.

9.6 Covered Health Plan Services

Services may be provided directly by the health plan or arranged through the health plan. Coverages include current Medicaid-covered services and any additional services the health plan may decide to provide that may not be Medicaid-covered services, other than excluded services listed below.

9.7 Excluded Health Plan Services

Services are either included or excluded from the health plan's monthly capitation rate. The following services are not included in the monthly capitation rate and may be provided by an enrolled provider who would be directly reimbursed by Medicaid.

- Dental services for Provider Type 12 or 74. (Oral surgeons providing services as Provider Type 10 are included in the health plan's capitation rate and should follow health plan authorization rules.)
- Nursing facility (NF) services. The health plan is responsible for providing up to 45 days of restorative health care in a nursing facility. If nursing facility services will exceed this coverage, the health plan may initiate the disenrollment process by submitting the Request for Disenrollment Long Term Care form (MSA-2007). The provider may bill Medicaid after the disenrollment is processed.
- Mental health services in excess of 20 outpatient mental health visits each contract year.
- Services provided to persons with developmental disabilities and billed through the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).
- Substance abuse treatment services.

- Inpatient hospital psychiatric services and outpatient partial hospitalization psychiatric services.
- Personal care authorized through DHS.
- School-based services.
- Pharmacy and related services prescribed by providers under the State's contract for specialty behavior services.
- Private Duty Nursing (PDN) services, for beneficiaries under 21 years. (Beneficiaries over 21 may receive PDN services through the Habilitation/Supports or MIChoice waiver programs.)

9.8 Health Plan Authorizations

The health plan must provide or arrange for services covered by the plan. Services that are not covered by the health plan do not require the health plan's authorization. If providers render both a health plan covered and a heath plan noncovered service, the health plan is responsible for providing/arranging and reimbursing for those health plan covered services. It is imperative that health plan providers obtain authorization from the health plan for plan-covered services.

For Medicaid-covered services:

- Nonemergency care – health plan authorization is required before rendering the service.
- Urgent care – health plan authorization is required before rendering the service.
- Emergency care to the point of stabilization – no authorization is required. The health plan is responsible for reimbursement of the service. The provider must inform the health plan as soon as possible that emergency services were provided. Post-stabilization treatment requires health plan authorization before rendering the service.

If a service requires PA from a health plan and from MDCH (e.g., cosmetic surgery), the provider must obtain the authorization from the health plan but does not have to obtain a second PA from MDCH.

9.9 Co-Payments

Health plan beneficiaries may be charged a co-payment for pharmacy, podiatric, chiropractic, vision, or hearing services. The co-payment requirements and amounts may not exceed the Medicaid FFS co-payments. Providers should charge health plan members co-payment as directed by the health plan.

Dental services are not provided by health plans. They are provided on a FFS basis or through the Healthy Kids Dental Program. Dental providers should charge the beneficiary 21 years of age or older a co-payment, even if the beneficiary is enrolled in a health plan. (Refer to the Dental Chapter of this manual for additional information.)

9.10 Billing

9.10.A. Health Plan Members

The health plan receives a monthly capitation fee for each Medicaid beneficiary enrolled in the plan as part of its contract with MDCH. Health plans and providers may not bill the beneficiary for services not authorized by the health plan unless the beneficiary was informed of his financial responsibility prior to receiving the service. Providers may bill Medicaid for a service that is excluded from the health plan contract, but Medicaid covered under FFS (e.g., dental services).

9.10.B. Referral Providers

If the health plan refers a beneficiary to a provider for health plan covered services, the health plan is responsible for reimbursement of those services.

9.10.C. Health Plan as a Private Insurance (Other Insurance Code 89)

A beneficiary who has an existing private health plan through employment, spouse or other source cannot be enrolled in a MHP at the same time. MDCH disenrolls that beneficiary from the MHP.

There may be FFS beneficiaries who are enrolled with a health plan as a private insurance. For example, the provider receives a monthly capitation rate for a beneficiary covered by a private health plan policy (such as Blue Care Network). These beneficiaries are identified by Other Insurance Code 89 on EVS and a private health insurance name if on the Third Party Liability (TPL) file.

The monthly capitation payment must not be reflected on the Medicaid claim. In most instances, the provider is billing Medicaid for the co-payment amount only. Medicaid only reimburses the provider for the Medicaid fee screen or co-payment amount, whichever is less. (Refer to the Billing & Reimbursement Chapters of this manual for additional information.)

If Medicaid's maximum allowable amount is less than the co-payment amount billed, the beneficiary or his representative may not be billed for the difference. The amount paid by Medicaid is considered as payment in full.

SECTION 10 – CHILDREN'S SPECIAL HEALTH CARE SERVICES

MDCH determines eligibility for the CSHCS Program. CSHCS provides medically necessary services to individuals who are eligible and apply under the following circumstances:

- Persons under the age of 21 with one or more qualifying medical diagnoses.
- Persons age 21 and older with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.

Medical eligibility must be established by MDCH before the individual is eligible to apply for CSHCS coverage. Based on medical information submitted by providers, a medically eligible individual is provided an application for determination of other CSHCS criteria. An individual may be eligible for CSHCS and eligible for other medical programs such as Medicaid, ABW, Medicare or MIChild. To be determined dually eligible, the individual must meet the eligibility criteria for CSHCS and all eligibility criteria for the other applicable program.

10.1 COVERAGE

The CSHCS coverage is limited to specialty health care services for the treatment of the beneficiary's qualifying medical condition. CSHCS does not cover primary care, well child visits or immunizations. Those with additional coverage (e.g., Medicaid, MIChild) continue to receive their well child visits, immunizations, etc. through that source or coverage.

Dental interventions may be covered for certain qualifying diagnoses. Beneficiaries must receive services from a Medicaid-enrolled dentist/orthodontist. Services must be related to the qualifying diagnosis and authorized by CSHCS.

CSHCS does not cover the treatment service needs related to developmental delay, mental retardation, autism, psychiatric, emotional, behavioral or other mental health diagnoses. A beneficiary who has both CSHCS and Medicaid or CSHCS and MIChild benefits receives his Medicaid or MIChild covered mental health services from the local PIHP/CMHSP.

CSHCS does not cover substance abuse treatment services. A beneficiary who has both CSHCS and Medicaid or CSHCS and MIChild benefits receives his Medicaid or MIChild covered substance abuse treatment services from the local Coordinating Agency (CA).

10.2 IDENTIFYING CSHCS ON THE EVS

The EVS will indicate when a beneficiary is enrolled in CSHCS for the date of service (DOS) entered in the inquiry. It will also identify if the provider ID number entered to access the EVS is authorized to render CSHCS services for the beneficiary on that DOS. CSHCS beneficiaries receive services through the FFS system.

Note: Certain provider types (e.g., pharmacies, hearing and speech centers, hearing aid dealers, home health agencies, medical suppliers, durable medical equipment providers, and orthotics/prosthetics suppliers) do not require CSHCS authorization to serve beneficiaries who have CSHCS covered diagnoses applicable to the services. Families are able to access these providers as they choose and the CSHCS qualifying diagnosis warrants.

10.3 Beneficiary Reviews

Beneficiaries may request a Department Review for denial of eligibility determinations/redeterminations and denial of services. They may contact their local health department (LHD) or the CSHCS Program through the Parent Participation Program Family Phone Line. (Refer to the Directory Appendix for contact information.)

SECTION 11 – APPLICATION FOR MEDICAL ASSISTANCE

If a person is potentially eligible for health care coverage, excluding CSHCS, but has not applied for assistance, an application form should be completed. If the person is unable to complete the application form and a relative, guardian, or other representative of choice is not available to complete the form on their behalf, then the hospital or NF may do so. The actual application form varies depending upon the situation presented (e.g., Healthy Kids, individual, family).

11.1 MEDICAID APPLICATION/REDETERMINATION

The Assistance Application form (FIA-1171) form is used for most potentially eligible beneficiaries. It may be obtained from the local DHS office or by contacting DHS at the address noted in the Directory Appendix.

The combined Healthy Kids/MIChild application (DCH-0373-D) may be obtained by calling the MIChild toll-free number or through the MDCH website. (Refer to the Directory Appendix for contact information.)

The Medicaid Patient of Nursing Home Application (FIA-4574) may be used as an alternative to the FIA-1171. The FIA-4574 is a Medicaid application/redetermination form used to determine Medicaid eligibility for the nursing facility patient only.

The application forms are self-explanatory. Questions regarding the forms should be referred to the local DHS office.

11.2 HEALTHY KIDS

The Healthy Kids/MIChild application (DCH-0373-D) may be used as an alternative to the FIA-1171. It is used to determine Medicaid eligibility only under the Healthy Kids categories for children under age 19 and pregnant women of any age. Persons can also apply for Healthy Kids/MIChild through the LHD or through the MDCH website. (Refer to the Directory Appendix for website information.)

The FIA-1171 must be used instead of the DCH-0373-D in the following situations:

- The family needs/wants other types of assistance in addition to Medicaid (e.g., cash assistance [FIP], food stamps, emergency needs); or
- Other family members need/want health care coverage. (In this case, the entire family must use the FIA-1171.)

The MIChild Renewal Form is considered a Medicaid application for a child who was receiving MIChild and, at redetermination, is now eligible for Healthy Kids Medicaid.

11.3 HOSPITALS AND NURSING FACILITIES

The person or his authorized representative should sign applications when possible. The local DHS office must determine Medicaid eligibility even if the beneficiary is receiving Supplemental Security Income (SSI) benefits. A beneficiary is not automatically eligible for Medicaid just because he has SSI benefits and resides in a nursing facility.

For state-owned and -operated facilities, if the person is unable to sign and the authorized representative is not available, the Reimbursement Office's authorized representative may sign the application using his personal signature and position title.

If retroactive Medicaid eligibility is requested, in addition to the application form, the Retroactive Medicaid Application (FIA-3243) must be completed for each retroactive month that eligibility is requested.

11.4 Initial Assessment of Assets

The local DHS office must make an initial assessment of an institutionalized or MIChoice waiver patient's assets upon request from that patient. The assessment should be requested even if the patient is not currently applying for Medicaid benefits. The assessment must be made from the date of admission to the facility.

An initial assessment is a determination of the total amount of countable assets owned by an institutionalized or MIChoice waiver patient and/or his spouse on a given day. The day is usually the day the patient was admitted to the NF or MIChoice waiver.

Nursing facilities are required to notify patients, their families, or authorized representatives of the need to request the initial assessment in case of future Medicaid application. The Asset Declaration - Nursing Home Resident and Spouse (FIA-4574B), is to be completed by the patient and submitted to the local DHS office to request that an initial assessment be completed. The facility may assist the patient with the completion of this form. Any questions regarding the form, or requests for copies of the form, should be directed to the local DHS office.

The patient may refuse to complete the assessment, but it should be stressed that it is easier to obtain the assessment at the time of admission than it is to try to recreate the situation at a future date.

SECTION 12 – ELIGIBILITY DETERMINATION OF INSTITUTIONAL CARE

12.1 FACILITY ADMISSION NOTICE

In addition to the Assistance Application (FIA-1171), the Facility Admission Notice (MSA-2565-C) is used by institutional providers to notify the local DHS office of the admission of a beneficiary or potentially eligible Medicaid beneficiary. It should be submitted even if Medicare or other insurance covers the person's stay. (Refer to the Forms Appendix of this manual for a copy of the form.)

12.1.A. HOSPITALS AND NURSING FACILITIES

The MSA-2565-C must be completed by facility personnel and signed by the beneficiary or his authorized representative. When a Hospice beneficiary enters a nursing facility, the MSA-2565-C should state "Hospice" in the Remarks section.

The facility must retain the original of the MSA-2565-C in the beneficiary's file. A copy must be sent to the local DHS office. The DHS returns a copy of the MSA-2565-C to the facility noting the eligibility status and the beneficiary's patient pay amount.

12.1.B. STATE-OWNED AND -OPERATED FACILITIES AND CMHSP FACILITIES

If no authorized beneficiary representative is available, an authorized representative of the facility's Reimbursement Office may sign the MSA-2565-C on behalf of the beneficiary. The representative must use his personal signature and position title.

A copy of the MSA-2565-C (and the completed FIA-1171, if necessary) must be forwarded to the local DHS office as soon as possible following admission.

The MSA-2565-C is generally self-explanatory. The facility should contact the local DHS office with any questions regarding completion of this form.

For state-owned and -operated facilities, the following instructions apply:

- Item 13: attending physician **-** This item may be left blank.
- Item 19: if NF, specify per diem rate. The facility should enter its private pay routine nursing care per diem rate to facilitate determination of Medicaid eligibility.

Medicaid does not pay the facility services rendered if:

- The returned copy of the MSA-2565-C indicates the person is not eligible for Medicaid.
- The person has a divestment penalty (LOC Code 56).

12.2 Patient Pay Amount

12.2.A. Nursing Facility Determinations

After the Medicaid application and MSA-2565-C have been submitted, the local DHS office determines eligibility for medical assistance. All allowable expenses and income are calculated, and any remaining income is considered excess income. Such excess income is then considered in determining the amount the beneficiary must pay toward his medical expenses each month. This monthly contribution by the beneficiary toward his care is called the patient pay amount.

The following forms are utilized to notify the facilities of patient pay and eligibility information:

- FIA-3227 – If the local DHS office is unable to determine final eligibility status within five working days of receipt of the application for medical assistance, the Tentative Patient Pay Amount Notice (FIA-3227) is sent to the facility as notification of the person's tentative patient pay amount. When the final determination is made, a copy of the MSA-2565-C is returned to the facility.
- FM-160 – At the end of each month, MDCH mails to each NF provider a list of his residents with LOC Code 02. The LTC Eligibility List (FM-160 Report) is generated from the Medicaid Management Information System (MMIS). This list is sorted by provider ID number, and shows eligibility, authorization, LOC, and patient pay information for each resident for the following month.

The identity of residents in each facility is determined from the provider ID number entered on the MSA-2565-C submitted at admission or re-admission. It is very important that providers ensure that their provider ID numbers are current and correct.

The FM-160 Report should be used in preparation of bills for services provided in that month. This avoids many billing problems stemming from eligibility information. The facility may contact the resident's local DHS office as identified on EVS if information on the FM-160 is incorrect.

In case of nonreceipt of the FM-160 or for answers to billing questions, the provider should contact MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Facilities are responsible for collecting the patient pay amount. If the facility receives the FIA-3227, it indicates a tentative patient pay amount to be collected by the facility. The patient pay amount is not prorated for partial months. This amount is subject to change as the beneficiary's financial eligibility changes. The patient pay amount must be exhausted before any Medicaid payment is made.

A beneficiary who has a patient pay amount cannot legally be charged more than the Medicaid rate for a short stay in a facility. For example, if a beneficiary is in a long term care facility for two days in a month, the provider must collect no more than the Medicaid rate for two days from the patient pay amount (even if the patient pay amount

is great enough to cover the higher private pay rate). The balance, or unused portion, of the patient pay amount must be returned to the beneficiary or his family.

For necessary medical or remedial care recognized under the State law but not covered by the Medicaid Program, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows NF beneficiaries to use their patient pay amount to obtain these services. For additional information, the facility may contact MDCH Long Term Care Services. (Refer to the Directory Appendix for contact information.)

12.2.B. HOSPITALS

Hospitals are not notified of a tentative patient pay amount via the FIA-3227. The hospital may obtain the patient pay amount by:

- Waiting for the **mihealth** card to be issued to the beneficiary, or verifying eligibility using the EVS.
- Submitting a claim to MDCH. (Medicaid deducts the patient pay amount and the claim is processed accordingly.)
- Contacting the local DHS office.

12.2.C. STATE-OWNED AND -OPERATED FACILITIES/PIHPS/CMHSPS

MDCH or the PIHP/CMHSP determines a financial liability, or ability to pay, separate from the DHS patient pay amount. The ability to pay may be an individual, spouse, or parental responsibility. It is determined and reviewed as required by the Mental Health Code. The beneficiary or his authorized representative is responsible for the ability to pay amount, even if the patient pay amount is greater.

12.3 PREADMISSION SCREENING

If a beneficiary is to be transferred from an acute care hospital to a NF, preadmission screening for mental illness/mental retardation must be completed prior to transfer.

COORDINATION OF BENEFITS

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SECTION 1 - INTRODUCTION

This chapter applies to all providers.

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a beneficiary with Medicare or Other Insurance coverage is enrolled in a Medicaid Health Plan (MHP), or is receiving services under a Prepaid Inpatient Health Plan (PIHP) or Community Mental Health Services Program/Coordination Agency (CMHSP/CA), that entity is responsible for the Medicaid payment liability.

Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage. The terms "third party liability" and "other insurance" are used interchangeably to mean any source, other than Medicaid, that has a financial obligation for health care coverage. Providers must investigate and report the existence of other insurance or liability to Medicaid and must utilize other payment sources to their fullest extent prior to filing a claim with the Michigan Department of Community Health (MDCH).

Billing Medicaid prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.

1.1 SUBROGATION

When a beneficiary has a third party resource available, Medicaid has the legal right to subrogation. Federal regulations grant Medicaid the right of recovery for any amounts payable to Medicaid. In order to recover the conditional payment, MDCH may bring direct action in it's own right against the entity responsible for payment or against any other entity that has received payment. To be eligible for Medicaid, beneficiaries must assign to MDCH the right to collect other insurance payments on their behalf.

1.2 VERIFICATION OF OTHER INSURANCE

Information about a beneficiary's other insurance is available through the automated Eligibility Verification System (EVS). It is not displayed on the **mihealth** card. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information, and the Directory Appendix for contact information.)

Providers should always ask the beneficiary if other insurance coverage exists at the time of service. If the beneficiary identifies other insurance coverage that is not listed on the EVS, the provider must use that other insurance and report it to MDCH by contacting the Medicaid Provider Inquiry Line or Third Party Liability Section. If the beneficiary belongs to a network, the provider must refer him to that preferred provider for services needed. (Refer to the Directory Appendix for contact information.)

If the beneficiary does not agree with the other insurance information contained in the EVS (e.g., other insurance coverage is no longer available), the beneficiary should be instructed to notify his local Department of Human Services (DHS) office of the change, or the provider may contact the Medicaid Provider Inquiry Line or Third Party Liability Section to initiate a change in the EVS. (Refer to the Directory Appendix for contact information.)

SECTION 2 - CATEGORIES OF OTHER INSURANCE

The major categories of other insurance are:

- Commercial health insurance carriers (including managed care carriers [MCC], preferred provider organizations [PPO], point of service organizations [POS], health maintenance organizations [HMO]) and traditional indemnity policies
- Auto Insurance (accident, no-fault)
- Workers' Disability Compensation
- Court-Ordered Medical Support
- General Liability Insurance
- Medicare

2.1 COMMERCIAL HEALTH INSURANCE

If a Medicaid beneficiary is enrolled in a commercial health insurance plan, the rules for coverage by the commercial health insurance must be followed. This includes, but is not limited to:

- Prior authorization (PA) requirements.
- Provider qualifications.
- Obtaining services through the insurer's provider network.

Beneficiaries must use the highest level of benefits available to them under their policy. Medicaid is not liable for payment of services denied because coverage rules of the commercial health insurance were not followed. For example, Medicaid does not pay the point of service sanction amount for the beneficiary electing to go out of the preferred provider network. Medicaid is, however, liable for Medicaid-covered services that are not part of the commercial health insurance coverage.

PA is not necessary for situations of other insurance coverage if all of the following apply:	**PA is required for the following:**
▪ The beneficiary is eligible for the other insurance and the primary insurer rules are followed; ▪ The provider is billing a standard Healthcare Common Procedure Coding System (HCPCS) code that Medicaid covers, and the primary insurer makes payment or applies the service to the deductible; and ▪ The service/item complies with Michigan Medicaid standards of coverage as described in this manual.	▪ PA is required for cases where the commercial carrier benefit has been exhausted or the service/item is not a covered benefit. ▪ PA is necessary for all other situations, including not otherwise classified (NOC) codes.

Inappropriately recoded claims are rejected by MDCH even if MDCH issued PA.

MDCH payment liability for beneficiaries with private commercial health insurance is the lesser of the beneficiary's liability (including co-insurance, co-payments, or deductibles), the provider's charge, or the maximum Medicaid fee screen, minus the insurance payments and contractual adjustments. (A contractual adjustment is an amount established in an agreement with a third-party payer to accept payment for less than the amount of charges.)

Providers may enter into agreements with other insurers to accept payment that is less than their usual and customary fees. Known as "Preferred Provider" or "Participating Provider" Agreements, these arrangements are considered payment-in-full for services rendered. Neither the beneficiary nor MDCH has any financial liability in these situations.

Providers must secure response(s) from other insurances (e.g., explanation of benefits, denials) prior to billing Medicaid except for the fixed co-pay amounts or payments for noncovered services. In these cases, providers must have documentation in the beneficiary's file. When billing on paper, this documentation must be submitted as an attachment to the paper claim. When billing electronically, no attachment is necessary, as all required data must be included in the electronic submission. (Refer to the Billing & Reimbursement Chapters of this manual for further information.)

If payments are made by another insurance carrier, the amount paid, whether it is paid to the provider or the beneficiary, must be reflected on the claim. It is the provider's responsibility to obtain the payment from the beneficiary if the other insurance pays the beneficiary directly. It is acceptable to bill the beneficiary in this situation. Providers may not bill a Medicaid beneficiary unless the beneficiary is the policyholder of the other insurance. Failure to repay, return, or reimburse Medicaid may be construed as fraud under the Medicaid False Claim Act if the provider has received payment from a third party resource after Medicaid has made a payment. Medicaid's payment must be repaid, returned, or reimbursed to MDCH Third Party Liability Section. (Refer to the Directory Appendix for contact information.)

2.2 Automobile Insurance (Accident, No-Fault)

Under Michigan's no-fault law, automobile insurance carriers are required to pay the medical expenses for injuries incurred in an automobile accident. However, in some instances, the insured's automobile policy contains a rider stating that his health insurance coverage takes priority over the automobile insurance carrier's policy. (This also applies to Coordination of Benefits riders.) In situations where more than one individual is involved in an accident, there is a possibility that multiple automobile insurance carriers are involved. As a result, the liable insurance carrier cannot always be readily identified at the time of initial medical treatment. The no fault law is designed to designate an order of priority of liability. Providers must bill the automobile insurance carrier prior to billing Medicaid.

The order of responsibility to pay for medical expenses for automobile accidents is as follows:

- The insurance company of the injured party, regardless of whether he was in his, or any, automobile.
- The insurance company of any resident relative of the house in which the injured party also resides.
- The insurer of the owner of the vehicle occupied. For nonoccupants (pedestrians) of the vehicles, the insurer of the vehicles involved.

- The insurer of the driver of the vehicle occupied. For nonoccupants (pedestrians) of the vehicles, the insurer of the drivers involved.

If a claim has been filed, providers should bill Medicaid while the other insurance claim is pending resolution. Medicaid must be billed within six months from the date of filing the no fault claim to keep the claim active with Medicaid. Providers must bill the appropriate procedure code, date of the accident, and any other pertinent information (e.g., the identification of the other insurance of the injured party) on the claim.

Providers may directly pursue no-fault or other casualty cases and submit claims directly to the other insurance carriers. If liability is in question, Medicaid may be billed. Medicaid then pursues reimbursement from the other insurance through subrogation.

2.3 Workers' Disability Compensation

Workers' Disability Compensation is a system established under state law that provides payments, without regard to fault, to employees injured in the course of their employment. Workers' Disability Compensation does not cover medical care incidental to or separate from the injury. Providers must establish if the beneficiary is covered by Workers' Disability Compensation.

If a claim has been filed and is contested, providers may bill Medicaid while the claim is pending resolution by Workers' Disability Compensation. The provider must bill the appropriate procedure code, the date the claim was submitted (if known), and any other pertinent information (e.g., employer, Workers' Disability Compensation carrier, and attorney's name). Medicaid may bill the compensation carrier, or may follow up in hearings as to redemption or settlement.

2.4 Court-Ordered Medical Support

Court-ordered medical support is medical coverage for beneficiaries that the court has ordered to be paid by an individual (who is also the policyholder) other than the beneficiary. This individual could be an absent parent, a grandparent, adoptive parent, etc. The provider must pursue recovery of the other insurance payment directly from the policyholder. In instances where the policyholder does not reside with the beneficiary (e.g., an absent parent), providers are encouraged to have the custodial parent obtain a Qualifying Medical Support Order through the local Friend of the Court. This allows the provider to bill the other insurance directly (e.g., Blue Cross/Blue Shield). If there is not a Qualifying Medical Support Order on file for the beneficiary, providers must still obtain the other insurance payment from the policyholder. (Refer to the Directory Appendix for contact information.)

2.5 General Liability

General liability insurance is coverage that generally pertains to claims arising out of the insured's liability for injuries or damage caused by the ownership of property, manufacturing operation, contracting operations, sale or distribution of products, or the operation of machinery, as well as professional services. If the beneficiary's injury is not work- or automobile-related, the beneficiary's medical services may be covered by another insurance carrier (e.g., homeowner's insurance policy). This insurance carrier is considered primary and must be billed according to the rules of the insurance carrier.

2.6 MEDICARE

2.6.A. MEDICARE ELIGIBILITY

Many beneficiaries are eligible for both Medicare and Medicaid benefits. If a provider accepts the individual as a Medicare beneficiary, that provider must also accept the individual as a Medicaid beneficiary.

If a Medicaid beneficiary is eligible for Medicare (65 years old or older) but has not applied for Medicare coverage, Medicaid does not make any reimbursement for services until Medicare coverage is obtained. The beneficiary must apply for Medicare coverage at a Social Security Office. Once they have obtained Medicare coverage, services may be billed to Medicaid as long as all program policies (such as time limit for claim submission) have been met.

Medicaid beneficiaries may apply for Medicare at any time and are not limited to open enrollment periods. Beneficiaries may be eligible for Medicare if they are:

- Sixty-five years of age or older.
- A disabled adult (entitled to SSI or RSDI due to a disability).
- A disabled minor child.

2.6.B. MEDICARE PART A

Since Medicare Part A pays for care in an inpatient hospital, nursing facility (NF), services provided by a home health agency (HHA) or in other institutional settings, Medicaid's reimbursement for services under Medicare Part A may vary.

If MDCH is paying a beneficiary's Medicare Part B premium and the beneficiary does not have free Medicare Part A, MDCH also pays the beneficiary's Medicare Part A premium.

MDCH monitors beneficiary files to identify all beneficiaries who currently have Medicare Part B coverage only, and have Part B buy-in. Once these beneficiaries are identified, MDCH automatically processes Part A buy-in.

When a beneficiary has incurred Medicare Part A charges and is eligible for, but does not have, Medicare Part A buy-in, the claim is rejected. Providers must wait for the beneficiary to obtain Medicare coverage, then bill Medicare for services rendered. After Medicare's payment is received, Medicaid should be billed for any co-insurance and/or deductible amounts. For Medicare Part A and Part B/Medicaid claims, Medicaid's liability never exceeds that of the beneficiary.

To expedite the buy-in process, providers may notify MDCH, in writing, when a beneficiary age 65 or older, covered by Medicare Part B only, is admitted to an inpatient hospital. (Refer to the Directory Appendix for Medicare Buy-In Unit contact information.)

The following information is required:

- Beneficiary's name, date of birth, and Medicaid identification (ID) number;
- Health insurance claim number (HICN);
- Inpatient hospital admission date; and
- Hospital name, address, and Medicaid provider ID number.

Special points to remember:

- Medicaid does not pay for any portion of the services Medicare would have otherwise covered if a provider's error prevents Medicaid from buying-in Medicare Part A.
- To bill a claim when Medicare Part A coverage for Medicare/Medicaid beneficiaries is exhausted prior to an admission or during an inpatient hospital stay, refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.
- To bill a claim when no Medicare payment has been made because the amount of Medicare co-insurance, plus the amount for lifetime reserve days, is greater than the Medicare diagnosis related group (DRG) amount, refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.

2.6.C. MEDICARE PART B

Medicare Part B covers practitioner's services, outpatient hospital services, medical equipment and supplies, and other health care services. When a beneficiary is eligible for and enrolled in Medicare Part B, Medicare usually pays for a percentage of the approved Medicare Part B allowable charges and Medicaid pays the applicable deductible and/or co-insurance up to Medicaid's maximum allowable amount. Coverage for outpatient therapeutic psychiatric coverage varies.

Beneficiaries are encouraged to enroll in Medicare Part B as soon as they are eligible to do so. A beneficiary's representative can apply for Medicare Part B benefits on behalf of the beneficiary. After the beneficiary's death, DHS is responsible for making the application to the Social Security Administration (SSA) to cover medical services provided prior to the death.

2.6.D. MEDICARE BUY-IN

If a beneficiary is eligible for Medicare but has not enrolled, he can do so at any time throughout the year through buy-in. If the beneficiary is unable to pay the Medicare premiums, Medicaid may pay the premiums through a contractual agreement (called the Medicare Buy-In Agreement) with the SSA. However, Medicaid cannot buy-in for the beneficiary until they apply for Medicare and the SSA is aware that they are Medicaid-eligible.

Some dual-eligible beneficiaries are classified as:

Qualified Medicare Beneficiaries (QMB)	Medicaid pays Medicare Parts A and B premiums for these individuals, and reimburses providers for Medicare co-insurance and/or deductible amounts only to the extent that the total payment does not exceed the Medicaid maximum allowable amount. These beneficiaries are identified by scope/coverage code 2B. Physicians and suppliers should be aware that services provided to QMBs are reimbursed on a Medicare assignment basis only. If a provider knowingly bills for Medicare services on other than an assignment basis, the Federal Department of Health and Human Services (HHS) can seek sanctions.
Specified Low Income Medicare Beneficiaries (SLM/SLMB)	Medicaid pays only the Medicare Part B premiums for these individuals. Medicaid does not reimburse providers for any services rendered to the beneficiary. No **mihealth** card is issued to these individuals.
Additional Low Income Medicare Beneficiaries (ALMB)	Medicaid pays only the Medicare Part B premiums for these individuals. Medicaid does not reimburse the provider for any services rendered to the beneficiary. No **mihealth** card is issued to these individuals.

2.6.E. MEDICAID LIABILITY

If Medicare has paid 100 percent of the allowable charges and there is no co-insurance involved, then Medicaid has no payment liability.

Neither the beneficiary nor Medicaid is liable for any difference in the amount billed by the provider and Medicare's allowable fee.

If the beneficiary is in a Medicare Risk HMO, MDCH pays fixed co-pays on the services up to the lesser of Medicaid's allowable amount for the service or the beneficiary's payment liability, as long as the rules of the HMO are followed.

The MDCH payment liability for beneficiaries with Medicare coverage is the lesser of:

- The beneficiary's liability for co-insurance, co-payments, and/or deductibles minus any applicable Medicaid co-payment, patient pay, or deductible amounts.
- The Medicaid fee screen/allowable amount minus any Medicare payments, contractual adjustments, and any applicable Medicaid co-payment, patient-pay, or deductible amounts.
- The provider's charge minus any Medicare payments, contractual adjustments, and any applicable Medicaid co-payment, patient-pay, or deductible amounts.

If Medicare has not paid the Medicare portion of a Medicare-covered service for a beneficiary enrolled in Medicare Part B, MDCH rejects the claim.

Medicare coverage is not available for a Medicaid beneficiary who is 65 years or older and is an alien who has been in the country less than five consecutive years.

When a Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part B, MDCH rejects any claim for Medicare Part B services. Providers should instruct the beneficiary to pursue Medicare through the SSA.

If Medicare reimburses for the service, Medicaid does not require PA for the service.

Approximately twice per year, MDCH issues an MW-861 Report which identifies beneficiaries who are retroactively eligible for Medicare. Medicaid payment for services provided to these beneficiaries is adjusted to recoup all monies except the Medicaid liability, and recovered via an automated claim adjustment. Providers are notified when these adjustments occur. Providers should refer to the MW-861 Report for beneficiary details. If a discrepancy in payment exists, the provider should contact the Provider Inquiry or Third Party Liability staff. (Refer to the Directory Appendix for contact information.)

Beneficiaries cannot be charged for Medicaid-covered services, except for approved co-pays or deductibles, whether they are enrolled as a fee-for-service (FFS) beneficiary, MDCH is paying the HMO premiums to a contracted health plan, or services are provided under PIHP/CMHSP or CA capitation.

2.6.F. Exceptions to the Billing Limitation

When a delay in payment from Medicare causes a delay in billing Medicaid, an exception may be made if the provider can document that Medicare was billed within 120 days of the date of service and Medicaid was billed within 120 days of the date of payment or rejection by Medicare. Medicaid payment is made provided all other requirements (e.g., beneficiary eligibility, medical necessity) are met. A copy of the Medicare claim submitted and Medicare's response must be attached to the Medicaid paper claim to document Medicare's delay. If billing electronically, a note should be added in the Remarks segment that the late billing is due to Medicare's delay in processing the claim. (Refer to the Billing & Reimbursement Chapters of this manual for additional information.)

2.6.G. Special Considerations for Inpatient Hospital Claims

Due to the nature of DRG calculations, the following instructions must be used when completing an inpatient hospital claim:

- All Medicare and other insurance payment information should be indicated on the claim which contains the Patient Status code that indicates the beneficiary has been discharged from the facility. If the inpatient service requires two claims, payment information (e.g., total other insurance payment, Medicare co-insurance and deductible) must be included

on the claim for the last date of service for the inpatient stay. Interim claims should not reflect a payment.

- Medicare Part A and Part B charges must be combined on one claim.
- The actual total Medicare Part A and Part B payment, which includes contractual adjustment, must be indicated on the inpatient hospital claim/adjustment. This amount is not the contract charge. The amount billed may equal both the sum of the co-insurance and deductible amounts; however, in order to provide proper reimbursement, the actual total Medicare Part A and Part B payment must be indicated.
- When a beneficiary has Medicare Part B only, this must be reflected in the Remarks Section of the claim. Additionally, the claim must reflect the 20 percent amount due from Medicaid. The Medicare Part A and Part B payment is the 80 percent of the allowable charges covered by Medicare for Part B services.

For Medicaid reimbursement, the amount billed for services does not equal the sum of the co-insurance and deductible items. It must be calculated as the gross hospital charges **minus** all Medicare payments, **minus** other insurance payments, and **minus** any patient-pay and/or co-payment amount. If a claim is submitted with the amount billed equal to zero, other payment greater than or equal to Medicaid's payment, or a negative amount, Medicaid does not make a payment. If there is a balance to be billed to Medicaid, the hospital may bill Medicaid for covered services only.

2.6.H. Lifetime Reserve Days

Medicare allows a one-time additional 60 days of coverage known as Lifetime Reserve Days (LRD). A Medicaid beneficiary who has Medicare Part A must use these 60 days before Medicaid makes a payment, except for deductibles and co-insurance.

2.6.I. Outpatient Hospital Laboratory Services

Medicare pays most diagnostic and clinical laboratory tests at 100 percent. Therefore, Medicaid has no payment liability.

2.6.J. Psychiatric Services

Diagnostic outpatient hospital psychiatric physicians services, including the initial psychiatric diagnostic and evaluation interview, family counseling and psychological testing, are reimbursed as a Medicare Part B service.

Medicare Part B reimbursement for therapeutic outpatient hospital services is different than reimbursement for other Part B services.

Medicare applies a special 37.5 percent fee reduction to the amount approved by Medicare. (The 37.5 percent fee reduction does not appear on the Medicare EOB.) Medicaid is liable for the 37.5 percent fee reduction, the annual Part B deductible, and the 20 percent co-insurance amount, up to the Medicaid maximum allowable amount.

2.6.K. Other Insurance Carrier ID List

The Other Insurance Carrier ID List on the MDCH website provides a listing of codes assigned by MDCH for each insurance carrier. (Refer to the Directory Appendix for website information.) The list is available by carrier code and by carrier name and is updated quarterly. All third-party carriers must be used to the fullest extent possible, prior to billing Medicaid and Children's Special Health Care Services (CSHCS) Programs, including Medicaid Health Plans (MHPs) and PIHPs/CMHSPs/CAs.

Major carriers (e.g., Blue Cross/Blue Shield, AETNA) are listed by the Other Insurance Code with the home offices first, usually followed by the district offices. Providers should submit the other insurance claims to the nearest office. If the provider is in doubt, claims should be sent to the home office of the carrier.

SECTION 3 - SPECIAL CONSIDERATIONS

3.1 MASTER MEDICAL

All insurance coverage, including Master Medical policy riders, must be used before filing a claim with Medicaid. If the beneficiary has a Master Medical policy rider (e.g., Blue Cross/Blue Shield), providers must identify whether the provider or policyholder must bill. If the policyholder must bill, the provider must provide a statement of charges to the beneficiary or policyholder to use when billing Master Medical. If there is a court order for medical support that includes Master Medical, the custodial parent may obtain a qualified medical support order for providers to be paid directly from the insurance carrier. Whether the payment is made to the policyholder or the provider, the provider must report it as other insurance payment on the bill submitted to Medicaid. Providers must pursue recovery of the insurance payment if it is made directly to the policyholder. The beneficiary, or his representative, must not be billed for this payment unless the beneficiary is the policyholder.

3.2 CO-INSURANCE/DEDUCTIBLE AND/OR CO-PAYMENT

Medicaid responsibility for payment of co-insurance/deductible and/or co-payment amounts is:

Co-pay	Medicaid pays fixed co-pay amounts up to the Medicaid-allowable amounts as long as the rules of the other insurance are followed. The provider must bill the fixed co-pay amount as the charge.
Co-insurance and deductible	Medicaid pays the appropriate co-insurance amounts and deductibles up to the beneficiary's financial obligation to pay or the Medicaid allowable amount (less other insurance payments), whichever is less. If the other insurance has negotiated a rate for a service that is lower than the Medicaid allowable amount, that amount must be accepted as payment in full and Medicaid cannot be billed.
Medicaid services not covered by another insurance	If the other insurance does not cover a service that is a Medicaid-covered service, Medicaid reimburses the provider up to the Medicaid allowable amount if all the Medicaid coverage rules are followed.

MDCH cannot be billed for co-pays, co-insurance, deductibles, or any fees for services provided to beneficiaries enrolled in a MHP, or who are receiving services under PIHP/CMHSP/CA capitation. Beneficiaries are responsible for payment of all co-pays and deductibles allowed under the MHP/PIHP/CMHSP/CA contract with MDCH. If the beneficiary with other insurance coverage is enrolled in a MHP or receiving services under a PIHP/CMHSP/CA capitation, the MHP/PIHP/CMHSP/CA assumes the Medicaid payment liabilities.

Beneficiaries cannot be charged for Medicaid-covered services, except for approved co-pays or deductibles, whether they are enrolled as a FFS beneficiary, MDCH is paying the HMO premiums to a contracted health plan, or services are provided under PIHP/CMHSP/CA capitation.

(Refer to the Medicaid Liability subsection of this chapter for additional information on Medicare claims.)

3.3 Claim Replacement

A claim replacement should be submitted if another insurance makes a payment subsequent to Medicaid's payment. (For specific claim replacement instructions, refer to the Billing & Reimbursement Chapters of this manual.)

SECTION 4 – CROSSOVER CLAIMS [CHANGES MADE 4/1/06]

The crossover process allows providers to submit a single claim for individuals dually eligible for Medicare and Medicaid, or qualified Medicare beneficiaries eligible for Medicaid payment of co-insurance and deductible to a Medicare fiscal intermediary, **(per bulletin MSA 06-07 issued 2/06)** and have it also processed for Medicaid reimbursement.

Additional information about the crossover claim process is available on the MDCH website. (Refer to the Directory Appendix for website information.)

4.1 ACCEPTABLE CROSSOVER CLAIMS [CHANGES MADE 4/1/06]

MDCH accepts Medicare Part B professional claims processed through any Medicare fiscal intermediary when submitted in the ASC X12N 837P version 4010A1 claim format.

When a claim is crossed over to MDCH, a remittance advice (RA) will be generated from the fiscal intermediary with the details of the Medicare payment and Remark Code MA07 (the claim information has also been forwarded to Medicaid for review). If this remark does not appear on the fiscal intermediary's RA, a separate claim will have to be submitted to MDCH. **(updated per bulletin MSA 06-07 issued 2/06)**

4.2 CLAIMS EXCLUDED FROM CROSSOVER PROCESS [CHANGES MADE 4/1/06]

The following types of claims will be **excluded** from the crossover process between MDCH and Medicare:

- Totally denied claims
- Claims denied as duplicates or missing information
- Replacement claims or void/cancel claims submitted to Medicare
- Claims reimbursed 100 percent by Medicare
- Claims for dates of service outside the beneficiary's Medicaid eligibility begin and end dates

Providers must resolve denied claims with the fiscal intermediary unless the service is an excluded benefit for Medicare, but covered by Medicaid (e.g., insertion of an IUD or hearing aid supply). In those cases, the excluded Medicare service can be billed directly to MDCH. **(updated per bulletin MSA 06-07 issued 2/06)**

4.3 SPECIAL INSTRUCTIONS FOR CROSSOVER CLAIMS

Providers must include their Medicaid provider ID number, along with their Medicare provider ID number, on the claim sent to Medicare. The Medicaid ID must be reported by repeating Loop ID 2010AA REF01 and REF02 in the 837P version 4010A1. The information must be entered as follows:

- Loop ID 2010AA REF01: enter "1D" for Medicaid
- Loop ID 2010AA REF02: enter the 9-digit Medicaid provider ID number (2-digit provider type followed by the 7-digit number)

If the Medicaid information is not included in the claim sent to Medicare, MDCH will not be able to process the claim.

Once payment is received from Medicare and the MA07 remark code appears on the Medicare RA, appearance of the claim on the Medicaid RA should be expected within 30 days. Claims not appearing within that time should be submitted directly to MDCH showing all Medicare payment information.

BILLING & REIMBURSEMENT FOR DENTAL PROVIDERS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers billing the ADA-2002 or 837 Dental claim formats. It contains information needed to submit dental claims to the Michigan Department of Community Health (MDCH) for Medicaid and Children's Special Health Care Services (CSHCS). It also contains information about how claims are processed and how providers are notified of MDCH actions.

Dental providers must use the ASC X12N 837D 4010 A1 dental format when submitting electronic claims and the ADA 2002 claim form for paper claims.

1.1 CLAIMS PROCESSING SYSTEM

All claims submitted and accepted are processed through the Claims Processing (CP) System. Paper claims are scanned and converted to the same file format as claims submitted electronically.

Claims processed through the CP system are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and combination of service edits. Electronic claims received by Wednesday may be processed as early as the next weekly cycle.

MDCH encourages providers to send claims electronically by file transfer or through the data exchange gateway (DEG). Electronic filing is more cost effective, more accurate, payment is received more quickly, and administrative functions can be automated.

1.2 REMITTANCE ADVICE

Once claims have been submitted and processed through the CP System, a paper remittance advice (RA) will be sent to each provider with adjudicated or pended claims. An electronic health care claim payment/advice (ASC X12N 835 4010A1) will be sent to the designated primary service bureau for providers choosing an electronic RA. (Refer to the Remittance Advice Section of this chapter for additional information about both the paper and electronic RA.)

1.3 ADDITIONAL RESOURCE MATERIAL

Additional information needed to bill may include:

Bulletins	These intermittent publications supplement the provider manual. Bulletins are automatically mailed to enrolled providers affected by the bulletin and to subscribers of the manual(s). Recent bulletins can be found on the MDCH website. (Refer to the Directory Appendix for contact information.)
CDT Codes	Providers must purchase this manual from the American Dental Association. For ordering information and catalog, contact the ADA. (Refer to the Directory Appendix for contact information.)

Companion Guide (Data Clarification Document)	This document is intended as a companion to the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim, ASC X12N 837D 4010A1. It contains data clarifications and identifiers to use when a national standard has not been adopted, and parameters in the implementation guide that provide options.
Electronic Submission Manual	This manual provides detailed instructions on obtaining approval for electronic billing and how to file electronic claims with MDCH. It is available on the MDCH website. (Refer to the Directory Appendix for website information.)
Databases	These list procedure codes, descriptions, fee screens, and other pertinent coverage, documentation, and billing indicators. The databases are only available on the MDCH website. (Refer to Directory Appendix for contact information.)
Numbered Letters	General program information or announcements are transmitted to providers via numbered letters. These can be found on the MDCH website. (Refer to Directory Appendix for website information.)
Medicaid Provider Manual	The manual includes program policy and special billing information. A CD copy of the manual is available at a nominal cost from MDCH. It is also available on the MDCH website for review or download. (Refer to the Directory Appendix for contact and/or website information.)

1.4 ELECTRONIC FUNDS TRANSFER

Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments into a provider's bank account. This replaces a paper warrant. To initiate an EFT, the facility should go to the Department of Management and Budget website. (Refer to the Directory Appendix for website information.)

SECTION 2 – GENERAL INFORMATION/PRIOR AUTHORIZATION

The Dental Prior Approval Request Authorization (PA) Request (MSA-1680-B) is a form designed to obtain authorization for those services that require PA, as indicated in the Dental Chapter and the Dental Procedure Code Database on the MDCH website. (Refer to the Directory Appendix for website information.)

The dentist must remember the following:

- X-rays must be sent along with the PA form.
- The PA form only needs to include the procedure that requires PA.
- Assess the general oral health and provide a five-year prognosis on the prosthesis requested.
- The dentist should make liberal use of the Pertinent Dental History and Medical areas on the request to better define symptomatology, treatment situations, etc. when the services requested or the accompanying documentation may leave unresolved questions. When health problems exist, they should be identified on the request along with any effect they might have upon the proposed plan of treatment.
- Any additional documentation submitted with the request must contain the beneficiary's name and identification (ID) number, date, and the dentist's name and ID number.

Additional information is generally required to be submitted with or indicated on the PA form. This is to enable staff to make an accurate determination regarding the proposed plan of treatment.

SECTION 3 – HOW TO FILE CLAIMS

Dental claims may be submitted electronically or on paper. Electronic claim submission is the preferred method for submitting claims to MDCH.

3.1 ELECTRONIC CLAIMS

Claims submitted electronically and accepted are received directly into the CP System, which results in faster payments and fewer claims that pend or reject. Claims can be submitted by file transfer or through the DEG. Providers submitting claims electronically must use the ASC X12N 837D 4010 A1 dental format. The payroll cut-off for electronic claims submission to MDCH is Wednesday of each week.

Complete information on submission of electronic claims is available on the MDCH website. (Refer to the Directory Appendix for website information.) The MDCH Electronic Submission Manual and other resources, such as Companion Guides, are on the website. Information on the website is updated as version changes occur at the national level and are adopted by MDCH.

3.1.A. AUTHORIZED BILLING AGENTS

Any entity (service bureau or individual provider) wishing to submit claims electronically to MDCH must be an authorized billing agent. The authorization process is:

- Contact the MDCH Automated Billing Unit for an application packet. (Refer to the Directory Appendix for contact information.)
- Complete and submit the forms in the application packet (an application and a participation agreement).
- Receive an ID number.
- Format and submit test files.
- When test files are approved, providers receive authorization from MDCH to bill electronically.

When authorized as an electronic billing agent, any provider (including providers who bill for themselves) who wants the billing agent to submit claims on their behalf must complete and submit the Billing Agent Authorization (DCH-1343) form to MDCH. (Refer to the Directory Appendix for contact information.) This form certifies that all services the provider has rendered are in compliance with Medicaid guidelines. MDCH notifies each provider when the DCH-1343 has been processed. After notification, approved billing agents can bill electronically for themselves or for other providers that have completed the DCH-1343 indicating that the billing agent may bill on their behalf. More than one billing agent per provider can be authorized to submit the provider's claims electronically. However, only one electronic billing agent may be the designated receiver of the electronic health care claim payment/advice ANSI X12N 835 4010A1. Authorizations remain in effect unless otherwise indicated in writing by the provider.

Complete details for the electronic billing agent authorization process, test file specifications, electronic billing information and the transaction set for dental claims can be found in the Electronic Submission Manual on the MDCH website. (Refer to the

Directory Appendix for website information.) Any production claims for services rendered must be billed on paper until the authorization process is complete.

Test claims are not processed for payment.

Any individual provider can submit claims electronically as long as the authorization process is completed and approved; however, many providers find it easier to use an existing authorized billing agent to submit claims to MDCH. Billing agents prepare claims received from their clients, format to HIPAA compliant MDCH standards, and submit the files to MDCH for processing. Whether claims are submitted directly or through another authorized billing agent, providers receive a paper remittance advice that reflects their individual claims. Billing agents receive a remittance advice that contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents, contact the Automated Billing Unit. (Refer to the Directory Appendix for contact information.)

3.1.B. Electronic Claims with Attachments

If comments or additional information are required with an electronic claim, electronic submitters must enter the information in the appropriate segments of the electronic record. If an operative report or other paper attachment is required and an electronic claim is submitted, refer to the Electronic Submission Manual for instructions for submitting paper attachments for electronic claims.

3.2 Paper Claims

The ADA Version 2002 claim form must be used when submitting paper claim forms. The MDCH Optical Character Reader (OCR) scans paper claims.

Claims may be prepared on a typewriter or on a computer. Handwritten claims are not accepted. Because claims are optically scanned, print or alignment problems may cause misreads, thus delaying processing of the claim. Keep equipment properly maintained to avoid the following:

- Dirty print elements with filled character loops.
- Light print or print of different density.
- Breaks or gaps in characters.
- Ink blotches or smears in print.
- Worn-out ribbons.

Dot matrix printers should not be used as they result in frequent misreads by the OCR.

Questions and/or problems with the compatibility of your equipment with MDCH scanners should be directed to the OCR Coordinator. (Refer to the Directory Appendix for contact information.)

Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period.

3.2.A. Guidelines to Complete Paper Claim Forms

To assure that the scanner correctly reads claim information, adhere to the following guidelines in preparing paper claims. Failure to do so can result in processing/payment delays or claims being returned unprocessed.

- Dates must be eight digits without dashes or slashes in the format MMDDCCYY (e.g., 10012003). Be sure the dates are within the appropriate boxes on the form.
- Use only black ink.
- Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- UPPER CASE alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12-point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. Do not squeeze comments below the service line.
- Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use correction fluid or correction tape, including self-correcting typewriters.
- If a mistake is made, start over and prepare a clean claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat, without folding, in 9" x 12" or larger envelopes. Do not fold the form.
- Put your return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut the edges of forms.
- Keep the file copy.
- Mail Dental claim forms separately from any other claim form type.

3.2.B. Paper Claims with Attachments

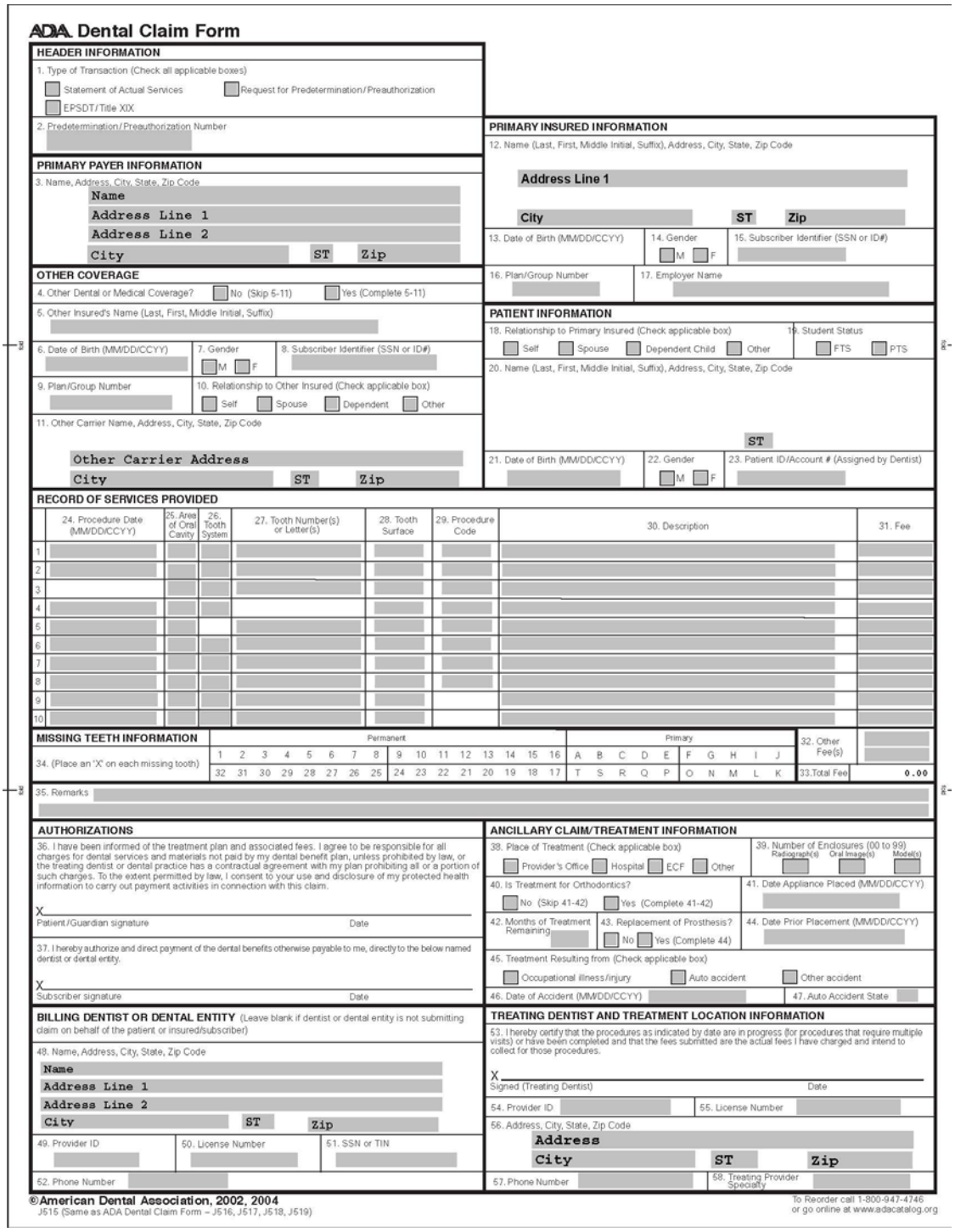
When a claim attachment(s) is required, it must be directly behind the claim it supports and be identified with the beneficiary's name and Medicaid ID Number. Attachments must be on 8 ½" x 11" white paper and one-sided. Do not submit two-sided materials. Multiple claims cannot be submitted with one attachment. Each claim form that requires an attachment must have a separate attachment. Do not staple or paperclip the documentation to the claim form.

Mail claim forms with attachments flat, with no folding, in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims without attachments in this envelope. Mail claims without attachments separately. Do not send attachments unless the attachment is required as unnecessary attachments delay processing of claims.

3.2.C. Mailing Paper Claims

All paper claim forms and claim forms with attachments must be mailed to MDCH. (Refer to the Directory Appendix for contact information.)

SECTION 4 – ADA COMPLETION INSTRUCTIONS



ADA Dental Claim Form

HEADER INFORMATION
1. Type of Transaction (Check all applicable boxes)
Statement of Actual Services | Request for Predetermination/Preauthorization | EPSDT/Title XIX
2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION
3. Name, Address, City, State, Zip Code
Name
Address Line 1
Address Line 2
City ST Zip

OTHER COVERAGE
4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)
5. Other Insured's Name (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) | 7. Gender M F | 8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number | 10. Relationship to Other Insured (Check applicable box) Self Spouse Dependent Other
11. Other Carrier Name, Address, City, State, Zip Code
Other Carrier Address
City ST Zip

PRIMARY INSURED INFORMATION
12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Address Line 1
City ST Zip
13. Date of Birth (MM/DD/CCYY) | 14. Gender M F | 15. Subscriber Identifier (SSN or ID#)
16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION
18. Relationship to Primary Insured (Check applicable box) Self Spouse Dependent Child Other | 19. Student Status FTS PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
ST
21. Date of Birth (MM/DD/CCYY) | 22. Gender M F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION
34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee 0.00

35. Remarks

AUTHORIZATIONS
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X
Patient/Guardian signature Date
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION
38. Place of Treatment (Check applicable box) Provider's Office Hospital ECF Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? No (Skip 41-42) Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? No Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from (Check applicable box) Occupational illness/injury Auto accident Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)
48. Name, Address, City, State, Zip Code
Name
Address Line 1
Address Line 2
City ST Zip
49. Provider ID | 50. License Number | 51. SSN or TIN
52. Phone Number

TREATING DENTIST AND TREATMENT LOCATION INFORMATION
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X
Signed (Treating Dentist) Date
54. Provider ID | 55. License Number
56. Address, City, State, Zip Code
Address
City ST Zip
57. Phone Number | 58. Treating Provider Specialty

©American Dental Association, 2002, 2004
J515 (Same as ADA Dental Claim Form – J516, J517, J518, J519)
To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

4.1 Dental Claim Form Completion Instructions [Change Made 4/1/06]

The following boxes must be completed on the ADA Version 2002 claim form unless otherwise indicated.

If no instruction is given, the boxes are optional and you do not have to enter any information.

1	**Type of Transaction**	Mark the box titled Dentist's statement of actual services. PA requests must continue to be submitted on the MSA-1680-B form. This is an optional field.
2	**Predetermination/ Preauthorization Number**	If the service you are billing requires a PA number, you must list the PA Number in the area provided. This is a required field.
3-23	**Patient/Beneficiary Information Section**	
3	**Primary Payer Information**	
4	**Other Dental or Medical Coverage?**	This information is necessary for Coordination of Benefits. This is a mandatory field.
5-11	**Other Coverage Information**	If the YES box is marked, then Box 5-11 are required. If NO, then skip to Box 12.
12-17	**Primary Insured Information**	Fill in the boxes with the patient/beneficiary information. Providers must enter Beneficiary Name and address in Box 12. Enter the Date of Birth in Box 13. Date of Birth must be an eight-figure configuration, e.g., 03152003. Enter the Beneficiary 8 digit ID number in Box 15. Boxes 12, 13 and 15 are mandatory. The other boxes are optional.
18 -23	**Patient Information**	Box 23 is used by the dental office to identify beneficiary/patient and is the Provider Reference Number. This is required when applicable. The other boxes are optional.
24-35	**Record of Services Provided**	
24	**Procedure Date**	List the date the service was provided. Date of Service must be an eight-figure configuration, e.g., 10132005. This is a mandatory field.

<table>
<tr><td>25</td><td>Area of Oral Cavity</td><td>List the appropriate numeric code when required along with the procedure code.
<table>
<tr><td>01=Maxillary Arch</td><td>20 = Upper Left</td></tr>
<tr><td>02=Mandibular Arch</td><td>30 = Lower Left</td></tr>
<tr><td>10= Upper Right</td><td>40= Lower Right</td></tr>
<tr><td colspan="2">(updated 4/1/06)</td></tr>
</table></td></tr>
<tr><td>26</td><td>Tooth System</td><td></td></tr>
<tr><td>27</td><td>Tooth Number(s) or Letter(s)</td><td>This is a required field when the procedure involves a tooth.</td></tr>
<tr><td>28</td><td>Tooth Surface</td><td>This is a required field when the procedure involves a surface(s).
Where applicable, the dentist must enter the appropriate code(s) indicating the tooth surface(s) being treated.
<table>
<tr><td>B = Buccal</td><td>L = Lingual</td></tr>
<tr><td>D = Distal</td><td>M = Mesial</td></tr>
<tr><td>F = Facial</td><td>O = Occlusal</td></tr>
<tr><td>I = Incisal</td><td></td></tr>
</table></td></tr>
<tr><td>29</td><td>Procedure Code</td><td>Use the appropriate procedure codes. This is a mandatory field.</td></tr>
<tr><td>30</td><td>Description</td><td></td></tr>
<tr><td>31</td><td>Fee</td><td>Report the dentist’s fee for the procedure. This is a mandatory field.</td></tr>
<tr><td>32</td><td>Other Fee</td><td>Report Other Insurance Payment information in this box. This is a required field, when applicable.</td></tr>
</table>

33	**Total Fee**	Each separate claim submitted must have the Total Fee box filled out even if there are multiple claims for a beneficiary. ▪ Do not put remarks in the Total Fee box, such as "See next page", then total all of the claims and put the entire fee on the last claim. Each claim is scanned and reimbursed separately. ▪ The Total Fee box must include the total of all ten claim lines. This is a mandatory field. ▪ Do not include dollar signs ($), decimals (.), dashes (-) or spaces in the fee amount field. For example, if a procedure is $50, then the payment information should be entered as 5000. ▪ If the Other Fee Box has been filled out with another insurance payment, the Total Fee should reflect the net difference between the Total charges minus the other insurance payment.
34	**Missing Teeth Information**	
35	**Remarks**	This is a required field, when applicable.
36-37	**Authorizations**	
36-37	**Signature Block**	
38-47	**Ancillary Claim/Treatment Information**	
38	**Place of Treatment**	Mark the box that applies to the setting. ECF is Extended Care Facility, e.g., nursing home. If place of treatment is a school setting, mark Other. If none of the other options apply, also mark Other. This is a mandatory field.
39	**Number of Enclosures**	
40	**Is Treatment for Orthodontics?**	
41	**Date Appliance Placed**	
42	**Months of Treatment Remaining**	

43	**Replacement of Prosthesis**	
44	**Date Prior Placement**	
45-47	**Treatment resulting from Occupational Illness or Injury; Auto Accident; or Other Accident**	Necessary to determine reimbursement in no-fault automobile accident cases. Indicates whether another party's insurance may be responsible. Important for Coordination Of Benefits (COB). Date of Accident must be an eight-figure configuration, e.g., 10132005. Boxes 45-47 are required fields, when applicable.
48-52	**Billing Dentist or Dental Entity**	
48	**Name, Address, City, State, Zip code of Billing Dentist or Dental Entity**	Include the individual dentist's name for billing. Enter address where treatment was performed. This is a mandatory field.
49	**Provider ID Number**	This is the unique provider type and provider number assigned by the Medicaid program for identification. This is a 9-digit field; the first two are the provider type and the last seven are the unique provider ID #. A space may be included between the provider type and ID number. For example, 12 7654321. This is a mandatory field.
50	**Dentist License Number**	
51	**Dentist Soc. Sec. or TIN**	Enter either the Dentist SSN or TIN. This is a mandatory field.
52	**Phone Number**	
53-58	**Treating Dentist and Treatment Location Information**	
53	**Signature & Date**	A signature is required. See the General Information for Providers Chapter of this manual for the provider certification requirements and acceptable signatures for the claim form. Date of signature is also mandatory.
54-55	**Provider ID & License Number**	

56	**Address, City, State, Zip Code**	
57	**Phone Number**	
58	**Treating Provider Specialty**	

SECTION 5 – SPECIAL BILLING INSTRUCTIONS

5.1 SUPERNUMERARY TEETH

Providers must bill D7999 (unspecified oral surgery by report code) for supernumerary teeth. This code can only be used once per claim. The extraction procedure performed (STI, PBI, CBI) and the location in the mouth must be included in the Remarks field. If there is more than one supernumerary tooth, the quantity extracted must also be included.

The total fee billed should reflect the number of extractions completed. The claim will pend for review. Payment will be based on the type of extraction performed.

5.2 LOSS OR CHANGE IN ELIGIBILITY

Providers can only bill for root canal therapy, complete and partial dentures, and laboratory-processed crowns if loss or change in eligibility occurs. Services must have been started prior to the loss of eligibility.

- Bill with Not Otherwise Classified (NOC) procedure code D5899
- Include a copy of the lab bill for complete or partial dentures, and laboratory-processed crowns
- Provide an explanation in the Remarks section of the claim
- For complete or partial dentures and laboratory-processed crowns, the date of service on the claim should be the date of the initial impression
- For root canal therapy, the date of service should be the first treatment appointment

5.3 INCOMPLETE ROOT CANAL

For an incomplete root canal:

- Providers must bill the Not Otherwise Classified (NOC) procedure code D3999
- Provide an explanation in the Remarks section of the claim
- Date of service should be the first treatment appointment

5.4 ORTHODONTIC BILLING INSTRUCTIONS

For interceptive orthodontic treatment procedure codes, the fee is all inclusive. The date of service on the claim is the banding/start date. Include the PA number on the claim.

Comprehensive orthodontic procedure codes are to be used in the first stage of each comprehensive treatment phase. The date of service on the claim is the banding/start date. Include the PA number on the claim.

The periodic orthodontic treatment visit is for a six-month timeframe. The date of service on the claim is the first day of the six-month timeframe. The entire timeframe is entered in the Remarks Section of the claim form. Include the PA number on the claim.

If the periodic orthodontic treatment ends before an entire six-month timeframe is completed, the fee for the treatment timeframe must be prorated. The periodic orthodontic treatment fee is based on a six-month timeframe. The fee charged should reflect the periodic treatment timeframe. The date of service on the claim is the first day of the periodic timeframe. The entire prorated timeframe is entered into the Remarks Section of the claim form. Include the PA number on the claim.

SECTION 6 – REPLACEMENT CLAIMS

6.1 GENERAL INFORMATION

Replacement claims must be submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after MDCH has made payment. Reasons claims may need to be replaced:

- To return an overpayment (report "returning money" in Remarks section);
- To correct information submitted on the original claim such as changing the date of service, tooth number or incorrect charges;
- To correct an incorrect provider ID number or beneficiary ID number (refer to the void/cancel process below);
- To report payment from another source after MDCH paid the claim (report "returning money" in Remarks section); and/or
- To correct information that the scanner may have misread (state reason in Remarks section).

If all service lines on a claim were rejected, the services must be resubmitted as a new claim, not a replacement claim.

6.2 CLAIM REPLACEMENT AND VOID / CANCEL CLAIMS

Providers may submit a replacement claim using the ADA paper dental claim form or electronically using the 837 claim format.

Providers using the paper dental claim form to submit a replacement claim must submit a new claim. All service lines, including correctly paid lines, must be reported on the replacement claim. All money paid on the first claim will be debited and the new payment will be based on the information reported on the replacement claim. All instructions for claim completion apply for the replacement claim.

In field 35 , "Remarks" on the paper claim form, providers must write the word CRN with a colon, then include the 10-digit Claim Reference Number (CRN). Any additional comments may be entered after this information.

Instructions for submitting an electronic replacement claim are contained in the MDCH 837D Companion Guide available on the MDCH website. (Refer to the Directory Appendix for website information.)

Providers using the paper dental claim form to submit a void/cancel claim must submit a new claim. Only one service line needs to be completed with zero dollars entered in the charges or money field. All money paid on the first claim line will be deleted. Upon notification through the Remittance Advice that the money has been deleted from the Medicaid system, a new claim with the correct provider ID and/or beneficiary ID may be submitted.

For submission of paper replacement and void/cancel claims, refer to the Directory Appendix for contact information.

6.3 Payment Refunds

Return of overpayments made by MDCH, due to either payment from a third party resource or due to an error, must be done through the use of a replacement claim or void/cancel claim. This process will result in a debit against future payment.

This requirement does not apply to inactive providers or monies being returned to MDCH due to settlements or lawsuits. In these situations, checks must:

- be made payable to the State of Michigan in the amount of the refund
- include the provider EIN (tax) number
- be sent to MDCH Cashier's Unit. (Refer to the Directory Appendix for contact information.)

Do not submit a replacement claim and manually send a refund to the Cashier's Unit as this results in an incorrect refund amount.

SECTION 7 – CHANGES IN ELIGIBILITY AND ENROLLMENT (FFS/CSHCS)

7.1 GENERAL INFORMATION

It is the provider's responsibility to determine eligibility/enrollment status of beneficiaries at the time services are provided and obtain the appropriate authorizations for payment.

Medicaid, Adult Benefits Waiver (ABW) or Children's Special Health Care Services (CSHCS) beneficiaries may lose their eligibility or change enrollment status on a monthly basis. Enrollment status changes include beneficiaries changing from FFS (Fee-For-Service Medicaid or CSHCS) to a Medicaid Health Plan (MHP), from one health plan to another health plan, or from a health plan to FFS. Normally the change occurs at the beginning of a month; however, some changes may occur during the month. It is important that providers check beneficiary eligibility before each service is provided to determine who is responsible for payment and whether authorization is necessary. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

7.2 BILLING REQUIREMENTS

MDCH policy directs providers to bill the date of delivery for dentures and laboratory-processed crowns. However, when a beneficiary has a change in eligibility status and services have been started for root canal therapy, dentures and laboratory-processed crowns, the provider has 30 days from the loss or change in eligibility status to complete the services. The date of service on the claim form should be the date of the initial impression for dentures and laboratory-processed crowns.

SECTION 8 – REMITTANCE ADVICE

A Remittance Advice (RA) is produced to inform providers about the status of their claims. RAs are available in paper and electronic formats, and utilize the HIPAA-compliant national standard claim adjustment group codes, claim adjustment reason codes, and remarks codes, as well as adjustment reason codes, to report claim status. Code definitions are available from the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

8.1 PAYMENTS / CLAIM STATUS

MDCH processes claims and issues payments (by check or EFT) every week unless special provisions for payments are included in the provider enrollment agreement. A RA is issued with each payment to explain the payment made for each claim. If no payment is due, but claims have pended or rejected, an RA is also issued. If claims are not submitted for the current pay cycle, no action is taken on previously pended claims, or no payment gross adjustments are processed in the pay cycle, an RA is not generated.

If the total amount approved for claims on any one RA is less than $5.00, a payment is not issued for that pay cycle. Instead, a balance is held until approved claims accumulate to an amount equal to or more than $5.00. Twice a year (usually June and December) all amounts of less than $5.00 are paid.

If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider ID number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment.

Payments to providers are issued by Tax Identification Number (TIN). All payments due to all providers enrolled with the MDCH under a specific TIN are consolidated and issued as one check or EFT.

Providers who would like to receive payments from MDCH through EFT must register through the Department of Management and Budget's (DMB) website. (Refer to the Directory Appendix for DMB website information.)

8.2 ELECTRONIC REMITTANCE ADVICE

The electronic RA is produced in the HIPAA-compliant ANSI X12N 835 version 4010A1 format. Providers opting to receive an electronic RA receive all information regarding adjudicated (paid or rejected) claims in this format. Information regarding pended claims is reported electronically in the 277 Unsolicited Claim Status format.

The electronic RA has many advantages:

- It can serve to input provider claim information into the provider's billing and accounting systems.
- It includes a MDCH trace number to identify the associated warrant or electronic funds transfer (EFT) payment.
- It returns the provider's internal medical record number, line item control number, and patient control number when submitted on the original claim.
- It contains additional informational fields not available on the paper RA.

The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835 and/or 277U, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835/277U transaction must identify a primary service bureau to receive the 835/277U. All providers under the same corporate TIN must utilize the same primary service bureau. An addition of and/or change to the identification of the primary service bureau must be submitted to Provider Enrollment. The primary service bureau is the only one to receive the 835/277U remittance information for all claims regardless of submission source. No other service bureau submitting claims for that provider/group TIN receives information regarding claims submitted.

For more information regarding the 835 and 277U transactions issued by the MDCH, refer to the MDCH Companion Documents on the MDCH website. For general information about the 835 and 277U, refer to the Implementation Guides for these transactions. The guides are available through the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

8.3 Paper Remittance Advice

All providers with approved or pended claims receive a paper RA, even if they opt to receive the 835/277U transactions.

The following information is supplied on the paper RA Header:

Provider ID# and Provider Type	This is the Medicaid Provider ID from the provider's claim. The first two digits of the Provider ID appear in the Provider Type box and the last seven digits appear in the Provider Number box.
Provider Name	This is from the MDCH provider enrollment record for the Provider ID# submitted on the claim.
Pay Cycle	This is the pay cycle number for this RA.
Pay Date	This is the date the RA is issued.
Page No.	Pages of the RA are numbered consecutively.
Federal Employer ID# (EIN) or Social Security Number (SSN)	This is in small print in the upper right corner and is unlabeled. The number on the provider's claim must match the billing provider ID# on file with the MDCH and it must be a valid number with the Michigan Department of Treasury. MDCH cannot issue a check if there is a discrepancy between the number on file with MDCH and the Michigan Department of Treasury. (Incorrect information should be reported to the Provider Enrollment Unit. Refer to the Directory Appendix for contact information.)

Claims appear on the RA in alphabetical order by the beneficiary's last name. If there is more than one claim for a beneficiary, they appear in Claim Reference Number (CRN) order under the beneficiary's name. The following table explains the fields of the RA:

Field Name	Explanation
Claim Header	**Patient ID Number:** Prints the beneficiary's Medicaid ID number that the provider entered on the claim. **Claim Reference Number (CRN):** A 10-digit CRN is assigned to each claim. If the claim has more than one service line, the same CRN is assigned to each line. The first four digits are the Julian Date the claim was received by MDCH. The fifth through tenth digits are the sequential claim number assigned by the MDCH. Example: In CRN 3223112345, 3 is the year 2003, 223 is the Julian day of the year (August 11), and 112345 is the sequence number. The combination of Julian day and sequence makes a unique number that is assigned to each claim. When asking about a particular claim, the provider must refer to the CRN and Pay Date. The 10-digit CRN is following by a two-character input ID (3223223445-XX). If a service bureau submitted the claim, this is the service bureau ID. If the provider submitted a paper claim, this is a scanner identifier.
Line No.	This identifies the line number where the information was entered on the claim.
Invoice Date	This identifies the date the provider entered on the claim or, if left blank, the date the claim was processed by the system.
Service Date	This identifies the service date entered on the claim line (admit date for inpatient service).
Procedure Code	This identifies the procedure code or revenue code entered on the service line.
Qty.	This identifies the quantity entered on the service line. If the MDCH changed your quantity, an informational edit appears in the Explanation Code column.
Amount Billed	This identifies the charge for the entire claim.
Amount Approved	This identifies the amount the MDCH approved for the service line (amount approved for DRG represents the entire claim and it is not approved by claim line). Pended and rejected service lines show the amount approved as zero (.00). Zero also prints when no payment is due from MDCH. For example, when other resources made a payment greater than MDCH's usual payment.
Claim Adjustment Reason Code	Claim adjustment reason codes communicate why a claim or service line was paid differently than was billed. If there is no adjustment to a claim line, then there is no adjustment reason code.

Field Name	Explanation
Claim Remark Code	Claim remark codes relay service line specific information that cannot be communicated with a reason code.
Invoice Total	Totals for the Amount Billed and the Amount Approved print here.
Insurance Information	If Medicaid beneficiary files show other insurance coverage, the carrier name, policy number, effective dates and type of policy (e.g., vision, medical) print below the last service line information.
History Editing	Certain edits compare the information on the claim to previously paid claims. In some cases, information about the previous claim prints on the RA. This information prints directly under the service line to which it relates.
Page Total	This is the total Amount Approved for all service lines on the page. If a claim has service lines appearing on two RA pages, the page total includes only the paid lines printed on each RA page.

8.4 Gross Adjustments

Gross adjustments are initiated by MDCH. A gross adjustment may pertain to one or more claims. Providers are notified in writing when adjustments are made to claims. Notification should be received before the gross adjustment appears on the RA.

The paper RA indicates gross adjustments have been made by:

- **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes are used. Code definitions can be found in the 835 Implementation Guide.
- **Gross Adjustment Code:** This is the MDCH gross adjustment code that corresponds to the gross adjustment description.

Code	Name	Explanation
GACR	Gross Adjustment Credit	This appears when the provider owes MDCH money. The gross amount is subtracted from the provider's approved claims on the current payroll.
GADB	Gross Adjustment Debit	This appears when MDCH owes the provider money. The gross adjustment amount is added to the provider's approved claims on the current payroll.

Code	Name	Explanation
GAIR	Gross Adjustment Internal Revenue	This appears when the provider has returned money to MDCH by check instead of submitting a replacement claim. It is subtracted from the provider's YTD (Year To Date) Payment Total shown on the summary page of the RA.

8.5 Remittance Advice Summary Page

The Summary Page is the last page of the RA and gives totals on all claims for the current payroll and year-to-date totals from previous payrolls. The table below explains the fields of the Summary Page.

Field Name	Explanation
This Payroll Status	The total number of claims and the dollar amount for the current payroll. This includes new claims plus pended claims from previous payrolls that were paid, rejected, or pended on the current payroll.
Approved	Number of claims from this payroll with a payment approved for every service line. The dollar amount is the total approved for payment.
Pends	Number of claims from this payroll that are pending. The dollar amount is the total charges billed.
Rejected	Number of claims from this payroll with a rejection for every service line. The dollar amount is the total charges billed.
App'd/Rejected	Number of claims from this payroll with a combination of paid and rejected service lines. The amount next to App'd Claim Lines is the total approved. The amount next to Rejected Claim Lines is the total charge billed.
Total Pends in System	Number of new and unresolved pended claims in the system and related total charges.
Previous YTD (Year to Date) Payment Total	The total amount paid for the calendar year before any additions or subtractions for this payroll.
Payment Amount Due This Payroll to Provider	Payment Amount Approved, plus any balance due to the provider, minus any balance owed by the provider to MDCH.

Field Name	Explanation
Payment Made This Payroll	The amount of the check or EFT issued for this payroll.
New YTD Payment Total This Payroll	Total payment for the calendar year, including payments made on this payroll.
Balance Owed or Balance Due	One or more of the following messages prints if there is a balance owed or a balance due. ▪ **Balance Due to Provider by MDCH:** This appears if the payment amount approved is less than $5.00 or a State account is exhausted. ▪ **Balance Owed by Provider to MDCH:** This appears when money is owed to MDCH, but you do not have sufficient approved claims from a particular State account (e.g., CC or ABW) to deduct what is owed. ▪ **Previous Payment Approved, Not Paid:** This appears if a balance is due from MDCH on the previous payroll. ▪ **Previous Payment Owed by Provider to MDCH:** This appears when a balance is due from you on a previous payroll.
Pay Source Summary	Identifies the dollar amounts paid from the designated State accounts.

8.6 Pended and Rejected Claims

When claims are initially processed, the Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid, rejected or pended and lists edits that apply.

- **Rejections:** If a service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. The provider should review the definitions of the codes to determine the reason for the rejection.
- **Pends:** If any service line pends for manual review, PEND prints in the Claim Adjustment Reason/Remark column of the RA. These pended claims do not print again on the RA until the claim:
  - Is paid or rejected;
  - Is pended again for another reason; or
  - Has pended for 60 days or longer.

When a claim is pended, the provider must wait until it is paid or rejected before submitting another claim for the same service.

After a claim initially pends, it may pend again for a different reason. In that case, a symbol sign (#) prints in front of the CRN on the RA to show that it is pending again for further review. CRNs may also appear with a # symbol if they have pended 60 days or longer.

SECTION 9 – JULIAN CALENDAR

Day Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	- -	88	119	149	180	210	241	272	302	333	363
30	30	- -	89	120	150	181	211	242	273	303	334	364
31	31	- -	90	- - -	151	- - -	212	243	- - -	304	- - -	365

For leap year, one day must be added to number of days after February 28. The next three leap years are 2008, 2012, and 2016.

Example: claim reference # 3351203770-59
3 = year of 2003
351 = Julian date for December 17
203770 = consecutive # of invoice
59 = internal processing

BILLING & REIMBURSEMENT FOR INSTITUTIONAL PROVIDERS

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION

This chapter applies to providers billing the UB-92 or 837 Institutional claim formats. It contains information needed to submit institutional claims to the Michigan Department of Community Health (MDCH) for Medicaid and Children's Special Health Care Services (CSHCS) and the Adult Benefits Waiver (ABW). It also explains how claims are processed and providers are notified of MDCH actions.

The following providers must use the ASCX12N 837 4010A1 institutional format when submitting electronic claims and the UB-92 claim form for paper claims.

- Home Health Agencies
- Hospice
- Hospital
- Nursing Facilities
- Outpatient Therapy Providers*
- Private Duty Nursing Agencies

*Comprehensive Outpatient Rehabilitation Facilities, Outpatient Rehabilitation Agencies, CARF-Accredited Medical Rehabilitation Programs, CAA-Accredited University Graduate Education Programs

1.1 CLAIMS PROCESSING SYSTEM

All claims submitted and accepted are processed through the Claims Processing (CP) System. Paper claims are scanned and converted to the same file format as claims submitted electronically.

Claims processed through the CP system are edited for many parameters including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services and combination of service edits. Electronic claims processed by Wednesday may be processed as early as the next weekly cycle.

MDCH encourages providers to send claims electronically by file transfer or through the data exchange gateway (DEG). Electronic filing is more cost effective, more accurate, payment is received more quickly and administrative functions can be automated.

1.2 REMITTANCE ADVICE

After claims have been submitted and processed through the CP System, a paper remittance advice (RA) is sent to each provider with adjudicated or pended claims. An electronic health care claim payment/advice (ASC X12N 835 4010A1) is sent to the designated primary service bureau for providers choosing an electronic RA. (Refer to the Remittance Advice Section of this chapter for additional information about both the paper and electronic RA.)

1.3 ADDITIONAL RESOURCE MATERIAL

Additional materials needed to bill include:

Bulletins	These intermittent publications supplement the Medicaid Provider Manual. Bulletins are automatically mailed to enrolled providers affected by the bulletin and subscribers of the Manual. Recent bulletins can be found on the MDCH website. (Refer to the Directory Appendix for website information.)
Companion Guide (Data Clarification Document)	This document is intended as a companion to the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional Claim, ASC X12N 837A1. It contains data clarifications and identifiers to use when a national standard has not been adopted, and parameters in the Implementation Guide that provide options.
Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Coding Manuals	These manuals are published annually listing national CPT and HCPCS codes. Publications are available from many sources, such as the American Medical Association (AMA) Press or Medicode. The HCPCS codes are available on the CMS website for free downloading. (Refer to the Directory Appendix for contact and website information.)
Electronic Submission Manual	This manual provides detailed instructions on obtaining approval for electronic billing and how to file electronic claims to MDCH. It is available on the MDCH website. (Refer to the Directory Appendix for website information.)
International Classification of Diseases, Clinical Modification (ICD-9-CM)	Diagnosis codes are required on claims using the conventions detailed in this publication. This publication is updated annually and may be requested from Medicode or the AMA. (Refer to the Directory Appendix for contact information.)
Databases	These databases list procedure codes, descriptions, fee screens, and other pertinent coverage, documentation, and billing indicators. The databases are only available on the MDCH website. (Refer to the Directory Appendix for website information.)
Numbered Letters	General program information or announcements are transmitted to providers via numbered letters. These can be found on the MDCH website. (Refer to the Directory Appendix for website information.)
Medicaid Provider Manual	The manual includes program policy and special billing information. A CD copy of the manual is available at a nominal cost from MDCH. It is also available on the MDCH website for review or download. (Refer to the Directory Appendix for contact and/or website.)
Uniform Billing Manual (UB-92 Manual)	This manual may be purchased from the Michigan Health and Hospital Association, Health Delivery and Finance Department. (Refer to the Directory Appendix for contact information.)

1.4 ELECTRONIC FUNDS TRANSFER

Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments into a provider's bank account. This replaces a paper warrant. To initiate an EFT, the facility should go to the Department of Management and Budget website. (Refer to the Directory Appendix for website information.)

SECTION 2 – HOW TO FILE CLAIMS

Institutional claims may be submitted electronically or on paper. Electronic claim submission is the preferred method for submitting claims to MDCH.

2.1 ELECTRONIC CLAIMS

Claims submitted electronically and accepted are received directly into the Claims Processing (CP) System, resulting in faster payments and fewer claims that pend or reject. Electronic claims can be submitted by file transfer or through the Data Exchange Gateway (DEG). Providers submitting claims electronically must use the ASC X12N 837 4010 A1 institutional format. The payroll cut-off for electronic claims submission to MDCH is Wednesday of each week.

Complete information on submission of electronic claims is available on the MDCH website. (Refer to the Directory Appendix for website information.) The MDCH Electronic Submission Manual and other resources, such as Companion Guides, are on the MDCH website. Information on the website is updated as version changes occur at the national level and are adopted by MDCH.

2.1.A. AUTHORIZED ELECTRONIC BILLING AGENT

Any entity (service bureau or individual provider) wishing to submit claims electronically to MDCH must be an authorized billing agent. The authorization process is:

- Contact the Automated Billing Unit for an application packet (refer to the Directory Appendix for contact information);
- Complete and submit the forms in the application packet (an application and a participation agreement);
- Receive an identification (ID) number;
- Format and submit test files; and
- When test files are approved, providers receive authorization from MDCH to bill electronically.

When authorized as an electronic billing agent, any provider (including providers who bill for themselves) who wants claims submitted on their behalf must complete and submit the Billing Agent Authorization (DCH-1343) form to MDCH. This form certifies that all services the provider has rendered are in compliance with Medicaid guidelines. MDCH notifies each provider when the DCH-1343 has been processed. After notification, approved billing agents can bill electronically for themselves or for other providers that have completed the DCH-1343 indicating that the billing agent may bill on their behalf. More than one billing agent may submit claims for a provider. However, only one billing agent may be the designated receiver of the Health Care Claim Payment/Advice (ANSI X12N 835). (Refer to the Remittance Advice Section of this chapter for additional information.) Authorizations remain in effect unless otherwise indicated in writing by the provider.

Test claims are not processed for payment.

Complete details for the electronic billing agent authorization process, test file specifications, electronic billing information and the transaction set for institutional claims can be found in the Electronic Submission Manual on the MDCH website. (Refer to the Directory Appendix for website information). Any live claims for services rendered must be billed on paper until the authorization process is complete.

Any individual provider can submit claims electronically as long as the authorization process is completed and approved; however, many providers find it easier to use an existing authorized billing agent to submit claims to MDCH. Billing agents prepare claims received from their clients, format to HIPAA-compliant MDCH standards and submit the file to MDCH for processing. Whether claims are submitted directly or through another authorized billing agent, providers receive a paper remittance advice (RA), which reflects their individual claims. Billing agents receive an RA that contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents, contact the Automated Billing Unit. (Refer to the Directory Appendix for contact information.)

2.1.B. Electronic Claims with Attachments

If comments or additional information is required with an electronic claim, electronic submitters must enter the information in the appropriate segments of the electronic record. Refer to the Electronic Submission Manual for electronic claims instructions on how to submit electronic data and an overview of the MDCH invoice processing system. (Refer to the Providing Attachments With Paper Claim Forms subsection of this chapter for additional information.)

Providers who bill electronically may submit required documentation separately at that time as follows:

- Documentation must have the following information, in the order indicated, in the upper right hand corner of each page:
  - Beneficiary ID number (eight characters);
  - Provider ID number;
  - From date of service; and
  - The page number of the documentation (such as page 1 of 5, page 2 of 5, etc).
- All documentation must be submitted:
  - On 8 ½" by 11" paper
  - Microfilm ready. This means that the facility must copy and insert, face up, the back page, immediately following the front page, for each two-sided original page. This allows MDCH to complete microfilming of the submitted documentation.

If the appropriate information is not recorded on each page of documentation, it is returned to the provider indicating the reason it is being returned. If the documentation is correct, it is filed for use in processing only electronic claim(s).

Documentation should be mailed to the MDCH Medicaid Payments Division. (Refer to the Directory Appendix for contact information.) When the provider electronically bills MDCH, they must submit the required documentation at that time. The claim should indicate in the Remarks Section that documentation was sent separately. For example, history and physical sent separately, or prior authorization (PA) sent separately or remittance advices verifying time limit exception sent separately.

2.2 Paper Claims

The UB-92 claim form must be used when submitting paper claims. It must be a red-ink form with UB-92 CMS-1450 in the lower left corner. Use of forms other than the red ink version will result in errors when they are scanned by the Optical Character Reader (OCR).

Claims may be prepared on a typewriter or on a computer. Handwritten claims are not accepted. Because claims are optically scanned prior to processing, print or alignment problems may cause misreads, thus delaying processing of the claim. Keep equipment properly maintained to avoid the following:

- Dirty print elements with filled character loops.
- Light print or print of different density.
- Breaks or gaps in characters.
- Ink blotches or smears in print.
- Worn out ribbons.

Dot matrix printers should not be used as they result in frequent misreads by the OCR.

Questions and problems with the compatibility of equipment with MDCH scanners should be directed to the OCR Coordinator. (Refer to the Directory Appendix for contact information.)

Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period.

2.2.A. Guidelines to Complete Paper Claim Forms

To ensure that the scanner correctly reads claim information, adhere to the following guidelines in preparing paper claims. Failure to adhere to these guidelines may result in processing/payment delays or claims being returned unprocessed.

- Date of birth must be eight digits without dashes or slashes in the format MMDDCCYY (e.g., 03212002). All other dates must be six digits in the format MMDDYY. Be sure the dates are within the appropriate boxes on the form.
- Use only black ink.
- Do not write or print on the claim, except for the Provider Signature Certification.

- Handwritten claims are not acceptable.
- UPPER CASE alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12-point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. Do not squeeze comments below the service line.
- Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use correction fluid or correction tape, including self-correction typewriters.
- If a mistake is made, the provider should start over and prepare a clean claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat, with no folding, in 9" x 12" or larger envelopes.
- Put a return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut edges of forms.
- Keep the file copy.
- Mail UB-92 claim forms separate from any other type of form.

2.2.B. Providing Attachments with Paper Claim Forms

When a claim attachment(s) is required, it must be directly behind the claim it supports and be identified on each page with the beneficiary's name and Medicaid ID number. Attachments must be on 8 ½" x 11" white paper and one-sided. Do not submit two-sided material. Multiple claims cannot be submitted with one attachment. Each claim form that requires an attachment must have a separate attachment. Do not staple or paperclip the documentation to the claim form.

Mail claim forms with attachments flat, with no folding, in a 9"x12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims that have no attachments in this envelope. Mail claims without attachments separately. Do not send attachments unless the attachment is required as unnecessary attachments delay claim processing.

2.2.C. Mailing Paper Claim Forms

All paper claim forms and claim forms with attachments must be mailed to MDCH. (Refer to the Directory Appendix for contact information.)

SECTION 3 – REPLACEMENT, VOID/CANCEL CLAIMS AND REFUND OF PAYMENT

3.1 REPLACEMENT CLAIMS (ADJUSTMENTS)

Replacement claims are submitted when all or a portion of the claim was paid incorrectly or a third-party payment was received after MDCH made payment. When replacement claims are received, MDCH deletes the original claim and replaces it with the information from the replacement claim. It is very important to include all service lines on the replacement claim, whether they were paid incorrectly or not. All money paid on the first claim will be recouped and payment will be based on information reported on the replacement claim only. Examples of when a claim may need to be replaced:

- To return an overpayment (report "returning money" in Remarks section);
- To correct information submitted on the original claim (other than to correct the Provider ID number and/or the beneficiary ID number). Refer to the Void/Cancel subsection below;
- To report payment from another source after MDCH paid the claim (report "returning money" in Remarks section); and/or
- To correct information that the scanner may have misread (state reason in Remarks section).

To replace a previously paid claim, indicate 7 (xx7) as the third digit in the Type of Bill Form locator frequency. Providers must enter the 10-digit Claim Reference Number (CRN) of the last approved claim being replaced and the reason for the replacement in Remarks. The Provider ID number and beneficiary ID number on the replacement claim must be the same as on the original claim. Providers must enter in Remarks the reason for the replacement. Refer to the Void/Cancel subsection below for additional information.

3.2 VOID/CANCEL A PRIOR CLAIM

If a claim was paid under the wrong provider or beneficiary ID Number, providers must void/cancel the claim. To void/cancel the claim, indicate an 8 in the Type of Bill (xx8) as the third digit frequency. The 8 indicates that the bill is an exact duplicate of a previously paid claim, and the provider wants to void/cancel that claim. The provider must enter the 10-digit CRN of the last approved claim or adjustment being cancelled and enter in the Remarks Section the reason for the void/cancel. A new claim may be submitted immediately using the correct provider or beneficiary ID number.

A void/cancel claim must be completed exactly as the original claim.

3.3 REFUND OF PAYMENT

Return of overpayments made by MDCH, due to either payment from a third party resource or due to an error, must be done through the use of a replacement claim or void/cancel claim. This process will result in a debit against future payment.

This requirement does not apply to inactive providers or monies being returned to MDCH due to settlements or lawsuits. In these situations:

- checks must be made payable to the State of Michigan in the amount of the refund
- include the provider EIN (tax) number

- be sent to MDCH Cashier's Unit (refer to the Directory Appendix for contact information)

Do not submit either a replacement claim or a void/cancel claim **and** manually send a refund to the Cashier's Unit as this will result in an incorrect amount.

SECTION 4 – CHANGES IN ELIGIBILITY/ENROLLMENT (FFS/MHP/CSHCS)

It is the provider's responsibility to determine eligibility/enrollment status of patients at time of treatment and obtain the appropriate authorizations for payment.

Medicaid, CSHCS or ABW beneficiaries may lose eligibility or change enrollment status on a monthly basis. Enrollment status changes include beneficiaries changing from FFS (FFS Medicaid or CSHCS) to a Medicaid Health Plan (MHP), from one health plan to another health plan, or from a health plan to FFS. Normally the change occurs at the beginning of a month; however, some changes may occur during the month. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.) It is important that providers check beneficiary eligibility before each service is provided to determine who is responsible for payment and whether PA is necessary.

4.1 AUTHORIZATION OF ADMISSIONS AND SERVICES

The following guidelines are intended to assist providers and health plans with common concerns regarding authorization of services and payment responsibility, particularly when a change in enrollment status has occurred.

- All admissions (other than emergency admissions) require PA. MDCH or its Admissions and Certification Review Contractor (ACRC) must authorize medical/surgical (non-psychiatric) admissions for FFS beneficiaries. If the beneficiary is enrolled in a MHP, the health plan must prior authorize the admission. All psychiatric admissions must be authorized by the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).
- Services provided during the inpatient admission may also require PA for health plan enrollees. Providers must be aware of the beneficiary's enrollment status and of health plan requirements and processes for authorization. Consultations, surgical procedures, and diagnostic tests are not reimbursed unless a health plan's PA process is followed.
- If a beneficiary is admitted by the local PIHP/CMHSP, the admission and all psychiatric services are the responsibility of the PIHP/CMHSP. However, for beneficiaries enrolled in a MHP, any non-psychiatric medical/surgical services needed during a psychiatric admission are the responsibility of the health plan and must be authorized by the health plan. For FFS beneficiaries, the non-psychiatric medical/surgical services should be billed to MDCH. This includes transportation to another facility for medical/surgical services. If a beneficiary is admitted for medical/surgical services authorized by the health plan and needs psychiatric consultation or care, the PIHP/CMHSP must be contacted for authorization and is then responsible for payment for the psychiatric services.
- If a beneficiary is admitted to an inpatient hospital facility and the enrollment status changes during the admission (e.g., a FFS beneficiary enrolls in a MHP), the payer at the time of admission is responsible for payment for all services provided until the date of discharge. Services provided after discharge are the responsibility of the new payer. The discharge planning process should include the new payer for authorization of any medically necessary services or treatments required after discharge from the hospital.
- If a beneficiary is transferred from one inpatient hospital to another inpatient hospital, this does not constitute a discharge. The payer at admission is the responsible party until the beneficiary is discharged from the inpatient hospital setting to a non-hospital setting.

The following examples illustrate payment responsibilities:

FFS to Health Plan	A FFS beneficiary is admitted on 9-15, enrolled in a health plan on 10-1, and discharged from the hospital on 10-5. The health plan is not responsible for services until 10-5, after discharge. FFS is responsible for the entire admission and physician services provided during the admission. The health plan must be contacted at discharge to transition care needs and authorize services needed after discharge, such as rental of equipment, ongoing medical supply needs, ongoing treatment (e.g., home health care, physical therapy, chemotherapy, IV infusion), etc.
Health Plan to Health Plan	If a beneficiary is in health plan "A" during September and changes to health plan "B" for October, health plan "A" is responsible for the admission. Health plan "B" must be contacted during the discharge planning process and is responsible for authorizing all services needed after discharge.
Health Plan to Health Plan with Transfer to Tertiary Hospital	A beneficiary enrolled in health plan "A" is admitted for authorized surgery in June. The beneficiary is enrolled in health plan "B" on July 1. After surgery, the beneficiary develops complications necessitating a transfer to a tertiary hospital on July 2. The beneficiary is subsequently discharged to home on July 6. Plan "A" is responsible for all hospital and physician services through July 6, and plan "B" is responsible for all services needed after discharge.
Hospitalization for Medical Reasons During an Inpatient Psychiatric Stay	A health plan beneficiary is admitted for inpatient psychiatric care by a PIHP/CMHSP. During the admission, the patient requires surgery for medical reasons at another facility. The beneficiary's health plan must authorize the surgery and is responsible for paying for transport between the facilities and for charges related to the surgery.

CSHCS Exception: Beneficiaries with CSHCS coverage are excluded from enrollment in a MHP.

- When a beneficiary becomes enrolled in CSHCS, he is disenrolled from the MHP.
- Upon review, MDCH may initiate a retroactive disenrollment from the MHP effective the first day of the month in which CSHCS medical eligibility was determined.
- Responsibility of payment transfers from the MHP to FFS on the effective date of the disenrollment.
- Providers are advised to check the Eligibility Verification System for changes of enrollment status prior to billing.

4.2 Ongoing Services and Extended Treatment Plans

Providers are responsible for verifying a beneficiary's eligibility/enrollment status before each service is rendered, particularly on the first day of a new month. Even though a beneficiary may be involved in an ongoing treatment or care plan, a change in enrollment status requires new authorization from the new responsible party. Enrollment in a health plan always triggers an authorization process through the new or "current" health plan. There is no requirement for a new health plan to reimburse providers for services that were authorized under a previous health plan. The new health plan must assess the need for continuing services and authorize, as appropriate. Health plans should facilitate the transition between providers to ensure continuity of care for the beneficiary.

The following are examples of situations that may occur while providing care to an eligible beneficiary:

FFS to Health Plan	A beneficiary is in FFS in June. On June 15, MDCH authorizes a breast reconstruction after mastectomy for breast cancer. The surgery is scheduled for July 20. On July 1, the beneficiary is enrolled in a health plan with the same primary care provider and surgeon. The surgeon must follow the health plan process for authorization of the reconstructive surgery, as the health plan is now the payer, not FFS. MDCH authorization would be void.
Voluntary Health Plan Change During a Course of Treatment	A beneficiary is in health plan "A" in July and is involved in a course of physical therapy (PT). The therapy program was authorized for six weeks. On August 1, the beneficiary changes enrollment to health plan "B" and still has two more scheduled weeks of PT. Before PT can continue, the provider must obtain a new authorization from health plan "B." Ideally, as a plan-to-plan change occurs at the request of the beneficiary, the provider would coordinate the transition to the new plan, maintain continuity of care and have an authorization in place from plan "B" so the ongoing PT is not interrupted. However, if PT continues without new plan "B" authorization, plan "A" is not responsible and plan "B" may or may not honor the treatment. Providers cannot bill the beneficiary as the services are covered and it is the provider's responsibility to verify eligibility/enrollment changes and obtain any necessary authorization.

4.3 Durable Items or Equipment

MDCH policy directs providers to bill the date of delivery for durable items or equipment. However, when a beneficiary has a change in enrollment status and the responsible payer is different on the date of delivery than on the date of order, providers must bill the date of order and specify the date of delivery in the comments/remarks section. This is especially important when a person changes from FFS to a health plan.

SECTION 5 – HOSPITAL CLAIM COMPLETION – INPATIENT

Information in this section should be used in conjunction with the Uniform Billing (UB-92) Manual when preparing Hospital claims.

The following references unique billing requirements for completing inpatient claims.

5.1 ACCOMMODATIONS

Hospitals must use the appropriate revenue code that best indicates the type of room the beneficiary occupied. If, during a stay, the beneficiary occupies more than one room, each having a different rate, the individual accommodation charge for each room must be entered on a separate claim line.

Personal comfort and convenience items (e.g., telephone, television) are not covered by Medicaid and cannot be used to offset the beneficiary-pay amount. Charges for these services must not be included on the claim.

5.1.A. PRIVATE ROOMS

Medicaid covers private rooms only when determined to be medically necessary. Condition code 39 (Private Room Medical Necessary) must appear on the claim.

If neither a semi-private nor multi-bed room is available, beneficiaries may be placed in a private room. Bill the appropriate revenue code for the private room. The rate should reflect the semi-private room rate. Condition code 38 (Semi-private Room Not Available) must appear on the claim.

Beneficiaries who request a private room when it is not determined medically necessary must be informed in advance that they are responsible for the entire private room charge. Hospitals must assure that the beneficiary understands that Medicaid does not pay for any part of the private room charge and that the beneficiary assumes responsibility for the entire charge. The Medicaid Program may not be billed for a semi-private room (using a semi-private revenue code) when the beneficiary is occupying a private room at their request.

5.1.B. INTENSIVE CARE

Revenue Code 0200 is used if the hospital does not have a specific cost center for a specific type of intensive care. Revenue Codes 0201 through 0208 are to be used if the hospital has the specific type of intensive care unit the codes define. Refer to the UB-92 Manual for the revenue codes and their definitions.

5.2 CHANGES IN FACILITY OWNERSHIP SPLIT BILLING

When a change in facility ownership occurs during a beneficiary's inpatient stay, two claims must be submitted (one by each provider). The first owner is entitled to payment for the day of transfer.

- The first claim must show the appropriate patient status code and a "through" date equal to the last day of ownership. The second claim must show the "from" date as the first day of ownership.

- The second claim must show the same admission date as the first claim.
- If a PACER number was required for the admission, both claims must use the same PACER number.
- "Change in ownership" must be stated in Remarks on the second claim.

5.3 Fiscal Year-End / Interim Billing (DRG Hospitals Only)

Hospitals reimbursed under the DRG system generally cannot submit interim billings. The hospital must wait until the beneficiary is discharged and then bill for all services on one claim. However, if a patient has been continuously hospitalized for at least one year and is expected to remain hospitalized for at least another six months, the hospital may submit a claim as if the patient has been discharged. At least every three months thereafter, the hospital should submit a replacement claim, which alters the date of discharge and increases the charges. The Remarks Section of the replacement claim must indicate the reason for filing (i.e., interim billing due to extended length of stay).

5.4 Hysterectomy

To encourage electronic billing and reduce administrative burden, MDCH allows for submission of the Acknowledgement of Receipt of Hysterectomy Information forms (MSA-2218) via fax. (Refer to the Forms Appendix for additional information.) This form must be submitted to Medicaid before reimbursement can be made for any hysterectomy procedure. Submitting this form via fax can eliminate submitting paper attachments for hysterectomy claims, and pre-confirms the acceptability of the completed acknowledgement form, as well as reduces costly claim rejections.

The provider who obtains the required acknowledgement and completes the MSA-2218 may fax the completed form, along with a cover sheet, to the Medicaid Payments Division. The form is reviewed within five working days. Either an explanation of errors or notice that the form has been accepted and is on file is returned to the submitting provider. When the provider receives notice that the form is accepted and on file, all invoices related to the service may be submitted without attachments.

The procedure for approval of the acknowledgement form is:

- Complete a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed acknowledgement form to Hysterectomy Acknowledgement Form Approval. (Refer to the Directory Appendix for contact information.) Do not fax claims.
- Wait for a response. When notified that the acknowledgement form has been accepted and is on file, inform the other providers via a copy of the response.
- If there is no response within five working days, confirm that the fax is working. Be sure that the cover sheet included the necessary information for Medicaid staff to contact the provider. Resend the information if necessary.
- All providers may then submit claims (either electronic or hard copy) to Medicaid. The Remarks Section or Comment Record must include the statement "Acknowledgement on File."

- When hysterectomy claims are received with this information in the Remarks, acknowledgement form edit requirements are forced if the submitted invoice matches the acknowledgement form on file.

This process is an option. Providers may continue to attach a copy of the acknowledgement form to the claim without going through this pre-approval process. If a paper copy of the MSA-2218 is attached with the claim, indicate "submitted attachment" in the Remarks Section.

5.5 Loss/Gain Medicaid Eligibility

Under the DRG system, hospitals must wait until a beneficiary is discharged and then bill all services on one claim. Hospitals generally cannot split-bill DRG claims. If a beneficiary loses or gains Medicaid eligibility during a hospital stay, the hospital must bill only for the Medicaid eligible days as follows:

- The "from" and "through" dates must reflect only the days of Medicaid eligibility.
- The patient status code must reflect the actual status of the entire admission.
- The Remarks Section must indicate that the beneficiary was Medicaid eligible for a portion of the hospital stay.

5.6 Medicare

For Medicare Parts A and B/Medicaid claims, Medicaid only pays up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance and deductible) or the Medicaid DRG, whichever is less. Medicaid payment does not include capital and direct medical education. For additional information, refer to the Medicaid Liability subsection of the Coordination of Benefits Chapter.

For Medicare Part B/Medicaid claims where Medicare Part A is exhausted, Medicaid pays appropriate co-pays and deductibles up to the beneficiary's financial obligation to pay or the Medicaid DRG (or per diem rate) less the total amount paid by all other payers, whichever is less. Medicaid reimbursement includes capital and direct medical education (made at final settlement).

Medicare Part A Exhausted Prior to Stay	▪ Enter occurrence code A3 and the date when Medicare Part A is exhausted. ▪ Noncovered days must be reflected on the claim to be paid correctly. ▪ Medicare Part B payment must be reflected on the claim.
Medicare Part A Exhausted During Stay	▪ Enter occurrence code A3 and the date when Medicare Part A is exhausted. ▪ Noncovered days must be reflected on the claim to be paid correctly. ▪ The Medicare payment must be reflected on the claim. ▪ Report value code A2 (coinsurance).

Medicare Part A Becomes Effective During Stay	▪ Enter occurrence code A2 and the date when Medicare Part A becomes effective. ▪ Noncovered days must be reflected on the claim to be paid correctly. ▪ The Medicare payment must be reflected on the claim. ▪ Report appropriate value codes A1 (deductible) and/or A2 (coinsurance) if applicable.

5.7 Multi-Page Claim (Paper Claim)

Inpatient hospitals can report charges on multiple pages when services exceed more than 22 lines.

5.7.A. Initial Claim

- Enter revenue code "0099" and "ADDL PG" on claim line 23 for all pages except the last page. On the last page, enter revenue code "0001" and "TOTAL" on claim line 23.
- When billing for Nursery/ICU accommodation charges, at least one Nursery/ICU revenue code must appear on the last page of the claim for proper DRG assignment.
- When billing for leave of absence charges, revenue code 0180 must appear on the last page for correct reimbursement.

5.7.B. Claim Replacement

When a multiple page approved claim requires changes to revenue codes and/or charges, a replacement claim should be submitted on all pages. For all pages except the last page of a multi-page replacement claim:

- Enter revenue code "0099" and "ADDL PG" on claim line 23.
- On the last page of the replacement claim, enter revenue code "0001" and "TOTAL" on claim line 23.
- Enter type of Bill "117" in F.L. 4.
- Enter the claim reference number (CRN) of the claim being replaced in F.L. 37.

When information which affects the entire claim needs to be corrected (i.e., diagnosis coding, other insurance payments, etc.), replace only the claim with an approved dollar amount greater than zero. The DRG assignment and/or amount approved may be changed.

5.8 Newborn Eligibility

All newborn services must be billed under the newborn's ID number. The hospital may not bill under the mother's ID number. If an ID number has not been assigned prior to or at the time of delivery, the hospital may submit a Facility Admission Notice (MSA-2565-C) form to the local Department of Human Services (DHS) office. (Refer to the Forms Appendix for additional information.) The local office then returns the MSA-2565-C to the hospital. Providers must not bill until the Eligibility Verification System (EVS) shows the newborn's ID number, date of birth, and the sex. (Refer to the Beneficiary Eligibility

Chapter of this manual for additional information regarding verifying beneficiary eligibility.) If the newborn does not yet have a Medicaid ID number and a readmission occurs, the PACER number may be obtained under the mother's name and ID number. Indicate in Remarks the mother's ID number and "PACER number was obtained under mother's ID number".

If the mother is enrolled with a MHP at the time of birth, all newborn charges must be billed to the MHP.

5.9 Patient-Pay Amount

- Value code D3 followed by the dollar amount is used to reflect the patient-pay amount.
- When the patient-pay amount is sufficient to cover the cost of the entire admission, the facility should not submit a bill to Medicaid nor bill the beneficiary for any balance between the facility charges and the patient-pay amount
- When the beneficiary is admitted as an inpatient from a nursing facility, the admission source code must be a 5, or the patient-pay amount is deducted from the payment in error. This is used whether the patient was admitted through the emergency room from the nursing facility or directly from the nursing facility. If the patient is admitted through the emergency room, the emergency room charges must be included on the inpatient claim.
- If a beneficiary is discharged and/or transferred to another facility within the same calendar month, the first facility collects the patient-pay amount. If patient-pay amount was deducted from the second admission in error, a claim replacement must be submitted.
- When an admission spans two or more months, the facility must collect the patient-pay amount for each month the beneficiary is in the facility.

5.10 Pre-Admission and Certification Evaluation Review

Elective admissions, readmissions within 15 days for other than the same/related condition and all transfers for surgical, medical and rehabilitation inpatient services require approval by the ACRC. If the admission is approved, a Pre-Admission and Certification Evaluation Review (PACER) number is issued. The PACER number must be entered in the treatment authorization field on the claim.

If the beneficiary is enrolled in an MHP, the MHP must be contacted for prior approval. For each circumstance in which a PACER number is required for FFS beneficiaries, a PA is required for MHP enrollees.

The following **do not** require PA through the PACER system:

- Urgent or emergent admissions, including OB patients admitted for any delivery. Newborn stays also do not require a PACER number. (Refer to the Newborn Eligibility subsection above for additional information.)
- Admissions of beneficiaries who are eligible for CSHCS only.
- Admissions of beneficiaries that are dually eligible for CSHCS and Medicaid, and the admission is related to the CSHCS qualifying condition.

- Transfers to a state psychiatric hospital.
- Medicare Part A beneficiaries
- Admission in which a beneficiary is determined Medicaid eligible after the admission has occurred for which preadmission certification was required. "Retroactive eligibility" must be stated in the Remarks Section.
- Admission to a hospital not enrolled with Medicaid.

Instructions for special circumstances:

Readmissions (DRG Hospitals Only)	Under the fee for service DRG reimbursement system, payment is intended to include all services required to treat the beneficiary. Since payment is made on a per case basis, incentives exist to inappropriately increase the number of cases (admissions) or to discharge patients early, in order to maximize revenue though new admissions. An early discharge could further increase the number of potential hospital readmissions. Michigan's DRG system is designed to carefully monitor and control readmissions. MDCH defines a readmission as any admission/hospitalization within 15 days of a previous discharge, whether the readmission is to the same or different hospital. **Example:** If a beneficiary is discharged on November 13, 2003, and is readmitted before November 28, 2003, this is considered a readmission within 15 days. (Count the day of the original discharge and the day of readmission.). If the beneficiary is discharged on November 13, 2003, and is readmitted on November 28, 2003, this is considered a new admission (the beneficiary is discharged and is readmitted after 15 days have elapsed.) MDCH reviews hospital claims on a pre-payment basis and, through its ACRC contractor, on a post-payment basis to determine the appropriateness of readmissions. If MDCH determines that a readmission within 15 days was inappropriate, monies are recovered from the admitting physician as well as the hospital.
Readmission within 15 days to the Same Hospital (Unrelated Readmission)	If a beneficiary is readmitted to the same hospital within 15 days for a condition(s) unrelated to the previous admission (e.g., admission for gall bladder removal, readmission for multiple injuries due to car accident), Medicaid considers the case a new admission for payment purposes. A PACER number for the readmission is required. ▪ The provider must submit two separate claims to assure appropriate processing. ▪ A claim for the first admission must be submitted and paid prior to submission of the readmission claim. ▪ When completing the second (readmission) claim, the hospital must indicate the PACER number in the treatment authorization field and Occurrence Span Code 71 with "from" and "through" dates from the previous admission.

Readmission within 15 days to the Same Hospital (Related Admission)	If a beneficiary is readmitted to the same hospital within 15 days for a related (required as a consequence of the original admission) condition, Medicaid considers the admission and the readmission as one episode for payment purposes. No PACER number is issued for continuation of care. ▪ Revenue code 0180 is used for the days the beneficiary was not in the hospital. ▪ Enter the number of leave days in the service unit item. ▪ Leave the rate and total charges blank. ▪ Include the leave days units in the total units. ▪ Report Occurrence Span Code 74 with "from" and "through" dates of the leave of absence. ▪ If the original admission has been submitted and paid, a replacement claim must be submitted that contains the combined services for the original admission and readmission.
Readmission within 15 days to a Different Hospital	If a beneficiary is readmitted to a different hospital within 15 days for a related or unrelated condition, a PACER number is required. Enter the PACER number in the treatment authorization field and Occurrence Span Code 71 with "from" and "through" date from the previous admission.
Transfers	If a beneficiary requires transfer from one hospital to another, or one unit to another for which the hospital is assigned a different provider ID number, a PACER number is needed. PA for a transfer is granted only if the transfer is medically necessary and the care/treatment is not available at the transferring hospital. Transfer for convenience is not considered. Authorization should be obtained by the next working day for urgent or emergent transfers. ▪ The receiving hospital enters the PACER number of the approved transfer in the treatment authorization field. ▪ It is not necessary to submit documentation when billing transfers. ▪ The receiving physician may obtain the PACER number (prior to discharge) for an urgent or emergent transfer if the transferring physician failed to do so. In the event that a transfer is determined to be inappropriate, monies are recovered from the transferring hospital on a post payment review basis.

5.11 REHABILITATION UNITS

Medicare recognized distinct part rehabilitation units must be enrolled with a separate provider type 30 ID number. This distinct rehabilitation unit number must be used on claims when billing for rehabilitation services. A PACER number must also be obtained for an elective admission or transfer to a distinct part rehabilitation unit.

Inpatient stays in a distinct part rehabilitation unit require an inpatient authorization by the ACRC.

- The PACER number must be entered on the claim in the treatment authorization field.

- Inpatient stays in a distinct part rehabilitation unit beyond 30 days require additional inpatient authorization by the ACRC. This phone call should take place between the 27th and 30th day of stay. If the extended stay is certified, a PACER number is issued.
- The hospital should call ACRC between the 57th and 60th day if the stay is expected to exceed 60 days. If the extended stay is certified, a PACER number is issued.

5.12 Sterilization

For coverage policy information, refer to the Hospital Chapter of this manual. Refer to the Forms Appendix of this manual for a copy of the Informed Consent to Sterilization form (MSA-1959), including completion instructions. If any field on the form is improperly completed, the claim is rejected.

The procedure for completion of the Informed Consent to Sterilization form is:

- Complete a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed Informed Consent to Sterilization. Do not fax claims.
- Wait for a response. When notified that the Consent to Sterilization form has been accepted and is on file, inform the other providers via a copy of the response.
- If there is no response within five working days, confirm that the fax is working. Be sure that the cover sheet included the necessary information needed for Medicaid staff to contact the provider. Resend the information if necessary.
- All providers may then submit claims (either electronic or hard copy) to Medicaid. The Remarks Section or Comment Record must include the statement "Consent on File."
- The information on the sterilization claim must match the information on the authorization form. If it does not, the claim is rejected.

This process is optional. Copies of the Informed Consent to Sterilization form may be attached to a claim without going through the pre-approval process. If choosing to include a paper copy of the MSA-1959, indicate "submitted attachment" in the Remarks Section.

5.13 Transplants

Heart, bone marrow, liver, lung, simultaneous pancreas/kidney and pancreas transplants are reimbursed at the hospital's Medicaid cost to charge ratio.

- Organ acquisition costs are reimbursed at 100% of charges when billed using either revenue code 0811 or 0812. This applies to heart, kidney, liver, lung, simultaneous pancreas/kidney, or pancreas transplants. This does not apply to bone marrow transplants. All bone marrow transplant charges are reimbursed at the hospital's cost to charge ratio.
- The letter of authorization for the transplant from the Office of Medical Affairs (OMA) or MHP must be attached to all transplant claims, otherwise, payment is denied.
- Indicate "PA letter submitted" in the Remarks Section of the submitted claim.

- For other transplant services not described by a specific DRG, identify in the Remarks Section the type of transplant that has been performed (i.e., small bowel transplant).
- If the donor and beneficiary are both Medicaid eligible, the services must be billed under each beneficiary's respective ID Number. If only the beneficiary is Medicaid eligible, bill services for both donor and beneficiary under the Medicaid beneficiary's ID Number.

All other insurance resources must be exhausted before Medicaid is billed. If Medicare eligibility is denied, the denial notice must be submitted with the claim.

SECTION 6 – HOSPITAL CLAIM COMPLETION – OUTPATIENT

The following section addresses situations which require completing the outpatient claim in a special manner.

6.1 GENERAL INFORMATION

6.1.A. MULTIPLE VISITS – SAME REVENUE CENTER

Multiple medical visits on the same day with the same revenue center, but the visits were distinct and constituted independent visits, must be submitted on separate claim lines when billed on the same claim. An example is a beneficiary going to the emergency room twice on the same day: in the morning for a broken foot, and later for chest pain.

- Condition Code G0 must be reported.
- The reason for each visit must be indicated in the Remarks section (e.g., seen twice on the same day: in the morning for a broken foot, and in the afternoon for chest pain).

6.1.B. MULTIPLE VISITS – DIFFERENT REVENUE CENTER

Modifier 22 must be used following the relevant CPT/HCPCS procedure code when reporting multiple visits in different revenue cost centers on the same date of service. Indicate in the Remarks section the reason for the multiple unrelated services on the claim.

6.1.C. LATE CHARGES

Late charges do not apply for outpatient hospital (Type of Bill 135). A claim replacement must be submitted to report correct charges. (Refer to the Replacement, Void/Cancel Claims, and Refund of Payment Section of this chapter for additional information.)

6.1.D. SERIES BILLING

Certain services (listed below) of the same type (i.e., same procedure code) rendered to one beneficiary in a single calendar month may be billed on one claim line (i.e., billed by calendar month). The following services may be series billed monthly:

Chemotherapy	Peritoneal Dialysis	Speech Pathology
Hemodialysis	Physical Therapy	Radiation Treatment Delivery
Occupational Therapy		

- Enter the first treatment date of the month as the "from" date and the last treatment date as the "through" date for a single calendar month.
- The quantity should reflect the total number of treatments in the series for that month.
- The combined charges for the services for that month should be used.

- Occupational, physical and speech-language therapy revenue codes should be billed using the appropriate therapy HCPCS code that describes the service provided.
- For appropriate reimbursement, report facility charges on a separate claim line for each date of service (e.g., 0270, 0636).

  (Refer to the Chemotherapy Treatment Subsection of this chapter for additional information.)
- The appropriate modifier must be used when billing a dual-use supporting HCPCS code for OT and PT services. The modifier must follow the dual-use HCPCS code on the claim line.

  (Refer to the PT and OT Section of this chapter for more details about billing for dual-use CPT/HCPCS codes.)
- Enter a quantity of 1 for every 15 minutes of therapy provided if the HCPCS code indicates 15-minute intervals of service.
- Enter the actual dates of service for that month in the Remarks section for each revenue code billed.

6.1.E. Individual Consideration

For requesting individual consideration, report modifier 22 following the relevant CPT/HCPCS code. Do not use modifier 22 unless it is indicated.

Indications for use of modifier 22 include:

- Reporting dose-specific description (report modifier 22 following the CHP/HCPCS code)
- Reporting a quantity greater than six in the operating room (OR) (report why additional OR time requested in the Remarks section)
- Reporting multiple visits in different revenue cost centers on the same date of service (indicate reason for the multiple unrelated services on the claim in Remarks section)
- Use modifier 22 only when the code description is exceeding the allowable quantity. Do **not** use modifier 22 when reporting multiple J-codes. (Report the actual dosage given in the Remarks section.)

6.2 Anesthesia

- A 037X category Revenue Code should be billed for anesthesia supplies that include oxygen gases, mask, breathing circuit, cannulas, anesthesia drugs, etc.
- The quantity must be 1.
- A HCPCS code that supports the facility charges for the services reported must be entered at least once on the claim.
- When billing for services that do not normally require anesthesia services, enter in Remarks Section "general anesthesia required".

CRNA and physician professional charges should not be included in the outpatient hospital bill. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for information related to billing professional services.)

6.3 Apheresis/Therapeutic

- Room charges for apheresis must be billed using Revenue Code 0260 - IV Therapy.
- A supporting HCPCS code must be listed in F.L. 44.
- Supplies may be billed using Revenue Code 0264.
- Pharmaceuticals may be billed using Revenue Code 0250.
- It is not necessary to repeat the supporting HCPCS code for multiple hospital charge revenue codes.

6.4 Blood Handling

Blood handling may be billed if the drawing, packaging, and mailing of blood samples are the only services provided.

- Revenue code 0300 with CPT/HCPCS code 36415 (routine venipuncture for collection of specimen[s]) and the usual and customary charge for the service must be used.
- The Remarks Section of the claim must indicate the reason the blood was obtained as a separate service and the reason the laboratory that performed the testing could not also perform the venipuncture.

6.5 Blood Not Replaced

- Blood not replaced must be billed using Revenue Code series 038X or 039X.
- Indicate in the "Units of Service" the number of units of blood that were used.
- If appropriate, Revenue Code 038X and the 039X series may be billed together as indicated with the appropriate supporting HCPCS code on the claim line.
- Use revenue code 0260 for transfusion service with CPT/HCPCS code 36430.

(Refer to the Intravenous Infusion subsection of this chapter for other related services billing instruction.)

6.6 Cardiac Catheterizations

- The room charge for use of the cardiac catheter lab must be billed using Revenue Code 0481. Report the quantity of 1 for each hour of catheter lab time up to a quantity of 2 hours. The supporting cardiac catheterization HCPCS code must be reported.
- When multiple injection procedures are performed during the cardiac catheterization, report Revenue code 0489 with CPT/HCPCS code 93555 and/or 93556 as appropriate. These CPT/HCPCS codes may be reported only once on the claim.
- If pharmacy, supplies, and anesthesia incident to radiology are used during the procedure, they should be billed using the appropriate revenue codes listed below:

- 0621 Supplies/Incident to Radiology;
- 0255 Pharmacy/Incident to Radiology; or
- 0371 Anesthesia/Incident to Radiology.

- All surgical supply revenue codes must be reported on the same claim as revenue code 0481 in order to be paid at a percent of charge for supplies utilized during the reported surgical procedure.
- Report observation room charges with Revenue Code 0762 "Observation Room"; quantity 1. If acute care recovery is necessary, report this service using Revenue Code 0710 "Recovery Room" reporting the quantity as 1 for each 30 minutes of time in the recovery room, up to a total of four hours, in Form Locator 46. These items must be reported on the same bill as the cardiac catheterization procedure.

6.7 Chemotherapy Treatment

- The cost of the antineoplastic drugs must be billed using Revenue Code 0636 and the appropriate CPT/HCPCS code (J code) on the claim line. The quantity should reflect the number of vials or ampules for the total dosage given. Example:
  - 70 mg of Adriamycin would be billed using code J9000 with a quantity of 7.
  - 850 mg of 5FU would be billed using code J9190 with a quantity of 2.
- Chemotherapy treatment requires a supporting HCPCS code to be reported on the claim to support the facility charges. The appropriate Revenue Code from the 033X series must be billed for hospital room charges. Related supplies should be billed using Revenue Code 0270.
- Chemotherapy 33x series may be series billed monthly.
- Facility charges must be reported on a separate claim line for each date of service (e.g., 0270, 0636) for appropriate reimbursement.
- A clinic room charge cannot be billed in addition to chemotherapy services.

6.8 Childbirth Education

Childbirth education services must be billed upon completion of the course.

- Use Revenue Code 0942 (Education/Training)
- Use S9442 as the support code
- Report the quantity as 1
- Enter the last date the beneficiary was seen for childbirth education in "statement covers period"
- The "from" and "through" dates must be the same

6.9 Clinic Services

Clinic Visit Revenue Codes (0510, 0511, 0514, 0515, 0516, or 0517) may be billed with a quantity of 1. A supporting HCPCS code is not required. No other facility charges can be billed on the same day as the clinic room (Group J).

6.10 Contrast Material

6.10.A. Low Osmolar Contrast Material

Separate additional payment may be made for low osmolar contrast material (LOCM) if used for beneficiaries that meet at least one of the following criteria:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting;
- A history of asthma or allergy;
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, or pulmonary hypertension;
- Generalized severe debilitation; or
- Sickle cell disease.

If the above criteria are met, the LOCM may be billed using Revenue Code 0636 with the appropriate CPT/HCPCS code. The Remarks Section must include:

- Name of the contrast material used (drug);
- The complete eleven-digit NDC number used to identify the specific contrast material; and
- The actual dosage of the drug (LOCM) given.

6.10.B. High Osmolar Contrast Material

The cost of high osmolar contrast material is reimbursed as part of the technical component of diagnostic radiology procedures and is not to be billed under Revenue Codes 0250, 0255 or 0636.

6.10.C. Paramagnetic Contrast Material

Paramagnetic contrast material used in MRI studies is included in the reimbursement for the technical component and is not paid separately.

6.11 Cosmetic Surgery

- A copy of the authorization letter that was sent to the attending physician from the OMA or MHP must be submitted with the claim.
- Indicate "PA letter submitted" in the Remarks Section.

6.12 Dental Services

PA is not required for the outpatient hospital setting for FFS beneficiaries. However, PA may be required for MHP enrollees.

- The hospital must bill the appropriate supporting HCPCS code and the appropriate revenue code(s).
- If an unlisted HCPCS code is billed, a complete description of the service provided must be entered in the Remarks section.

6.13 Diabetes Self-Management Education Program

- Diabetes self-management training services provided in the outpatient hospital must be reported under revenue code 0942 with CPT/HCPCS code G0108 or G0109 on the claim line.
- Each individual session must be billed on a separate claim line.

6.14 Diagnostic Testing

- Do not bill for routine screening tests (e.g., to establish baseline values, etc.).
- Use Revenue Code 0920 and the appropriate supporting CPT/HCPCS code for a test recognized as relevant to the condition being investigated.
- Use Revenue Code 0740 or 0920 with the appropriate supporting CPT/HCPCS code to bill for diagnostic sleep studies.
- A fetal monitoring stress contraction test or fetal nonstress test may be billed as a diagnostic test on the same day as a medical visit.

6.15 Donor Searches

Charges for donor searches which do not result in an organ acquisition and transplant should be billed as an outpatient service.

- Revenue Code 0814 should be used. No supporting HCPCS code is required.
- A copy of the PA for the transplant that was sent to the attending physician from the OMA or MHP must be submitted with the claim.
- Indicate "PA letter submitted" in the Remarks Section.

6.16 Drugs Administered on Premises

For products administered in conjunction with laboratory, radiology, or other medical procedures, bill the appropriate revenue code and HCPCS code, and include the drug costs in the charges.

- For administration routes other than injectables (e.g., oral, topical, rectal, etc.), bill using Revenue Codes 0250, 0251, 0252, 0257, or 0259. The supporting HCPCS code must be billed on the claim.
- For low osmolar contrast material (LOCM), refer to the Contrast Material subsection above.
- Medicaid does not cover Revenue Code 0637 (self-administered drugs).

6.17 Emergency Department Services

Emergency Department services are to be billed as follows:

EMTALA Screen	▪ Use Revenue Code 0451 with CPT/HCPCS code 99281 when billing the EMTALA screen without follow-up treatment/stabilization services. ▪ Bill diagnostic procedures per Medicaid FFS policy. ▪ The EMTALA screen can be reported only with Revenue Code 0452 and is not reimbursed in combination with any other Emergency Department (045x) or Clinic (051x) Revenue Code for Medicaid FFS beneficiaries.
Emergency Department Stabilization/Emergency Treatment Services	▪ Use Revenue Code 0450 or a combination of 0451 and 0452. ▪ Use appropriate ED Evaluation and Management procedure code (99281-99285) to indicate the level of service provided. ▪ All other services, (e.g., pharmacy, x-ray, etc.) must be billed consistent with Medicaid's FFS policy. ▪ Revenue Code 0450, or a combination of 0451 and 0452, will not be separately reimbursed in conjunction with the Revenue Code and Reimbursement Group E (RC 0360, 0369, 0481) on the same visit. ▪ The principle diagnosis code field must reflect the emergency diagnosis resulting from the EMTALA screen. The admitting diagnosis code field should reflect the beneficiary's reason for the emergency room visit. **Exception:** The reason the encounter was considered an emergency must be entered in the Remarks Section if the principal diagnosis or the admitting diagnosis does not reflect the definition of an emergency as stated in the Balanced Budget Act of 1997 and its regulations. Information in the Remarks Section should include vital signs, medical problems or conditions noted during the ED visit, if an IV was started, and medications administered during the visit. This information must be adequate to confirm the emergent condition.

	▪ All outpatient hospital charges for ED services resulting in an inpatient admission must be billed on the inpatient claim, using the Inpatient Hospital provider type and ID number. Payment is made through the inpatient reimbursement system (as part of the DRG). ▪ When an OPH service encounter spans two dates, use the date of service care was accessed (the first date) as the "From" and "Through" date.
Emergency Department Non-Emergency Treatment Services	Medicaid covers all appropriate hospital charges for ED services, as previously defined, provided that the diagnosis supports procedures billed and/or documentation supports the facility charges. ▪ Use Revenue Code 0456 ▪ Use appropriate ED Evaluation and Management procedure code (99281-99285) to indicate level of service provided. ▪ All other services (e.g., laboratory, x-ray, etc.) must be billed consistent with Medicaid's FFS policy. For MHP enrollees, authorization must be obtained prior to provision of non-emergency services in the ED.
Multiple Emergency Department Visits In One Day	▪ If the beneficiary requires treatment in the ED more than once within a 24-hour period, use Condition Code G0. ▪ The Remarks Section of the claim must include the reason the beneficiary was treated more than once in the 24-hour period.

6.18 Gastro-Intestinal Services

- The room charge for use of gastro-intestinal services (e.g., Endoscopy, Laparoscopy) must be billed with Revenue Code 0750 and appropriate CPT/HCPCS code on the claim.
- Revenue Codes 0250, 0258 and 0270 may be billed in addition to Revenue Code 0750 when provided.

6.19 Hemodialysis and peritoneal Dialysis

- Dialysis services should be series billed to avoid payment delay.
- Bill the appropriate 082X through 085X series Revenue Code.
- A supporting HCPCS code is not required.
- Enter the first treatment date of the month as the "from" date and the last treatment date as the "through" date for a single calendar month.
- The quantity must reflect the total number of treatments in the series for that month.
- The charges should reflect the combined charges for the services for that month.

6.20 Hyperbaric Oxygen Therapy

- Hyperbaric Oxygen Therapy must be reported with Revenue Code 0413.
- A supporting HCPCS code must be billed on the claim.
- This service cannot be series billed.

6.21 Hysterectomy

- Refer to the Hospital Claim Completion-Inpatient Section of this chapter for additional information.
- When billing for a hysterectomy performed during a beneficiary's period of retroactive eligibility, indicate in the Remarks section "MSA-2218 not completed. Not eligible on date of service." Also indicate the beneficiary was informed prior to the hysterectomy that the service would render her incapable of reproducing.
- When billing for a beneficiary that was sterile prior to the hysterectomy, the Acknowledgement of Receipt of Hysterectomy Information form is not required. The Remarks field of the claim must indicate "Beneficiary sterile prior to hysterectomy", along with the cause/procedure that rendered her sterile.

6.22 Injections

- Intramuscular, subcutaneous or intravenous injections given in the outpatient hospital setting should be billed using Revenue Code 0636, "Drugs Requiring Detailed Coding," and the appropriate CPT/HCPCS code on the claim line.
- For medications that do not have a specific code, document the National Drug Code (NDC), the dose administered, the drug name, and the cost in the Remarks section of the claim. Enter a quantity of 1.
- When billing a code with a dose-specific description, enter the appropriate quantity. If the dose specified in the code description is exceeded, use modifier 22 and document the actual dosage given in the Remarks Section.
- **Do not** recode injectable drugs from a national procedure code covered by Medicare or other payer to a not otherwise classified (NOC) code unless MDCH does not cover that procedure code. If MDCH covers the procedure code, the same code must be submitted to MDCH that was submitted to the other payer.

6.23 Intravenous Infusion

- Room and equipment charges for intravenous (IV) fluid administration must be billed using Revenue Code 0260, "IV Therapy".
- IV solutions such as dextrose and saline solutions used as dilutents/vehicles for drug therapy must be billed under Revenue Code 0262, "IV Therapy/Pharmacy Services".
- IV solutions used to hydrate and not in conjunction with drug therapy must be billed under Revenue Code 0258, "IV Solutions".

- Tubing, syringes, needles, and other miscellaneous items such as sterile gloves and gauze used during IV fluid administration must be billed under Revenue Code 0264, "IV Therapy/Supplies."
- A supporting HCPCS/CPT code must be entered once on the claim.
- Charges for active drugs administered via intravenous infusion must be billed using Revenue Code 0636, "Drugs Requiring Detailed Coding," and the appropriate CPT/HCPCS code (J codes) on the claim line.

6.24 Labor and Delivery Room

Labor and delivery room charges must only be billed when labor progresses to delivery.

- Bill using Revenue Codes 0720-0724.
- A supporting HCPCS code is required on the claim line.
- Units reported for Revenue Codes 0720-0724 must be 1 for each 30 minutes, rounded up to the nearest half hour, with a maximum of 2 billable units (1 hour).
- Do not report a fetal monitoring stress contraction stress test, or a fetal nonstress test, in addition to a labor and delivery or false labor room charge.

Charges for rooms used for a beneficiary in active labor who does not progress to delivery:

- Must be billed using Revenue Code 0729, "False Labor." A supporting HCPCS code is not needed. The appropriate diagnosis code must be used.
- Revenue Code 0729 must not be billed for fetal monitoring, or treatment of other medical conditions for a beneficiary who is not in active labor.
- No other room charge may be billed with Revenue Code 0729 for the same date of service.

For fetal monitoring non-stress test, report Revenue Code 0920 with CPT/HCPCS code 59025. This test may not be billed with any Labor Room/Delivery 072X Revenue Code series.

6.25 Laboratory

- The date of service indicated on the claim must be the date the specimen is collected.
- If the MDCH daily reimbursement limit of $75 is exceeded, the outpatient hospital must request an exception to the daily reimbursement limit by submitting documentation of medical necessity for each laboratory procedure. For prompt payment of laboratory procedures that exceed the daily reimbursement limit, all claims for a single date of service should be submitted together with one copy of the accompanying documentation for each claim, and indicate "submitted attachment" in the Remarks section.

6.26 Minor Surgery / Procedures

Minor surgery/procedures are services that are normally performed in the office setting. Reimbursement for these office-based procedures is no more in the hospital setting than the fee paid in the office setting.

Outpatient hospitals must bill Revenue Code 0361 (OR/Minor) and the appropriate CPT/HCPCS code on the claim line.

A list of CPT/HCPCS codes billable with 0361 is available on the MDCH website. (Refer to the Directory Appendix for website information.)

6.27 Multiple Surgical Procedures

When multiple surgical procedures are performed at the same session, it is not necessary to bill a separate charge for each procedure, although hospitals continue to have the option of doing so.

It is acceptable to bill a single charge using the revenue code that describes where the surgical procedure was performed for the applicable procedure HCPCS code (i.e., operating room, RC 0360), and bill the other procedures using an acceptable HCPCS code and the same revenue code with $0.00 entered for charges.

6.28 Observation Room

Observation room charges can only be billed separately for cardiac catheterizations or myelograms.

Report Revenue Code 0762, Observation Room, with a quantity of 1. Observation room charges must be reported on the same claim as the cardiac catheterization or myelogram. (For additional information, refer to the Interventional Radiology or the Cardiac Catheterization subsections of this chapter.)

6.29 Operating Room

Operating room charges are covered for surgical procedures that require a sterile environment and equipment generally found in an operating room. Charges for preoperative holding rooms or surgical suites are not a covered benefit. If these services are reported separately on the claim line, they are rejected without payment.

- The units billed for the operating room cannot reflect pre- or post-surgery room charges.
- The unit billed should be 1 for each 30 minutes rounded up to the nearest half hour. For example, if the operation started at 7:50 a.m. and ended at 9:00 a.m. the total time would be 1 hour and 10 minutes. The units billed would be 3. Units up to 6 are approved for payment. When more than 6 units are reported, use modifier 22 and document the reason for the prolonged time in the Remarks section.

Surgical Revenue Codes (0360, 0369) must be billed with a supporting HCPCS code to support facility charges. All surgical supply revenue codes listed in the Hospital Claim Completion Section of this chapter under Revenue Code and Reimbursement Group D should be reported on the same Operating Room claim to be paid a percent of charge for supplies utilized during the reported surgical procedure.

6.30 Percutaneous Trans-Luminal Coronary Angioplasty

Room charges for Percutaneous Trans-Luminal Coronary Angioplasty (PTCA) procedures utilizing the Revenue Codes 0360 (OR services) or 0369 (OR/other) should be billed. Charges for pre-operative holding rooms are not a covered benefit. If pre-procedure holding rooms are billed separately on the claim, the line is rejected without payment.

- The quantity for Operating Room time billed should be 1 for each 30 minutes spent in the Operating Room, up to a maximum of two hours.
- Disposable, non-reusable items (such as sutures, dressings, etc.) can be reported as supplies. To bill the additional use of supplies, pharmacy, and/or anesthesia, report the supporting HCPCS code once on the claim. Use the appropriate revenue codes as indicated to identify the items used. The following Revenue Codes can be used:

025X	Pharmacy	027X	Surgical Supplies
0264	IV/Ther/Supplies	037X	Anesthesia

- If acute care recovery is necessary, report this service using Revenue Code 0710 (Recovery Room) with the quantity as 1 for each 30 minutes of time in the Recovery Room, up to a total of four hours. These items must be reported on the same claim as the PTCA procedure.

6.31 Radiation Treatments

These services may be series billed.

6.32 Radiology

Diagnostic and therapeutic x-rays, nuclear medical services, CT scans, MRAs and MRIs must be billed using one of the appropriate revenue codes listed, along with the supporting HCPCS code reported on the claim line.

032X	Radiology-Diagnostic	040X	Other Imaging Services
0333	Radiology Therapeutic and/or Chemo Adm.	035X	CT Scan
034X	Nuclear Medicine	061X	MRI/MRA

6.32.A. Interventional Radiology

Facility charges may be billed for interventional radiology procedures listed in the Hospital Claim Completion section of this chapter.

- Bill Revenue Code 0369 (OR/other) with the appropriate supporting HCPCS code. (A list of appropriate supporting codes is available on the MDCH website. Refer to the Directory Appendix for website information.)
- Charges for pre-procedure holding rooms are not a covered benefit. If pre-procedure holding rooms are billed separately, the entire claim is rejected without payment.

- For Revenue Codes 0360 and 0369, the time quantity billed should be 1 for each 30 minutes spent in the Operating Room up to a maximum of three hours.
- Disposable, non-reusable items such as sutures, dressings, etc., can be reported as supplies. Use the appropriate revenue codes as indicated to identify the items used.
  - 0621 Supplies/Incident to Radiology
  - 0255 Pharmacy/Incident to Radiology
  - 0371 Anesthesia/Incident to Radiology

All surgical supply revenue codes should be reported on the same claim as Revenue Code 0369 to be paid a percent of charge for supplies utilized during the reported surgical procedure.

- To report observation room charges related to the interventional radiology procedure, use Revenue Code 0762, Observation Room, with a quantity of 1.
  - Observation room charges can only be billed separately for cardiac catheterizations and myelograms.
  - If acute care recovery is necessary, use Revenue Code 0710, Recovery Room, reporting a quantity of 1 for each 30 minutes of time in the Recovery Room, up to a total of four hours.
  - These items must be reported on the same claim as the myelography.

6.32.B. Multiple Radiological Procedures

- To bill more than one x-ray of the same area on the same day, hospitals must combine the x-ray services on one claim line (Revenue Code 032X-0330). Use modifier 22, bill a quantity equal to the total number of x-rays provided and document the medical necessity in the Remarks Section of the claim.
- Specific information and medical need must be documented (i.e., the medical condition that exists for each x-ray) to receive approval for additional payment. Entering "Quantity of 2" or "medically necessary" in the Remarks Section of the claim is not adequate information.
- Several radiology procedures are considered bilateral procedures by definition of the procedure code (e.g., mastoids, orbits, paranasal sinuses, peripheral flow study, and bone length studies). Therefore, individual consideration from MDCH should not be requested when bilateral views are taken.

6.33 Recovery Room

- If acute care recovery is provided after a surgical procedure, report using Revenue Code 0710, Recovery Room.
- Report the quantity as 1 for each 30 minutes of time in the Recovery Room. A maximum of four hours can be approved for payment.
- A supporting HCPCS code must be reported once on the claim.

Revenue Code 0360, 0369 or 0481 must be on the claim for the recovery room (Revenue Code 0710) to be covered.

6.34 Self-Care Dialysis Training

- Bill self-care dialysis training using Revenue Code 0855.
- If a beneficiary completes a course:
  - Report HCPCS code 90989 (dialysis patient training, complete course).
  - The quantity should be 1.
- If a beneficiary does not complete a course:
  - Report each session separately using HCPCS code 90993 (dialysis patient training, per session).
  - The service date on the claim line must indicate the actual date that the session occurred.
- A quantity of 1 must be entered, not to exceed a maximum of nine sessions per course.

6.35 Sterilization

Refer to the Hospital Claim Completion-Inpatient Section for additional information.

6.36 Therapies (Occupational, Physical and Speech-Language)

Dual-use therapy codes may be billed by both a physical therapist and an occupational therapist on the same date of service when both professionals provided covered therapy services on the same day under their corresponding treatment plans. The codes are identified on the Outpatient Therapy Database with required modifiers GO and GP. The appropriate modifier must always be used on the claim line to avoid a claim rejection when billing a dual-use code.

- Occupational therapy modifier: GO
- Physical therapy modifier: GP

Occupational Therapy (OT)	▪ OT does not require PA for a maximum of 36 visits with in the first 90 consecutive calendar days of therapy. For MHP enrollees, the provider should check with the MHP for PA requirements.

	▪ OT must be billed with a revenue code along with the appropriate HCPCS code on the claim line. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report 1 as the quantity. ▪ Therapy must be provided by the evaluating discipline. Evaluation or reevaluation cannot be paid when it is billed with other OT services on the same day.OT may be series billed. ▪ The fee for OT includes all services. Hospitals cannot bill a clinic room charge in addition to the therapy, unless the visit is unrelated to OT. ▪ OT may be provided to nursing facility beneficiaries by the outpatient department of a general hospital. ▪ PA is required for continuing therapy beyond the initial 90 days of therapy.
Physical Therapy (PT)	▪ PT does not require PA for maximum of 36 visits with in the first 90 consecutive calendar days of therapy. ▪ For PT services use a revenue code with the appropriate HCPCS code on the claim line. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report 1 as the quantity. The fee screen for PT includes all services. Hospitals cannot bill a clinic room charge in addition to the therapy unless the visit is unrelated to PT. ▪ Evaluation or reevaluation cannot be paid when it is billed with other PT services on the same day. Therapy must be provided by the evaluating discipline. ▪ PA is required for continuing therapy beyond the initial 90 days of therapy. ▪ PT may be series billed.
Speech-Language Therapy (ST)	▪ Speech-language therapy does not require PA for a maximum of 36 visits within the first 90 consecutive calendar days of therapy. ▪ Speech therapy must be billed with a revenue code along with the appropriate HCPCS code on the claim line. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report 1 as the quantity. ▪ Therapy must be provided by the evaluating discipline. Evaluation or reevaluation cannot be paid when it is billed with other speech pathology services on the same day. ▪ Speech pathology may be series billed. ▪ The fee for speech-language therapy includes all services. Hospitals cannot bill a clinic room charge in addition to the therapy unless the visit is unrelated to speech therapy. ▪ PA is required for continuing therapy beyond the initial 90 days of therapy.

When billing outpatient therapies, hospitals must use the revenue codes and HCPCS codes identified on the Outpatient Therapy Database available on the MDCH website. (Refer to the Directory Appendix for website information.)

6.37 Ultrasonography

- If two ultrasound codes are billed, the diagnosis must reflect the medical need for two procedures.
- Claims for diagnostic ultrasound procedures which are performed more than once require documentation of medical necessity. Documentation with the claim should clearly state the reason for the repeat procedure (e.g., multiple gestation, breach presentation, pre-term labor, etc.). Claims are rejected if the documentation does not support the medical necessity for the repeat diagnostic procedure.

6.38 Weight Reduction

- A copy of the letter of authorization for the weight reduction that was sent to the attending physician from the OMA must be submitted with the claim.
- Indicate "PA letter submitted" in the Remarks Section.

SECTION 7 – HOSPITAL CLAIM COMPLETION

7.1 REVENUE AND CPT/HCPCS CODES

These revenue codes require a CPT/HCPCS code on the **claim line**:

Revenue Code	Description	Revenue Code	Description
0280	Oncology	0460	Pulmonary Function
0289	Oncology/Other	0469	Pulmonary Function/Other
0300	Laboratory/Clinical	0470	Audiology
0301	Lab/Chemistry	0471	Audiology/Diagnostic
0302	Lab/Immunology	0472	Audiology/Treatment
0303	Lab/Renal Patient (Home)	0479	Audiology/Other
0304	Lab Non-routine Dialysis	0480	Cardiology
0305	Lab Hematology	0482	Stress Test
0306	Lab/Bacteriology and Microbiology	0483	Echocardiology
0307	Lab/Urology	0489	Cardiology/Other
0309	Lab/Other	0513	Clinic/Psychiatric (PT 21 only)
0310	Laboratory/Anatomical	0519*	Clinic/Other
0311	Lab/Cytology	0610	MRT
0312	Lab/Histology	0611	MRI – Brain
0314	Lab/Biopsy	0612	MRI – Spinal Cord
0319	Lab/Other	0614	MRI - Other

Revenue Code	Description	Revenue Code	Description
0320	Radiology/Diagnostic	0615	MRA - Head and Neck
0321	Radiology/Angiocardiography	0616	MRA - Lower Ext
0322	Radiology/Arthrography	0618	MRA - Other
0323	Radiology/Arteriography	0619	MRT - Other
0324	Radiology/Chest X-ray	0631	Single Source Drug
0329	Radiology/Digital Subtraction Angiography	0632	Multiple Source Drug
0330	Radiology/Therapeutic	0634	Erythropoeitin less than 10,000 units
0333	Radiation Treatment	0635	Erythropoeitin greater than 10,000 units
0339	Radiology/Other	0636	Drugs Requiring Detailed Coding
0340	Nuclear Medicine	0720	General
0341	Nuclear Medicine/Diagnostic	0721	Labor
0342	Nuclear Medicine/Therapeutic	0722	Delivery
0343	Diagnostic Radiopharmaceuticals	0723	Circumcision
0344	Therapeutic Radiopharmaceuticals	0724	Birthing Center
0349	Nuclear Medicine/Other	0730	EKG/ECG
0350	CT Scan/Head	0731	Holter monitor
0351	Head Scan	0732	Telemetry
0352	Body Scan	0739	Computerized EKG/ECG

Revenue Code	Description	Revenue Code	Description
0359	CT Scan/Other	0740	EEG
0361	OR/Minor	0749	Other EEG
0400	Imaging Services	0771	Vaccine Administration
0401	Diagnostic Mammography	0855	CCPD/Home/Supserv
0402	Ultrasound	0900	Psychiatric/Psychological Treatments Imaging
0403	Screening Mammography	0901	Electroshock Treatment
0404	Positron Emission Tomography	0902	Milieu Therapy
0409	Imaging Services/Other	0903	Play Therapy
0420	Physical Therapy	0909	Psychiatric/Psychological Other
0421	Physical Therapy/Visit	0910	Psychiatric/Psychological Services
0422	Physical Therapy/Hourly	0911	Rehabilitation
0423	Physical Therapy/Group	0914	Individual Therapy
0424	Physical Therapy/Evaluation	0915	Group Therapy
0429	Physical Therapy/Other	0916	Family Therapy
0430	Occupational Therapy	0918	Psychiatric/Testing
0431	Occupational Therapy/Visit, regardless of time	0919	Psychiatric/Other
0432	Occupational Therapy/Hour	0920	Other Diagnostic Services
0433	Occupational Therapy/Group, regardless of time	0921	Peripheral Vascular Lab

Revenue Code	Description	Revenue Code	Description
0434	Occupational Therapy/Eval	0922	Electromyelogram
0439	Occupational Therapy/Other	0923	Pap smear
0440	Speech Pathology	0924	Allergy Test
0441	Speech Pathology/Visit	0925	Pregnancy Test
0442	Speech Pathology/Hourly, 30-60 minutes	0929	Other Diagnostic Services
0443	Speech Pathology/Group	0940	Other Therapeutic Services
0444	Speech Pathology/Eval	0942	Education/Training
0449	Other Speech Path		

These revenue codes require CPT/HCPCS code on the claim.

Revenue Code	Description	Revenue Code	Description
0250	Pharmacy	0381	Blood/Packed Red Cells
0251	Drugs/Generic	0382	Blood/Whole
0252	Drugs/Non-Generic	0383	Blood Plasma
0254	Drugs/Incident Other Dx	0384	Blood Platelets
0255	Drugs/Incident Radiology	0385	Blood Leucocytes
0257	Drugs/Non-Script	0386	Blood Components
0258	IV Solutions	0387	Blood Derivatives
0259	Drugs/Other	0389	Blood/Other

Revenue Code	Description	Revenue Code	Description
0260	IV Therapy	0390	Blood/Stor-Proc
0262	IV Therapy/Pharm/SVC	0391	Blood/Admin
0263	IV Therapy/Drug/Supply	0399	Blood/Other Stor
0264	IV Therapy/Supplies	0410	Respiratory Service
0269	IV Therapy/Other	0412	Inhalation Service
0270	Med-Surg-Supplies	0413	Hyperbaric O2
0271	Non-Sterile Supply	0419	Other Respiratory Service
0272	Sterile Supply	0450	Emergency Room
0274	Prosth/Orth Device	0451	EMTALA Emergency Medical Screening Services
0275	Pacemaker	0456	Urgent Care
0276	Intra-Occular Lens	0481	Cardiac Cath Lab
0278	Supply/Implants	0621	Med-Surg/Supp/Incdnt Rad
0279	Supply/Other	0623	Surgical Dressings
0331	Chemo Ther/Inj.	0700	Cast Room
0335	Chemo Ther/IV	0709	Other Cast Room
0360	OR Services	0710	Recovery Room
0369	OR/Other	0719	Other Recovery Room
0370	Anesthesia	0750	Gastro-Intestinal Services

Revenue Code	Description	Revenue Code	Description
0371	Anesthesia/Incdnt Rad	0759	Other Gastro-Inst
0372	Anesthesia/Incdnt Other	0762	Observation Room
0379	Anesthesia/Other	0790	Lithotripsy
0380	Blood	0799	Lithotripsy/Other

7.2 Revenue Code and Reimbursement Groups

Charges for each group of the following revenue codes are accumulated and reimbursed as a single fee or the total charge (whichever is less). The amount approved for the first revenue code billed in the group equals the lesser of the charge or fee for the group. Each revenue code within the group represents the same service. Providers must report the appropriate charges (from a group) that support the service being performed. Subsequent claim lines for revenue codes in the group reflect an amount-approved equal to the lesser of the charge or balance of the fee.

Exception: Revenue codes in Group D are paid a percent of charges if provided in conjunction with a supporting HCPCS code in F.L. 44 and Revenue Code 0360, 0369, or 0481 is also reported on the claim.

Group A Pharmacy	0250	Pharmacy
	0251	Drugs/Generic
	0252	Drugs/Non-Generic
	0254	Drugs/Incdnt Other Dx
	0255	Drugs/Incdnt Rad
	0257	Drugs/Non-Generic
	0259	Drugs/Non-Script
Group B IV Solutions	0258	IV Solutions
	0262	IV Ther/Pharm/Svc
	0263	IV Ther/Drug/Supp
	0269	IV Therapy/Other
Group C Procedure Room	0260	IV Therapy
	0331	Chemo Ther/Inj
	0335	Chemo Ther/IV
	0700	Cast Room
	0709	Other Cast Room
	0750	Gastro-Inst Svs
	0759	Other Gastro-Inst
Group D Supplies	0264	IV Ther/Supplies
	0270	Med-Surg/Supplies
	0271	Non-Ster Supply
	0272	Sterile Supply
	0274	Prosth/Orth Dev
	0275	Pacemaker
	0276	Intra-Oc Lens
	0278	Supply/Implants
	0279	Supply/Other
	0621	Med-Sur Supp/ Incdnt Rad
	0623	Surgical Dressings
Group E Operating Room	0360	OR Services
	0369	OR/Other
	0481	Cardiac Cath Lab

Group F	0370	Anesthesia
Anesthesia Supplies	0371	Anesth/Incdnt Rad
	0372	Anesth/Incdnt Other
	0379	Anesth/Other
Group G	0380	Blood
Blood Not Replaced	0381	Blood/Pkd Red
	0382	Blood/Whole
	0383	Blood/Plasma
	0384	Blood/Platelets
	0385	Blood/Leucocytes
	0386	Blood/Components
	0387	Blood/Derivatives
	0389	Blood/Other
	0390	Blood/Stor-Proc
	0391	Blood Admin
	0399	Blood/Other Stor
Group H	0410	Respiratory Svc
Oxygen	0412	Inhalation Svc
	0413	Hyperbaric O2
	0419	Other Respir Svc
Group J	0456	Urgent Care
Clinic Room	0510	Clinic
	0511	Chronic Pain Clinic
	0514	OB-GYN Clinic
	0515	Peds clinic
	0516	Urgent Care clinic
	0517	Family Practice
	0760	Treatment/Observ
	0761	Treatment Room
	0769	Other Treatment Room
	0770	Preventive Care/Genera
	0779	Other Preventive Care Services
Group K	0710	Recovery Room
Recovery Room	0719	Other Recovery Rm
Group L	0720	Delivery Room/Labor
Clinic Room	0721	Labor
	0722	Delivery Room
	0724	Birthing Center
Group M	0820	Hemo/OPOR Home
Hemodialysis/	0821	Hemo/Composite
Peritoneal Dialysis	0825	Hemo/Home/Sup.
Service	0829	Hemo/Home/Other
	0830	Peritoneal/Op or Home
	0831	Pertnl/Composite
	0835	Peritoneal/Home/ Sup. Serv
	0839	Peritoneal/Home Other
Group N	0840	CAPD/OP OR Home
Continuous	0841	CAPD/Composite
Ambulatory	0845	CAPD/Home/ Sup. Service
Peritoneal Dialysis	0849	CAPD/Home/Other
	0850	CCPD/OP OR Home
	0851	CCPD/Composite
	0859	CCPD/Home/Other

SECTION 8 – NURSING FACILITY CLAIM COMPLETION

This section contains information that should be used in conjunction with the UB-92 Manual when preparing nursing facility claims.

Only one calendar month is to be billed on a nursing facility claim.

8.1 SPLIT BILLING – STATEMENT COVERS PERIOD

The Statement Covers Period on the claim is used for reporting the beginning and ending dates of service for the entire period reflected on the claim. In instances where the facility is split billing the month, the From and Through dates must be for only the period reflected on the claim.

Example: Facility is split billing April. On the first claim, the From date would be 040105 and the Through date would be 041505 for 15 days. The second claim From date would be 041605 and the Through date would be 043005 for 15 days.

If a patient-pay amount is involved on both claims, the facility is reminded that the first claim must be paid before submitting the second claim. Refer to the Patient-Pay portion of this section for additional information.

Failure to follow the above claim completion instructions will result in unnecessary pending of claims and delays in processing.

8.2 PATIENT-PAY AMOUNT

8.2.A. ONE FACILITY – TWO CLAIMS IN ONE MONTH

When a nursing facility must submit two claims within the same month for the same beneficiary who has a patient-pay amount, the following instructions must be followed:

- The claim for the first service dates in the month must be submitted before the claim for the remainder of the month, even if the patient-pay amount is equal to or greater than the amount billed, and
- The first claim must be paid before submitting the second claim. If the first claim is pended or rejected, and the second claim is submitted and paid, the whole patient-pay amount is deducted incorrectly from the net amount due on the second claim, even if all or a portion of the patient-pay amount was to have been deducted from the first claim. A replacement claim is required for the second claim to correct the underpayment after both claims are paid.

Facilities must report the total patient-pay amount on the first claim. If there is any remaining patient-pay amount, the amount must be reported on the second claim. The total patient-pay amount is not to be reported on both the first and second claims.

8.2.B. Two Facilities – Two Claims in One Month

If a beneficiary with a patient-pay amount resides in more than one Medicaid-certified facility in the same month:

- The first facility must submit a claim:
  - For the days the beneficiary resided in the facility (even if the amount billed is zero because the amount due is covered by the patient-pay amount);
  - To be paid for any amount due that is more than the patient-pay amount; and
  - For the second facility to receive the correct payment.

The first facility must indicate the Patient Status as 03, Discharged-transferred to SNF.

- The second facility must indicate 05, Transfer from a SNF, as the Source of Admission, and bill in the usual manner, reflecting the days the beneficiary resided in the facility. The remainder of the patient-pay amount that was not used by the first facility, if any, must be entered in the Value Code Amount and the Value Code must be D3.
- If the first claim has not been submitted or is pended or rejected, and the second facility submits its claim, the whole patient-pay amount is deducted incorrectly from the amount due on the second claim. The second facility needs to submit a replacement claim in order to receive its proper payment. On the replacement claim, the remainder of the patient-pay amount that was not used by the first facility must be entered in the Value Code amount and the Value Code must be D3. An explanation of the need for the replacement claim must be entered in the Remarks Section.

8.2.C. Offset to Patient-Pay Amount for Noncovered Services

Claims containing an offset to the patient-pay amount cannot be split-billed. The facility must submit one claim for the particular month of service.

The offset for the noncovered service must be reported on the claim using the appropriate value code and FL 39 and the related dollar amount. Only value codes for Michigan Medicaid noncovered services will be activated for approval through the claims processing system.

The dollar amount of Value Code D3 minus Estimated Responsibility Patient (patient-pay amount) is the beneficiary's monthly patient-pay amount MINUS the dollar amount of the offset.

The total of D3 and the offset must equal the beneficiary patient-pay amount for that given month.

Offsetting the patient pay amount may involve more than one month. For example, the beneficiary may have a patient-pay amount of $200 per month. The amount to be offset is $500. The amount to be offset would involve a three-month period. The first month claim would indicate $200 as an offset with D3 as zero. The second month claim would indicate $200 as an offset with D3 as zero. The third month claim would indicate $100 as an offset with D3 as $100.

8.2.D. Patient -Pay Amount Greater Than Amount Billed

Nursing Facilities must bill Medicaid even if the patient-pay amount is greater than the amount billed to Medicaid. Medicaid requires that a claim be billed so it can obtain particular information off the claim for statistical purposes.

8.2.E. Billed Facility Days

Day of Admission	Medicaid reimburses the day of admission if the beneficiary is counted in the facility census (e.g., if they are in the facility at midnight).
Day of Discharge	Medicaid does not reimburse the day of discharge unless the discharge is due to the resident's death. When billing, the facility must indicate 20 (expired) as the Patient Status Code. A discharge due to death is counted in the facility census.
Hospital Leave Days	▪ If the resident is expected to be in the hospital for ten days or fewer and dies while in the hospital, the nursing facility may bill for the hospital leave days up to the day before the resident died. ▪ For Medicaid to pay for hospital leave days, Medicaid must have been paying for the nursing facility stay before the beneficiary was admitted to the hospital. ▪ If the resident returns to the nursing facility under Medicare coverage, the facility may bill for the hospital leave days if the emergency hospitalization was for ten days or fewer. ▪ A resident is counted in the facility census if he is in the facility at midnight. If the resident is out of the facility on hospital leave at midnight, that day must be counted as a hospital leave day. If the resident returns to the nursing facility from the hospital, then is readmitted to the hospital for the same condition that he was hospitalized for previously, the 10-day period of Medicaid reimbursed hospital leave days continues if the resident was not counted in the facility census for that day. If, given the circumstances above, the resident was counted in the facility census, a new 10-day period of Medicaid reimbursed hospital leave days may begin.

One-Day Stay	A nursing facility is reimbursed for a one-day stay if a Medicaid beneficiary is admitted to the facility and, the same day, is discharged from the facility due to death, return home, or transfer to another institution that is not a Medicaid-enrolled provider. The one-day stay does not apply to a beneficiary admitted to a nursing facility if, later that day, the beneficiary is discharged and transferred to another nursing facility or an inpatient hospital and, at midnight, the second facility or hospital claims the beneficiary in its daily census.

8.3 Hospital Leave Days

For Hospital Leave Days, Medicaid will pay to hold a beneficiary's bed only when the facility's total available bed occupancy is at 98 percent or more on the day the beneficiary leaves the facility. Facilities at 97.50 percent occupancy may round up to 98 percent. Facilities may not round up 97.45 percent – 97.49 percent to 98 percent. Hospital leave days are limited to a total of 10 days per admission to the hospital for emergency medical treatment. The patient must return to the nursing facility in 10 or fewer days in order for the nursing facility to bill for hospital leave days. When billing, the facility must use:

- Revenue Code 0185; and
- Occurrence Span Code 74, with dates representing the leave days.

Facilities should not submit claims with Revenue Code 0185 when the charges are zero.

8.4 Therapeutic Leave Days

Therapeutic leave days are limited to a total of 18 days during a 365-day period. When billing, the facility must use:

- Revenue Code 0183; and
- Occurrence Span Code 74, with dates representing leave days.

8.5 Complex Care Memorandum of Understanding

Complex Care Memorandum of Understanding (MOU) is used for services beyond those covered by the normal per diem rate.

- MOUs require PA.
- Facilities must enter the nine-digit PA number from the Medicaid authorization letter on the claim. In the event a beneficiary is approved for both an MOU and therapy services, one PA number is issued for both the MOU and therapy.
- Facilities must bill with the appropriate daily care accommodation revenue code (e.g., 0110, 0120). For information on Complex Care MOUs, providers should call MDCH Long Term Care Services. (Refer to the Directory Appendix for contact information.)

8.6 Facility Under New Ownership

If a facility changes ownership, the facility must obtain a new provider ID Number for the new owner. In this case, the facility must submit separate claims for each provider ID Number. For example, if the facility changes ownership in the middle of the month and the beneficiary was in continuous residency at the facility for the month, the facility must submit a claim using the old provider ID Number for the first part of the month and another claim for the second part of the month using the new provider ID number. The process for two facilities and two claims in a month should be followed for beneficiaries with patient–pay amounts. (Refer to the Patient-Pay Amount subsection above for additional information.)

8.7 Beneficiary Transfer

When a beneficiary is transferred from one facility to another, MDCH recommends that the second facility obtain the therapeutic leave day record and Medicare status for the year from the first facility. Maintenance of these records allows the second facility to bill properly and prevents unnecessary rejections.

8.8 Hospital Swing Beds

Providers of Medicaid swing bed services may not bill for swing bed days unless the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid hospital diagnosis related group (DRG) of the admission.

- The Admission Date on the claim is the date the beneficiary was admitted to the swing bed. A beneficiary may not be admitted to the swing bed until discharged from an acute care bed.
  - The admission date to the swing bed is not included in the billing period if the admission date to the swing bed is within the Medicare DRG coverage period.
- The "from" date and "through" dates on the claim are the beginning and end dates of the billing period. No more than one calendar month may be billed on a claim. The billing period for a Medicaid covered swing bed stay begins when the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid hospital DRG for the hospital admission.
- Hospitals that are exempt from the DRG system may bill for Medicaid covered swing bed days beginning the day of admission to the swing bed.
- The Units of Service entered on the claim is the number of swing bed care days provided. The day of admission to the swing bed may not be included in the billing period. To determine if the admission date is included in the billing period, refer to the instruction (above) for the "from" date.
- The total number of swing bed care days is limited to 100 days per beneficiary per stay.

8.9 Cost Settled Provider Detail Report (FD-622)

MDCH sends each nursing facility a Cost Settled Provider Detail Report (FD-622). The FD-622 is designed to provide detailed information of a facility's charges paid by Medicaid. Since MDCH acts as a fiscal agent for many different sources of payment, the FD-622 includes all of these sources.

This report is an excellent accounting tool when maintained and used properly. It can be used in conjunction with the Remittance Advice (RA) to reconcile the accounts receivable. More important, the FD-622 can be used as the actual log that the facility must maintain for Medicaid. This should eliminate duplication of paperwork by the facility.

For the most part, the FD-622 includes Medicaid Payroll information, facility's Medicaid billing information, the facility's current interim reimbursement rate; indicator if the facility is on Medicaid Interim Payments, beneficiary information on services billed to Medicaid, summary of cost settled services, total charges billed to Medicaid, amount paid by other Medicare/other insurance/beneficiary, Medicaid payments, gross adjustments, and Medicaid claim statistic information.

The detail portion of the FD-622 does not print unless there were paid services for a facility for that week.

8.10 Daily Care

The following providers may bill for daily care and must enter the appropriate revenue code that identifies the specific daily care accommodation being billed:

Provider Type	Definition
60	Nursing Home Facilities
61	County Medical Care Facilities
62	Hospital Long Term Care Units
63	Hospital Swing Beds
63	Ventilator Dependent Units
72	Nursing Facilities for the Mentally Ill

The UB-92 Manual provides the revenue codes to be used for Michigan Medicaid.

8.11 Ancillary Physical and Occupational Therapy, Speech Pathology

Ancillary services can be billed on the same claim as daily care (room and board).

The following providers may bill physical/occupational therapy and speech pathology:

Provider Type	Definition
60	Nursing Home Facilities
61	County Medical Care Facilities
62	Hospital Long Term Care Units
64	Outpatient County Medical Care Facilities
72	Nursing Facilities for the Mentally Ill

When billing on the UB-92 claim form, facilities must use the Revenue Codes and HCPCS Codes identified on the Outpatient Therapy Database available on the MDCH website. (Refer to the Directory Appendix for website information.)

- Each ancillary service must be billed on a separate claim line. Series billing is not allowed.
- Each claim line requires a:
  - Date of service.
  - Revenue code and a HCPCS code.
  - Nine-digit PA number on the claim.

When billing, facilities must enter on the claim the nine-digit PA number listed on the Medicaid authorization letter. In the event a beneficiary is approved for both a MOU and therapy services, one PA number is issued for both the MOU and therapy.

Dual-use therapy codes may be billed by a physical therapist and an occupational therapist on the same date of service when both professionals provide covered therapy services on the same day under their corresponding treatment plans. The codes are identified on the Outpatient Therapy Database with required modifiers GO and GP. The appropriate modifier must always be used on the claim line to avoid a claim rejection when billing a dual-use code.

- Occupational therapy modifier: GO
- Physical therapy modifier: GP

8.12 Outpatient County Medical Care Facilities

- When billing for therapies, outpatient county medical care facilities must indicate the Type of Bill as 23X.
- Each service must be billed on a separate claim line. Series billing is not allowed.
- Each claim line requires a revenue code and a CPT/HCPCS code.
- Each claim requires a nine-digit PA number on the UB-92.

8.13 Medicare Part B Coinsurance and Deductible Amounts

The following providers are allowed to bill Medicaid for Medicare Part B coinsurance and deductible:

Provider Type	Definition
60	Nursing Home Facilities
61	County Medical Care Facilities
62	Hospital Long Term Care Units
72	Nursing Facilities for the Mentally Ill

For the following revenue codes, Medicaid reimburses for any Medicare Part B coinsurance and deductible amounts, based on Medicare's payment, up to Medicaid's maximum amount allowed. Also, Medicaid covers the coinsurance and deductible amounts on any Medicare covered services not normally covered by Medicaid. When billing, each claim line requires a CPT/HCPCS code and the date of service (DOS).

If a beneficiary has Medicare Part B coverage and Medicare does not cover the service(s), the service(s) is considered routine nursing care.

Allowed Revenue Codes: 0270, 0272, 0274, 0275, 0276, 0301-0359, 0400-0409, 0420-0449, 0460, 0469, 0480-0489, 0610-0619, 0636, 0730-0749, 0800-0809, 0920-0929, 0940-0949.

8.14 Other Service Revenue Codes

County Medical Care Facilities (Provider Type 61) and Hospital Long Term Care Units (Provider Type 62) may bill the following Revenue Codes for ancillary services as indicated:

- 0160 - For dually eligible beneficiaries who wish to return to their Medicaid NF bed and refuse their Medicare SNF benefit following a qualifying Medicare hospital stay.

  Services for nursing facility beneficiaries requiring outpatient physical therapy, outpatient speech pathology, and outpatient occupational therapy must be provided and billed under Medicare Part B where applicable, even if no payments are made under Medicare Part A for the nursing facility stay.
- 0410 - Oxygen (gas, equipment, and supplies) – Covered when billed by a county medical care facility or hospital long-term care unit.

  Interim reimbursement is based on a percentage of charge. Final reimbursement is calculated during the respective period's cost settlement and is based on that period's audited cost to charge ratio.
- Medicare/Medicaid – If Medicare is being billed for the nursing facility stay, neither the nursing facility nor a medical supplier can bill Medicaid for oxygen services (i.e., gas, equipment, supplies). Oxygen services are included in the Medicare payment to the facility under Medicare's Prospective Payment System.

SECTION 9 – HOME HEALTH CLAIM COMPLETION

This section contains information that should be used in conjunction with the UB-92 Manual when preparing Home Health claims.

9.1 INTERMITTENT NURSING VISITS/AIDE VISITS/THERAPIES

Each visit must be reported on a separate claim line: Medicaid follows Medicare policy on the requirement that each home health agency visit (e.g., nursing, therapy) must be billed on an individual line. This policy includes two visits performed on the same day (i.e., two visits on the same day must be billed on individual lines).

Report 15-minute time increments: Medicaid follows Medicare policy for reporting home health visits in 15-minute increments. When billing on the UB-92 form, each home health visit Revenue Code that is reported must have a corresponding 15-minute increment HCPCS code along with the number of 15-minute increments reported in the Service Units as follows:

Units	Time Requirements
1	1 minute to < 23 minutes
2	23 minutes to < 38 minutes
3	38 minutes to <53 minutes
4	53 minutes to <68 minutes
5	68 minutes to <83 minutes
6	83 minutes to <98 minutes
7	98 minutes to < 113 minutes
8	113 minutes to < 128 minutes

If services continue for longer periods of time, the home health agency would follow the above pattern.

Time of Service Visit: The timing of the visit begins at the beneficiary's home when services actively begin, and end when services are completed. The time counted must be the time spent actively treating the beneficiary. For example:

- If a beneficiary interrupts a treatment to talk on the telephone for other than a minimal amount of time (less than three minutes), then the time the beneficiary spends on the telephone and not engaged in treatment does not count in the amount of service.
- The home health aide completed bathing and transferring the beneficiary into a chair, and now begins to wash the kitchen dishes before leaving. Washing the dishes is considered incidental and does not meet the definition of a home health aide service. Therefore, the time to perform this activity would not be included in the 15-minute incremental reporting to Medicaid.

Other nontreatment related interruptions would follow the same principle. If the beneficiary is late returning home from a doctor's appointment, the waiting time of the home health agency personnel also cannot be counted as treatment time.

However, if the professional spends time with family or other caretakers in the home teaching them to care for the beneficiary, this activity is counted as treatment time. Calls to the physician by the nurse while in the beneficiary's home to report on the beneficiary's condition can also be counted as treatment time.

If beneficiary assessment activities for completion of the Outcome and Assessment Information Set (OASIS) are a part of an otherwise covered and billable visit, time spent in beneficiary assessment may be included in the total count of 15-minute increments. Completion of the assessment activities must be incorporated into a visit providing otherwise necessary home health care to the beneficiary. A separate visit made only to collect information for the OASIS assessment but not to provide other covered home health services is not billable.

9.2 Postpartum / Newborn Follow-up Nurse Visit

- Medicaid allows one initial postpartum and one initial newborn visit per pregnancy. The initial postpartum visit must be billed using the mother's Medicaid ID number. The initial newborn visit must be billed using the newborn's Medicaid ID number.
- Medicaid allows one subsequent visit to the mother and newborn. This subsequent visit may be billed under either the mother's or newborn's ID number, based on with which beneficiary the nurse spent the majority of the time.

9.3 Blood Lead Poisoning Nursing Assessment / Investigation Visits

Coverage is limited up to two visits per episode per child diagnosed with blood lead poisoning. If more than one child in the home has blood lead poisoning, nurse education visits may be billed for each child. As with other home health services, this service must be ordered by the beneficiary's physician.

These services must be billed as a nurse visit.

- Use Revenue Codes 0550, 0551 or 0552.
- HCPCS code of G0154.
- Applicable ICD-9-CM diagnosis code of 984.0, 984.1, 984.8, or 984.9.

9.4 Intravenous Infusions

If the beneficiary is in need of intravenous infusion and an Infusion Clinic or ancillary Medicaid provider (who has no nurse) does not cover the service, or family member/caregiver will not accept this task, the HHA may perform this service and bill accordingly.

These services must be billed as Infusion Nurse Visit:

- Use Revenue Codes 0550, 0551, or 0552
- Use Procedure Codes:
  - 99601 (per visit - up to two hours). Must be billed on the first claim line.
  - 99602 (each additional hour). Must be billed on each additional claim line for each additional hour.

9.5 Home Health Procedure Codes

When billing on the UB-92 claim form, home health agencies must use the HCPCS codes located in the Healthcare Common Procedure Coding System manual and the Revenue Codes in the UB-92 Manual. Providers should refer to the Home Health Fee Screen on the MDCH website for a listing of covered Revenue Codes and HCPCS Codes. (Refer to the Directory Appendix for website information.)

SECTION 10 – PRIVATE DUTY NURSING AGENCY CLAIM SUBMISSION/COMPLETION

10.1 MI AUTHENTICARE

MI AuthentiCare is an Interactive Voice Response (IVR) system that allows a PDN provider to check-in by calling a toll-free telephone number when arriving at a beneficiary's home and check-out when care is completed. Information captured through the IVR is validated against MDCH prior authorization (PA) files, provider files, beneficiary eligibility files, and other insurance files to verify that the service should be paid. Once validated, MI AuthentiCare automatically submits a HIPAA compliant 837 claim to Medicaid.

Except as detailed in the Direct Billing to MDCH subsection below, private duty nursing services are billed through the MI AuthentiCare system.

All workers (RN or LPN) providing PDN services must have a seven-digit worker ID number registered in MI AuthentiCare. PDN agencies must contact MI AuthentiCare through the MDCH website to enroll its workers (RN or LPN) and obtain a Worker ID number for each. The MI AuthentiCare Manual, which contains information regarding the MI AuthentiCare system, how to obtain Worker ID numbers, and detailed instructions for the use of the system, is available on the MDCH website. (Refer to the Directory Appendix for website information.) Newly enrolled PDN providers will receive instructions on how to obtain a Personal Identification Number (PIN) (necessary for accessing the MI AuthentiCare system via the web) as part of their enrollment package.

Failure to provide timely, accurate worker information can result in delayed or rejected claims.

10.2 DIRECT BILLING TO MDCH

Providers must bill MDCH directly (either paper or electronically) if the beneficiary has other insurance, the other insurance made a payment, and the provider is billing Medicaid for the balance due. If the provider is not billing for the balance due, no claim is to be submitted to Medicaid.

When direct billing to MDCH, note the following:

- Information in this subsection should be used in conjunction with the UB-92 Manual.
- Each month must be billed on a separate claim.
- Each date of service must be reported on a separate claim line.
- Each claim line must report the number of units of care in the Days or Units item for that date of service.
- The PA number listed on the Medicaid authorization letter must be recorded on the claim.
- The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter must not be mailed with the claim when billing.
- A plan of care is not to be attached to the claim or otherwise submitted to MDCH unless specifically requested to do so by MDCH.

- The total number of units reported must not exceed the total units that were authorized for that month.
- Adjustments to claims are made through a total claim replacement or void/cancel process.

10.2.A. Revenue Codes / HCPCS Codes / Modifiers

When billing, the provider must use the following codes. The HCPCS Codes/Modifiers are located in the Healthcare Common Procedure Coding System manual.

Description	Revenue Code	HCPCS Code / Modifier
Nursing Care, RN, Per Hour	0582	S9123
Nursing Care, RN, Per Hour, Holiday	0582	S9123
Nursing Care, LPN, Per Hour	0582	S9124
Nursing Care, LPN, Per Hour, Holiday	0582	S9124
Nursing Care, 1 RN to 2 Patients, Per Hour	0582	S9123 TT
Nursing Care, 1 RN to 2 Patients, Per Hour, Holiday	0582	S9123 TT
Nursing Care, 1 LPN to 2 Patients, Per Hour	0582	S9124 TT
Nursing Care, 1 LPN to 2 Patients, Per Hour, Holiday	0582	S9124 TT
For ratios of more than 2 patients per nurse, the provider must contact the patient's case manager at the Children's Special Health Care Services (CSHCS), Home and Community-Based Services Waiver for the Elderly and Disabled, Children's Waiver (CMHSP), or Habilitation/Supports Waiver (CMHSP). These ratios are considered exceptional cases and require prior approval.		

10.2.B. Payment in 15-Minutes Increments

Private duty nursing is paid in 15-minutes increments. In the event an increment of service is less than 15 minutes, the following rule applies.

Duration of Service	Units Billed
Less than 8 minutes	0
8 – 15 minutes	1

Examples: 53 minutes of service = 4 units

42.5 minutes of service = 3 units

10.2.C. Multiple Beneficiaries Seen at Same Location

The total Medicaid reimbursement for multiple beneficiaries is time-and-one-half for two beneficiaries. The specific procedure codes listed below must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. These procedure codes must be used for each beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, as approved, the multiple beneficiary code must be used for both children.

10.2.D. Holidays

Medicaid allows additional reimbursement for holidays. Medicaid currently recognizes the following holidays: New Year's Day, Easter, Memorial Day, July 4, Labor Day, Thanksgiving, and Christmas Day. A holiday begins at 12:00 am and ends at 12:00 midnight of that holiday day.

SECTION 11 – HOSPICE CLAIM COMPLETION

This section contains information that should be used in conjunction with the UB-92 Manual when preparing Hospice claims.

11.1 BILLING INSTRUCTIONS FOR HOSPICE CLAIM COMPLETION

- **Admission Date:** Include the admission date for hospice care.
- **Inpatient Respite Care:** "Occurrence Span Code" - include occurrence span code M2 and complete the "from and through" dates for an episode of inpatient respite care.
- **Metropolitan Statistical Area (MSA):** "Value Codes" - include value code 61 in value code field. Additionally, report the MSA number followed by two zeros.
- Use the Revenue Codes listed below:

Revenue Code	Description
0651	Routine Home Care I
0652	Continuous Home Care
0655	Inpatient Respite Care
0656	General Inpatient Care
0657	Physician Services
0658	Other Hospice I

- To bill for room and board in a nursing home or licensed hospice long-term care unit, use Revenue Code 0658. Providers must bill their customary room and board rate and Medicaid pays the usual and customary rate or the Medicaid fee screen, whichever is less. Room and board is reimbursable on the day of discharge only if the discharge is due to resident death.
- Revenue Code 0657 Physician Services requires inclusion of a HCPCS code on the claim line. Each Physician service must be billed on a separate claim line.
- Revenue Code 0652 Continuous Home Care must be billed for each date of service on separate claim lines.
- Hospital Leave Days must be billed using Revenue Code 0185 (must not exceed 10 consecutive days). Reimbursement is at 100 percent of class-wide Nursing Facility Hospital Leave Day rate for qualifying facilities.
- Therapeutic Leave Days must be billed using Revenue Code 0183 (must not exceed 18 total days for the year). Reimbursement is at 95 percent of Nursing Facility rate for leave days.

- Services for day of discharge are reimbursable if services were rendered, regardless of the setting. (See first bullet for instructions regarding room and board.)
- When billing for a hospice/NF resident with a Memorandum of Understanding (MOU), bill Revenue Code 0120 and include the assigned prior authorization (PA) number in F.L. 84.

11.2 Application of the Patient-Pay Amount

The following examples are provided for application of the patient-pay amount (PPA).

Example 1: The beneficiary resides in a NF but is not receiving Medicaid hospice benefits. The beneficiary has a PPA of $500. The room and board for the NF is $125. The NF collects $500 from the beneficiary and provides the beneficiary with a receipt.

Example 2: The beneficiary resides in a NF and elects the Hospice benefit at the beginning of the month. The beneficiary has a PPA of $500. The hospice or the NF collects the $500 PPA from the beneficiary and applies it to the hospice room and board rate which includes the daily QAS amount ($150 which is $125 [NF rate] + $25 [QAS]). The hospice or the NF provides the beneficiary with a receipt.

Example 3: The beneficiary resides in a NF for the first two days of the month before electing the Hospice benefit. The beneficiary's PPA is $500. The NF collects the $500 from the beneficiary, applies $250 from the PPA (the NF rate of $125) toward the room and board owed the NF, and passes $250 on to the hospice. The hospice then bills, showing on its claim the $250 PPA balance available to be applied to the hospice room and board rate. The NF provides the beneficiary with a receipt.

11.3 Offset to Patient-Pay Amount for Noncovered Services

Claims containing an offset to patient-pay amounts cannot be split-billed. The hospice must submit one claim for the particular month of service.

The offset for the noncovered service must be reported on the claim using the appropriate value code and F.L. 39 and the related dollar amount. Only value codes for Michigan Medicaid noncovered services will be activated for approval through the claims processing system.

The dollar amount of Value Code D3 minus Estimated Responsibility Patient (patient-pay amount) is the beneficiary's monthly patient-pay amount MINUS the dollar amount of the offset.

The total of D3 and the offset must equal the beneficiary patient-pay amount for that given month.

Offsetting the patient-pay amount may involve more than one month. For example, the beneficiary may have a patient-pay amount of $200 per month. The amount to be offset is $500. The amount to be offset would involve a three-month period. The first month claim would indicate $200 as an offset with D3 as zero. The second month claim would indicate $200 as an offset with D3 as zero. The third month claim would indicate $100 as an offset with D3 as $100.

11.4 Patient-Pay Amount Greater Than Amount Billed

Hospices must bill Medicaid even if the patient-pay amount is greater than the amount billed to Medicaid. Medicaid requires that a claim be billed so it can obtain particular information off the claim for statistical purposes.

SECTION 12 – REMITTANCE ADVICE

A Remittance Advice (RA) is produced to inform providers about the status of their claims. RAs are available in paper and electronic formats, and utilize the HIPAA-compliant national standard claim adjustment group codes, claim adjustment reason codes, and remarks codes, as well as adjustment reason codes, to report claim status. Code definitions are available from the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

12.1 PAYMENTS / CLAIM STATUS

MDCH processes claims and issues payments (by check or EFT) every week unless special provisions for payments are included in the provider's enrollment agreement. A RA is issued with each payment to explain the payment made for each claim. If no payment is due, but claims have pended or rejected, an RA is also issued. If claims are not submitted for the current pay cycle, no action is taken on previously pended claims, or no payment gross adjustments are processed in the pay cycle, an RA is not generated.

If the total amount approved for claims on any one RA is less than $5.00, a payment is not issued for that pay cycle. Instead, a balance is held until approved claims accumulate to an amount equal to or more than $5.00. Twice a year (usually June and December) all amounts of less than $5.00 are paid.

If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider ID number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment.

Payments to providers are issued by Tax Identification Number (TIN). All payments due to all providers enrolled with MDCH under a specific TIN are consolidated and issued as one check or EFT.

Providers who would like to receive payments from the MDCH through EFT must register through the Department of Management and Budget's (DMB) website. (Refer to the Directory Appendix for DMB website information.)

12.2 ELECTRONIC REMITTANCE ADVICE

The electronic RA is produced in the HIPAA-compliant ANSI X12N 835 version 4010A1 format. Providers opting to receive an electronic RA receive all information regarding adjudicated (paid or rejected) claims in this format. Information regarding pended claims is reported electronically in the 277 Unsolicited Claim Status format.

The electronic RA (835) has many advantages:

- It can serve to input provider claim information into the provider's billing and accounting systems;
- It includes a MDCH trace number to identify the associated warrant or electronic funds transfer (EFT) payment;
- It returns the provider's internal medical record number, line item control number, and patient control number when submitted on the original claim; and
- It contains additional informational fields not available on the paper RA.

The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835 and/or 277U, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835/277U transaction must identify a primary service bureau to receive the 835/277U. All providers under the same corporate TIN must utilize the same primary service bureau. An addition of and/or change to the identification of the primary service bureau must be submitted to Provider Enrollment. The primary service bureau is the only one to receive the 835/277U remittance information for all claims regardless of submission source. No other service bureau submitting claims for that provider/group TIN receives information regarding claims submitted.

For more information regarding the 835 and 277U transactions issued by the MDCH, refer to the MDCH Companion Documents (Data Clarification Documents) on the MDCH website. For general information about the 835 and 277U, refer to the Implementation Guides for these transactions. The guides are available through the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

12.3 Paper Remittance Advice

All providers with approved or pended claims receive a paper RA, even if they opt to receive the 835/277U transactions.

The following information is supplied on the paper RA Header**:**

Provider ID# and Provider Type	This is the Medicaid provider ID number from the provider's claim. The first two digits of the Provider ID number appear in the Provider Type box and the last seven digits appear in the Provider No. box.
Provider Name	This is from the MDCH provider enrollment record for the provider ID number submitted on the claim.
Pay Cycle	This is the pay cycle number for this RA.
Pay Date	This is the date the RA is issued.
Page Number	Pages of the RA are numbered consecutively.
Federal Employer ID# (EIN) or Social Security Number (SSN)	This is in small print in the upper right corner and is unlabeled. The number on the provider's claim must match the billing provider ID number on file with the MDCH and it must be a valid number with the Michigan Department of Treasury. MDCH cannot issue a check if there is a discrepancy between the number on file with the MDCH and the Michigan Department of Treasury. (Incorrect information should be reported to the Provider Enrollment Unit. Refer to the Directory Appendix for contact information.)

Claims appear on the RA in alphabetical order by the beneficiary's last name. If there is more than one claim for a beneficiary, they appear in CRN order under the beneficiary's name. The following table explains the fields of the RA:

Field Name	Explanation
Claim Header	Patient ID Number: Prints the beneficiary's Medicaid ID number that the provider entered on the claim. Claim Reference Number (CRN): A 10-digit CRN is assigned to each claim. If the claim has more than one service line, the same CRN is assigned to each line. The first four digits are the Julian Date the claim was received by MDCH. The fifth through tenth digits are the sequential claim number assigned by the MDCH. Example: In CRN 3223112345, 3 is the year 2003, 223 is the Julian day of the year (August 11), and 112345 is the sequence number. The combination of Julian day and sequence makes a unique number that is assigned to each claim. When asking about a particular claim, the provider must refer to the CRN and Pay Date. The 10-digit CRN is following by a two-character input IN (3223223445-XX). If a service bureau submitted the claim, this is the service bureau ID. If the provider submitted a paper claim, this is a scanner identifier.
Line No.	This identifies the line number where the information was entered on the claim.
Invoice Date	This identifies the date the provider entered on the claim or, if left blank, the date the claim was processed by the system.
Service Date	This identifies the service date entered on the claim line (admit date for inpatient service).
Procedure Code	This identifies the procedure code or revenue code entered on the service line.
Qty	This identifies the quantity entered on the service line. If the MDCH changed your quantity, an informational edit appears in the Explanation Code column.
Amount Billed	This identifies the charge for the entire claim.
Amount Approved	This identifies the amount the MDCH approved for the service line (amount approved for DRG represents the entire claim and it is not approved by claim line). Pended and rejected service lines show the amount approved as zero (.00). Zero also prints when no payment is due from MDCH. For example, when other resources made a payment greater than MDCH's usual payment.
Claim Adjustment Reason Code	Claim adjustment reason codes communicate why a claim or service line was paid differently than was billed. If there is no adjustment to a claim line, then there is no adjustment reason code.

Field Name	Explanation
Claim Remark Code	Claim remark codes relay service line specific information that cannot be communicated with a reason code.
Invoice Total	Totals for the Amount Billed and the Amount Approved print here.
Insurance Information	If Medicaid beneficiary files show other insurance coverage, the carrier name, policy number, effective dates and type of policy (e.g., vision, medical) print below the last service line information.
History Editing	Certain edits compare the information on the claim to previously paid claims. In some cases, information about the previous claim prints on the RA. This information prints directly under the service line to which it relates.
Page Total	This is the total Amount Approved for all service lines on the page. If a claim has service lines appearing on two RA pages, the page total includes only the paid lines printed on each RA page. Amounts for pended service lines and rejected service lines are not included on the page total. All hospitals and NFs on the Medicaid Interim Payment (MIP) program have "MIP PROGRAM" printed on the bottom of each page.

12.4 GROSS ADJUSTMENTS

Gross adjustments are initiated by MDCH. A gross adjustment may pertain to one or more claims. Providers are notified in writing when adjustments are made to claims. Notification should be received before the gross adjustment appears on the RA.

The Paper RA indicates gross adjustments have been made by:

- **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes are used. Code definitions can be found in the 835 Implementation Guide.
- **Gross Adjustment Code:** This is the MDCH gross adjustment code that corresponds to the gross adjustment description.

Code	Name	Explanation
GACR	Gross Adjustment Credit	This appears when providers owe MDCH money. MDCH subtracts the gross adjustment amount from providers' approved claims on the current payroll.

Code	Name	Explanation
GADB	Gross Adjustment Debit	This appears when MDCH owes providers money. The gross adjustment amount is added to the providers' approved claims on the current payroll.
GAIR	Gross Adjustment Internal Revenue	This appears when the provider has returned money to MDCH by check instead of submitting a replacement claim. It is subtracted from the Year-to-Date (YTD) Payment Total shown on the summary page of the RA.

12.5 Remittance Advice Summary Page

The Summary page is the last page of the RA and gives totals on all claims for the current payroll and year-to-date totals from previous payrolls. The following table explains the fields of the Summary Page.

Field Name	Explanation
This Payroll Status	The total number of claims and the dollar amount for the current payroll. This includes new claims plus pended claims from previous payrolls that were paid, rejected, or pended on the current payroll.
Approved	Number of claims from this payroll with a payment approved for every service line. The dollar amount is the total approved for payment.
Pends	Number of claims from this payroll that are pending. The dollar amount is the total charges billed.
Rejected	Number of claims from this payroll with a rejection for every service line. The dollar amount is the total charges billed.
App'd/Rejected	Number of claims from this payroll with a combination of paid and rejected service lines. The amount next to App'd Claim Lines is the total approved. The amount next to Rejected Claim Lines is the total charge billed.
Total Pends in System	Number of new and unresolved pended claims in the system and related total charges.
Previous YTD (Year to Date) Payment Total	The total amount paid for the calendar year before any additions or subtractions for this payroll.

Field Name	Explanation
Payment Amount Due This Payroll to Provider	This amount is the Payment Amount Approved plus any balance due to the provider minus any balance owed by the provider to MDCH.
Payment Made This Payroll	The amount of the check or EFT issued for this payroll.
New YTD Payment Total This Payroll	Total payment for the calendar year, including payments made on this payroll.
Balance Owed or Balance Due	One or more of the following messages prints if there is a balance owed or a balance due: ▪ Balance Due to Provider by MDCH – This appears if the payment amount approved is less than $5.00 or a State account is exhausted. ▪ Balance Owed by Provider to MDCH – This appears when money is owed to MDCH, but the provider does not have sufficient approved claims from a particular State account (e.g., CC or ABW) to deduct what is owed. ▪ Previous Payment Approved, Not Paid – This appears if a balance is due from MDCH on the previous payroll. ▪ Previous Payment Owed by Provider to MDCH – This appears when a balance is due from the provider on a previous payroll.
Pay Source Summary	Identifies the dollar amounts paid from the designated State accounts.

12.6 Pended and Rejected Claims

When a claim is initially processed, the Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid, rejected or pended and lists edits which apply.

- **Rejections:** If a service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. Providers should review the definition of the codes to determine the reason for the rejection.
- **Pends:** If any service line pends for manual review, PEND prints in the Claim Adjustment Reason/Remark column of the RA. An explanation code(s) followed by a P (e.g., 936P) prints in the explanation code column of the RA. These pended claims do not print again on the RA until the claim is paid or rejected, is pended again for another reason, or has pended for 60 days or longer.

When a claim is pended, wait until it is paid or rejected before submitting another claim for the same service(s).

After a claim initially pends it may pend again for a different reason. In that case, a # symbol prints in front of the CRN on the RA to show that it is pending again for further review. CRNs may also appear with a # symbol if they have pended 60 days or longer.

SECTION 13 - JULIAN CALENDAR

Day Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	- -	88	119	149	180	210	241	272	302	333	363
30	30	- -	89	120	150	181	211	242	273	303	334	364
31	31	- -	90	- - -	151	- - -	212	243	- - -	304	- - -	365

For leap year, one day must be added to number of days after February 28. The next three leap years are 2008, 2012, and 2016.

Example: claim reference # 1351203770-59
1 = year of 2001
351 = Julian date for December 17
203770 = consecutive # of invoice
59 = internal processing

BILLING & REIMBURSEMENT FOR PROFESSIONALS

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers billing the CMS-1500 or 837 Professional claim formats. It contains information needed to submit professional claims to the Michigan Department of Community Health (MDCH) for Medicaid, Children's Special Health Care Services (CSHCS), and the Adult Benefits Waiver (ABW). It also contains information about how claims are processed and how providers are notified of MDCH actions.

The following providers must use the ASC X12N 837 4010 A1 professional format when submitting electronic claims and the CMS 1500 claim form for paper claims.

Provider	Provider
Ambulance	Medical Clinics
Certified Nurse Midwives	Medical Suppliers
Certified Nurse Practitioners	Optical Companies
Certified Registered Nurse Anesthetists	Optometrists
Chiropractors	Oral Surgeons
Community Mental Health Services Programs/Prepaid Inpatient Health Plans	Orthotists and Prosthetists
Family Planning Clinics	Physical Therapists
Federally Qualified Health Centers	Physicians (MD & DO)
Hearing Aid Dealers	Podiatrists
Hearing and Speech Centers	Private Duty Nurses (Individually Enrolled)
Independent Laboratories	Rural Health Clinics
Indian Health Centers	School Based Services
Maternal Infant Health Program	Shoe Stores

1.1 Claims Processing System

All claims submitted and accepted are processed through the Claims Processing (CP) System. Paper claims are scanned and converted to the same file format as claims submitted electronically.

Claims processed through the CP system are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services and a combination of service edits. Electronic claims filed by Wednesday may be processed as early as the next weekly cycle.

MDCH encourages providers to send claims electronically by file transfer or through the data exchange gateway (DEG). Electronic filing is more cost effective, more accurate, payment is received more quickly and administrative functions can be automated.

1.2 Remittance Advice

Once claims have been submitted and processed through the CP System, a paper remittance advice (RA) will be sent to each provider with adjudicated or pended claims. An electronic health care claim payment/advice (ASC X12N 835 4010A1) will be sent to the designated primary service bureau for providers choosing an electronic RA. (Refer to the Remittance Advice Section of this chapter for additional information about both the paper and electronic RA.)

1.3 Additional Resource Materials

Bulletins	These intermittent publications supplement the provider manual. Bulletins are automatically mailed to enrolled providers affected by the bulletin and subscribers of the Manual. Recent bulletins can be found on the MDCH website. (Refer to the Directory Appendix for website information.)
Companion Guide (Data Clarification Document)	This document is intended as a companion to the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional Claim, ASC X12N 837A1. It contains data clarifications and identifiers to use when a national standard has not been adopted, and parameters in the implementation guide that provide options.
Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Coding Manuals	These manuals are published annually listing national CPT and HCPCS codes. Publications are available from many sources, such as the AMA Press or Medicode. The HCPCS codes are available on the CMS website for free downloading. (Refer to the Directory Appendix for contact information.)
Electronic Submission Manual	This manual provides detailed instructions on obtaining approval for electronic billing and how to file electronic claims with MDCH. It is available on the MDCH website. (Refer to the Directory Appendix for website information.)

International Classification of Diseases, Clinical Modification (ICD-9-CM)	Diagnosis codes are required on claims using the conventions detailed in this publication. This publication is updated annually and may be requested from Medicode or the AMA. The HCPCS codes are available on the CMS website for free downloading. (Refer to the Directory Appendix for contact and website information.)
Databases	These list procedure codes, descriptions, fee screens, and other pertinent coverage, documentation, and billing indicators. The databases are only available on the MDCH website. (Refer to the Directory Appendix for website information.)
Numbered Letters	General program information and announcements are transmitted to providers via numbered letters. These can be found on the MDCH website. (Refer to the Directory Appendix for website information.)
Medicaid Provider Manual	The manual includes program policy and special billing information. A CD copy of the manual is available at a nominal cost from MDCH. It is also available on the MDCH website for review or download. (Refer to the Directory Appendix for contact and/or website.)

1.4 ELECTRONIC FUNDS TRANSFER

Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments into a provider's bank account. This replaces a paper warrant. To initiate an EFT, the facility should go to the Department of Management and Budget website. (Refer to the Directory Appendix for website information.)

SECTION 2 – HOW TO FILE CLAIMS

Professional claims may be submitted electronically or on paper. Electronic claim submission is the preferred method for submitting claims to MDCH.

2.1 ELECTRONIC CLAIMS

Claims submitted electronically and accepted are received directly into the CP system, which results in faster payments and fewer claims that pend or reject. Claims can be submitted by file transfer or through the DEG. Providers submitting claims electronically must use the ASC X12N 837 4010 A1 professional format. The payroll cut-off for electronic claims submission to MDCH is Wednesday of each week.

Complete information on submission of electronic claims is available on the MDCH website. (Refer to the Directory Appendix for website information.) The MDCH Electronic Submission Manual and other resources, such as the Companion Guides, are on the website. Information on the website is updated as version changes occur at the national level and are adopted by MDCH.

2.1.A. AUTHORIZED ELECTRONIC BILLING AGENTS

Any entity (service bureau or individual provider) wishing to submit claims electronically to MDCH must be an authorized billing agent. The authorization process is:

- Contact the MDCH Automated Billing Unit for an application packet. (Refer to the Directory Appendix for contact information.)
- Complete and submit the forms in the application packet (an application and a participation agreement).
- Receive an identification (ID) number.
- Format and submit test files.
- When test files are approved, providers receive authorization from MDCH to bill electronically.

When authorized as an electronic billing agent, any provider (including providers who bill for themselves) who wants the billing agent to submit claims on their behalf must complete and submit the Billing Agent Authorization (DCH-1343) form to MDCH. (Refer to the Directory Appendix for contact information.) This form certifies that all services the provider has rendered are in compliance with Medicaid guidelines. MDCH notifies each provider when the DCH-1343 has been processed. After notification, approved billing agents can bill electronically for themselves or for other providers that have completed the DCH-1343 indicating that the billing agent may bill on their behalf. More than one billing agent per provider can be authorized to submit the provider's claims electronically. However, only one electronic billing agent may be the designated receiver of the electronic health care claim payment/advise ANSI X12N 835 4010A1. (Refer to the Remittance Advice Section of this chapter for additional information.) Authorizations remain in effect unless otherwise indicated in writing by the provider.

Complete details for the electronic billing agent authorization process, test file specifications, electronic billing information and the transaction set for professional claims can be found on the MDCH website. (Refer to the Directory Appendix for website information.) Any live claims for services rendered must be billed on paper until the authorization process is complete.

Test claims are not processed for payment.

Any individual provider can submit claims electronically as long as the authorization process is completed and approved; however, many providers find it easier to use an existing authorized billing agent to submit claims to MDCH. Billing agents prepare claims received from their clients, format to HIPAA compliant MDCH standards, and submit the files to MDCH for processing. Whether claims are submitted directly or through another authorized billing agent, providers receive a paper remittance advice (RA) that reflects their individual claims. Billing agents receive a RA that contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents, contact the Automated Billing Unit. (Refer to the Directory Appendix for contact information.)

2.1.B. Electronic Claims with Attachments

If comments or additional information is required with an electronic claim, electronic submitters must enter the information in the appropriate segments of the electronic record. If an operative report or other paper attachment is required and an electronic claim is submitted, refer to the Electronic Submission Manual for instructions for submitting paper attachments for electronic claims.

2.2 Paper Claims

The CMS 1500 Form must be used when submitting paper claims. It must be a form printed with red ink with numbers (12-90) RRB-1500 in the lower right corner. The CMS 1500 form that contains four black alignment bars in the upper left corner is the preferred version to use. Use of forms other than the red ink version will result in errors when they are scanned by the Optical Character Reader (OCR). (Refer to the Claim Completion Section of this chapter for a sample form and complete instructions.)

Claims may be prepared on a typewriter or on a computer. Handwritten claims are not accepted. Because claims are optically scanned, print or alignment problems may cause misreads thus delaying processing of the claim. Keep equipment properly maintained to avoid the following:

- Dirty print elements with filled character loops;
- Light print or print of different density;
- Breaks or gaps in characters;

- Ink blotches or smears in print; and
- Worn out ribbons.

Dot matrix printers should not be used as they result in frequent misreads by the OCR.

Questions and/or problems with the compatibility of equipment with MDCH scanners should be directed to the OCR Coordinator. (Refer to the Directory Appendix for contact information.)

Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period.

2.2.A. Guidelines to Complete Paper Claim Forms

To assure that the scanner correctly reads claim information, adhere to the following guidelines in preparing paper claims. Failure to do so can result in processing/payment delays or claims being returned unprocessed.

- Dates must be eight digits without dashes or slashes in the format MMDDCCYY (e.g., 10012003). Be sure the dates are within the appropriate boxes on the form.
- Use only black ink.
- Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- UPPER CASE alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12-point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. Do not squeeze comments below the service line.
- Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use correction fluid or correction tape, including self-correcting typewriters.
- If a mistake is made, start over and prepare a clean claim form.
- Do not submit photocopies.

- Claim forms must be mailed flat, without folding, in 9" x 12" or larger envelopes. Do not fold the form.
- Put your return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut edges of forms.
- Keep the file copy.
- Mail CMS 1500 claim forms separately from any other claim form type.

2.2.B. Providing Attachments with Paper Claims

When a claim attachment is required, it must be directly behind the claim it supports and be identified with the beneficiary's name and Medicaid ID number. Attachments must be on 8 ½" x 11" white paper and one-sided. Do not submit two-sided materials. Multiple claims cannot be submitted with one attachment. Each claim form that requires an attachment must have a separate attachment. Do not staple or paperclip the documentation to the claim form.

Mail claim forms with attachments flat, with no folding, in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims without attachments in this envelope. Mail claims without attachments separately. Do not send attachments unless the attachment is required as unnecessary attachments delay processing of claims.

2.2.C. Mailing Paper Claims

All paper claim forms and claim forms with attachments must be mailed to MDCH. (Refer to the Directory Appendix for contact information.)

SECTION 3 -CLAIM COMPLETION

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

3.1 CMS 1500 Claim Completion Instructions

The following claim completion instructions apply to all claims submitted to MDCH by providers. Providers who submit claims to a Medicaid Health Plan (MHP) must contact that plan directly to determine if there are any different or additional requirements for claim completion.

1	**Insurance**	Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
1a	**Insured's I.D. Number**	Enter the patient's eight-digit Medicaid identification number.
2	**Patient's Name**	Enter the patient's last name, first name, and middle initial, if any.
3	**Patient's Birth Date and Sex**	Enter the patient's eight-digit date of birth (MMDDCCYY) and sex.
4	**Insured's Name**	If there is private or group health insurance covering the beneficiary, list the name of the insured (policy holder) here. When the insured and the patient are the same, enter the word SAME. If there is no other insurance, leave blank.
5	**Patient's Address**	Enter the patient's mailing address and telephone number. On the first line, enter the street address; the second line, the city and state; the third line, the zip code and phone number.
6	**Patient's Relationship to Insured**	Check the appropriate box for patient's relationship to insured when item 4 is completed.
7	**Insured's Address**	Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4 and 11 are completed.
8	**Patient Status**	Check the appropriate box for the patient's marital status and whether employed or a student.
9	**Other Insured's Name**	If the patient has more than one insurance in addition to Medicaid, enter the primary other insurance information in 11 through 11d and enter the name of the insured for the second commercial insurance here.
9a	**Other Insured's Policy or Group Number**	Enter the second insurance policy or group number.

9b	**Other Insured's Date of Birth and Sex**	Enter the insured's eight-digit date of birth (MMDDCCYY) and check the appropriate box for sex.
9c	**Employer's Name or School Name**	Enter the employer name or school name if applicable.
9d	**Insurance Plan Name or Program Name**	Enter the plan or program name of the second insurance.
10a	**Is Patient's Condition Related to Employment?**	Check YES or NO as appropriate.
10b	**Is Patient's Condition Related to Auto Accident?**	Check YES or NO. If YES, the two-digit state code must be entered and the date of the accident must be reported in item 14.
10c	**Is Patient's Condition Related to Other Accident?**	Check YES or NO. If YES, the date of the accident must be reported in item 14.
10d	**Reserved for Local Use**	Leave blank. Not used by Medicaid.
11	**Insured's Policy Group or FECA Number**	This item MUST be completed if there is other insurance, including Medicare. Enter the insured's policy or group number or HIC (Medicare Health Insurance Claim) number and proceed to items 11a. – 11c. Do NOT enter Medicaid information here.
11a	**Insured's Birth Date and Sex**	Enter the insured's eight-digit date of birth (MMDDCCYY) and sex if different from item 3.
11b	**Employer's Name or School Name**	Enter the employer's name or school name if applicable.
11c	**Insurance Plan Name or Program Name**	Enter the complete insurance plan or program name.

11d	**Is There Another Health Benefit Plan?**	If there is a second health benefit plan, mark the YES box and complete fields 9 through 9d. If no other plan, mark NO.
12	**Patient's or Authorized Person's Signature**	Not required for Medicaid. The patient's Medicaid application authorizes release of medical information to MDCH necessary to process the claim.
13	**Insured's or Authorized Person's Signature**	Not required for Medicaid. The patient's Medicaid application authorizes release of medical information to MDCH necessary to process the claim.
14	**Date of Current Illness, Injury or Pregnancy**	Enter the date of current illness, injury, or pregnancy as appropriate. If YES in item 10b or 10c, the date of accident is required. Report the date as eight digits (MMDDCCYY).
15	**If Patient has had a same or similar illness, give first date**	Leave blank. Not required by Medicaid.
16	**Dates Patient Unable to Work in Current Occupation**	Leave blank. Not required by Medicaid.
17	**Name of Referring Physician or Other Source**	Enter the referring/ordering provider's first and last name, and professional designation (e.g., MD, DO). All covered services that are the result of a physician's order or referral must include the referring/ordering physician's name.
17a	**I.D. Number of Referring Physician**	Enter the nine-digit Medicaid ID number of the referring/ordering provider. The first two digits must be the Medicaid provider type code and the last seven digits must be the Medicaid provider ID number. Refer to the provider-specific chapters of this manual for situations where this number may be required. The referring/ordering provider ID number is always required when billing the following services: ▪ Laboratory Services; ▪ Consultation Services; and ▪ Nonemergency Ambulance Services. Ask for the ID number when the referral is made. If the referring/ordering provider is not enrolled in Medicaid, enter nine 8's (888888888). The provider's name and professional designation must be reported in field 17.

18	**Hospitalization Dates Related to Current Services**	When services are provided during an inpatient hospital stay, enter the date admitted and, if available, the date discharged. Report the dates as eight digits (MMDDCCYY.)
19	**Reserved For Local Use**	If services reported on the claim require documentation or special remarks, enter the information here.
20	**Outside Lab/Charges**	Leave blank. Not required by Medicaid.
21	**Diagnosis or Nature of Illness or Injury**	Enter the patient's diagnosis/condition that identifies the reason for the service. Providers must enter an ICD-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary condition). Lab providers may use the laboratory examination code if a diagnosis is not available.
22	**Medicaid Resubmission Code and Original Reference Number**	Complete only if replacing or voiding/canceling a previously paid claim. ▪ If submitting a replacement claim, enter resubmission code 7 in the left side of item 22 and enter the 10-digit Claim Reference Number (CRN) of the paid claim being replaced in the right side of item 22. ▪ If submitting a void/cancel claim, enter resubmission code 8 in the left side of item 22 and enter the 10-digit CRN of the paid claim being voided/cancelled in the right side of item 22.
23	**Prior Authorization (PA) Number**	Enter the nine-digit Medicaid authorization number for services requiring authorization. Refer to the provider-specific chapters of this manual for specific requirements. Following are some of the services that require authorization: ▪ Elective inpatient services; ▪ Out-of-state ambulance transports; ▪ Select medical equipment and supplies; ▪ Select prosthetic and orthotic services; ▪ Select vision services; ▪ Transplant services; and ▪ Other services as described in the provider-specific chapters of this manual or the MDCH databases. If billing for clinical lab services, the CLIA registration number must be reported here. The number is a 10-digit number with "D" in the third position.

24A	**Date(s) of Service**	Enter the eight-digit date (MMDDCCYY) for each procedure, service or supply. List each date of service on a separate line. Both the "From" and "To" date must be completed. (Refer to the Special Billing Section of this chapter for instructions on reporting the date of service in special circumstances.)
24B	**Place of Service (POS):**	Enter the appropriate two-digit place of service code from the list of CMS approved definitions for place of service below: **01** **Pharmacy:** A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. MDCH only recognizes place of service 01 for pharmacies dually enrolled as medical suppliers. **03** **School:** A facility whose primary purpose is education. **04** **Homeless Shelter:** A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). **05** **Indian Health Service Free-standing Facility:** A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. MDCH does not recognize place of service 5 as a location for provision of a covered service. **06** **Indian Health Service Provider-based Facility:** A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. MDCH does not recognize place of service 6 as a location for provision of a covered service. **07** **Tribal 638 Free-standing Facility:** A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization. **08** **Tribal 638 Provider-based Facility**: A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatient or outpatient. MDCH does not recognize place of service 8 as a location for provision of a covered service.

		11 **Office**: Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. **12** **Home**: Location, other than a hospital or other facility, where the patient receives care in a private residence. **13** **Assisted Living Facility**: Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services, including some health care and other services. **14** **Group Home**: Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and support services and that that promotes rehabilitation and reintegration of residents into the community. **15** **Mobile Unit**: A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services. **20** **Urgent Care Facility**: Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. **21** **Inpatient Hospital**: A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by or under the supervision of physicians to patients admitted for a variety of medical conditions. **22** **Outpatient Hospital:** A portion of a hospital, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. **23** **Emergency Room – Hospital:** A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided. **24** **Ambulatory Surgical Center**: A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis. **25** **Birthing Center**: A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants. **26** **Military Treatment Facility**: A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF). MDCH does not recognize place of service 26 as a location for provision of a covered service.

		31 **Skilled Nursing Facility**: A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital **32** **Nursing Facility**: A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals. **33** **Custodial Care Facility**: A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component. **34** **Hospice**: A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided. **41** **Ambulance – Land**: A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured. **42** **Ambulance – Air or Water**: An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured. **49** **Independent Clinic**: A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. **50** **Federally Qualified Health Center**: A facility located in a medically underserved area that provides beneficiaries preventive primary medical care under the general direction of a physician. **51** **Inpatient Psychiatric Facility**: A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician. **52** **Psychiatric Facility - Partial Hospitalization**: A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility. **53** **Community Mental Health Center (CMHC)**: A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

		54 **Intermediate Care Facility/Mentally Retarded**: A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals, but does not provide the level of care or treatment available in a hospital or SNF. MDCH does not recognize place of service 54 as a location for provision of a covered service. **55** **Residential Substance Abuse Treatment Facility**: A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board. **56** **Psychiatric Residential Treatment Center**: A facility or distinct part of a facility for psychiatric care, which provides a total 24-hour therapeutically, planned and professionally staffed group living and learning environment. **57** **Nonresidential Substance Abuse Treatment Facility**: A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies and psychological testing. **60** **Mass Immunization Center**: A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting. MDCH does not recognize place of service 60 as a location for provision of a covered service. **61** **Comprehensive Inpatient Rehabilitation Facility**: A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services. **62** **Comprehensive Outpatient Rehabilitation Facility**: A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services. **65** **End-stage Renal Disease Treatment Facility**: A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis. **71** **Public Health Clinic**: A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.

		72 **Rural Health Clinic:** A certified facility that is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician. **81** **Independent Laboratory:** A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office. **99** **Other Place of Service:** Other place of service not identified above. (Provide description in item 32.) MDCH does not recognize place of service 05, 06, 08, 26, 54, or 60 as locations for provision of covered services. Additionally, some locations may be covered only for select providers. Refer to the appropriate provider-specific chapters of this manual for more information.
24C	**Type of Service**	Leave blank. Not required by Medicaid.
24D	**Procedures, Services, or Supplies (CPT/HCPCS Codes plus modifiers)**	Enter the code for the procedure, service, or supply rendered. Some procedure codes require the use of 2 character modifiers to accurately identify the service provided and to avoid delay or denial of payment. Up to two modifiers can be reported on one service line. If more than two must be reported, use the most pertinent modifier in the first position, modifier 99 in the second position and identify the additional modifier(s) in item 19. (Refer to the Modifiers Section of this chapter for a list of the modifiers that must be reported to Medicaid.) Additional information on use is found in the provider-specific chapters of this manual. Other modifiers may be reported for information purposes only. If a code for the exact procedure cannot be found, use the appropriate unlisted services or Not Otherwise Classified (NOC) code listed within the service classification. Enter a complete description of the service in item 19 or attach the appropriate documentation. Do not use initials or abbreviations, unless they are universally recognized.
24E	**Diagnosis Code (Pointer)**	Enter the primary diagnosis code pointer or reference number (i.e., 1, 2, 3, or 4) from item 21, which reflects the reason the procedure was performed. The primary diagnosis must always be reported as the first number. An "E" code cannot be reported as a primary diagnosis. Up to 4 pointers (reference numbers) may be reported per line. Do not report the actual diagnosis code in this item.
24F	**Charges**	Enter your usual and customary charge to the general public. Do not use decimals, commas, or dollar signs. Fifty dollars is recorded as 5000. ▪ When billing Medicaid for services covered by Medicare, report the Medicare allowable amount. ▪ When billing Medicaid for services covered by other third party carriers who have participating provider agreements in effect, report the carrier's allowable amount. ▪ For beneficiaries enrolled in a commercial HMO or a Medicare risk HMO, report the fixed co-pay amount for the service as the charge.

24G	**Days or Units**	Enter the number of days or units. If only one service is performed, the number "1" must be entered. Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., mileage, allergy testing, injectable drug dosages, medical supply items). When multiple services are provided, enter the actual number provided. For anesthesia claims, show the elapsed time in minutes. Convert hours into minutes and show the total minutes required for this procedure. Refer to the provider-specific chapters of this manual for additional information on billing quantity in special circumstances.
24H	**EPSDT/Family Plan**	Leave blank. Not required by Medicaid.
24I	**EMG – Emergency**	Enter the appropriate emergency code: ▪ Y = emergency ▪ N = not an emergency
24J	**Coordination of Benefits (COB)**	For paper claims enter the appropriate code from the list below. If none of the following conditions apply, leave this item blank. Do not bill Medicare covered and excluded services on the same claim. 1 An insurance carrier other than Medicare made payment. Enter the payment in item 24K. 2 Commercial HMO fixed co-pay only. Item 24F should be the fixed co-pay amount only. 3 An insurance carrier other than Medicare applied the charges to the deductible. 4 Both Medicare and another carrier made payment. Enter the total payment in 24K. 5 Medicare only made payment. Enter the payment in 24K. 6 Medicare risk HMO co-pay only. Item 24F should be the fixed co-pay amount only. 7 Medicare applied all charges to the deductible. 8 The patient has other insurance (other than Medicare) and this service is not covered or the patient's other insurance is terminated or expired. Indicate the reason for nonpayment in Box 19. The policy number of the other insurance must be reported in box 11 even if the other insurance is terminated or expired. 9 Medicaid deductible liability. Enter the Medicaid deductible liability of the patient in item 24K. The Medicare EOB and/or the other insurance EOB must be submitted with the paper claim if 1, 3, 4, 5, or 7 was entered. For electronic claims, the COB codes do not apply. The appropriate segments must be completed as explained in the transaction set and no EOB is required.

24K	**Reserved for Local Use**	For Medicaid, report the sum of Medicare payment and any other insurance payment or Medicaid deductible liability. Medicaid deductible liability is the amount that the beneficiary owes for the service. Do not use decimals, commas, or dollar signs.
25	**Federal Tax I.D. Number (check box/SSN or EIN)**	Enter the provider of service or supplier Federal Tax I.D. number (Employer Identification Number or EIN) or Social Security Number (SSN). Check the box of the number reported. The EIN or SSN reported here must correspond with the billing provider ID# in item 33.
26	**Patient's Account Number**	Enter the patient's account number assigned by the provider of service or supplier's accounting system. This field is to assist providers in patient identification. As a service, account numbers reported here are reported back to the provider on the remittance advice.
27	**Accept Assignment**	Leave blank. Not required for Medicaid.
28	**Total Charge**	Enter total of charges from item 24F, lines 1-6.
29	**Amount Paid**	Enter the total amount of all payments/Medicaid deductible liability reported in item 24K. If the other insurance amount was not indicated on each service line, enter the lump sum amount in item 29 and attach the EOB to the claim. If there was no other payment, leave blank.
30	**Balance Due**	Enter the balance due (from Medicaid) by subtracting Amount Paid (item 29) from Total Charge (item 28).
31	**Signature of Physician or Supplier including degrees or credentials**	A signature is required. (Refer to the General Information for Providers Chapter of this manual for the provider certification requirements and acceptable signatures for the claim form.)
32	**Name and Address of Facility Where Services Were Rendered (if other than home or office)**	Enter the name and address of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or the physician's office. Use this item to describe where the service was provided when place of service code 99 is used. When the name and address of the facility where the services were furnished is the same as the name and address shown in item 33, enter the word "SAME."

33	**Physician's, Supplier's Billing Name, Address, Zip code and Phone #, PIN# and Group #**	Enter the provider of service/supplier's billing name, address, zip code and telephone number. Enter the provider's Medicaid nine-digit provider identification number on the bottom left side of the box next to "PIN#". Leave the space right of "GRP#" blank. The first two digits are the provider type code and the last seven digits are the assigned provider ID number for the location where the service was provided. Leave the space right of GRP# blank. The provider ID number reported here must correspond with the EIN or SSN reported in item 25.

3.2 MANDATORY/CONDITIONAL ITEMS

The following table lists mandatory and conditional claim completion requirements by item number. By definition:

- **Mandatory** means the item is required for all claims. If the item is left blank, the claim cannot be processed.
- **Conditional** means the item is required if applicable. Claims may not be processed if conditional items are blank.

Item	Status	Information
1 a	**Mandatory**	Enter the patient's eight-digit Medicaid ID number.
2	**Mandatory**	Enter the patient's last name, first name, and middle initial, if any.
3	**Mandatory**	Enter the patient's eight-digit birth date (MMDDCCYY) and sex.
4	**Conditional**	Mandatory if the patient has insurance primary to Medicaid.
6	**Conditional**	If item 4 is complete, check the appropriate box.
7	**Conditional**	Complete if items 4 and 11 are completed.
9	**Conditional**	Mandatory if item 11d is YES.
9a	**Conditional**	Enter second insurance policy or group number for policyholder in item 9.
9b	**Conditional**	Enter date of birth (MMDDCCYY) and sex for policyholder in item 9.
9c	**Conditional**	Enter employer or school name for policyholder in item 9.

Item	Status	Information
9d	**Conditional**	Enter insurance plan name or program name for policyholder in item 9.
10a	**Mandatory**	Check YES or NO if condition is employment related.
10b	**Mandatory**	Check YES or NO if condition is related to an auto accident. If YES, indicate the state zip code.
10c	**Mandatory**	Check YES or NO if condition is related to accident other than auto.
11	**Conditional**	Mandatory if patient has insurance primary to Medicaid. Enter primary insurance policy group number.
11a	**Conditional**	Enter the date of birth (MMDDCCYY) and sex for policyholder in item 4.
11b	**Conditional**	Enter the employer's name or school for policyholder in item 4.
11c	**Conditional**	Enter the insurance plan or program name for policyholder in item 4.
11d	**Conditional**	Check YES if appropriate and complete item 9-9d.
14	**Conditional**	If item 10b or 10c is YES, date of accident must be reported.
17	**Conditional**	Enter the referring/ordering physician's name as required.
17a	**Conditional**	Enter the 9-digit Medicaid provider ID# of the provider in item 17.
18	**Conditional**	Report the admit and discharge dates for services during an inpatient hospital stay.
19	**Conditional**	Enter documentation or remarks as required.
21	**Mandatory**	Enter the ICD-9-CM diagnosis code(s) that identify the reason for the service.
22	**Conditional**	Resubmit code 7 and the last paid 10-digit Claim Reference Number (CRN) is mandatory to replace a previously paid claim.
23	**Conditional**	Enter nine-digit Medicaid authorization number or ten-digit CLIA number as appropriate.

Item	Status	Information
24A	**Mandatory**	Enter the eight-digit (MMDDCCYY) 'from' and 'to' date for each service.
24B	**Mandatory**	Enter the appropriate two-digit place of service code.
24D	**Mandatory**	Enter code and modifier (if appropriate) for the procedure, service or supply rendered.
24E	**Mandatory**	Enter the reference number(s) from item 21 that relates to the procedure/service. Report the primary diagnosis reference number first.
24F	**Mandatory**	Enter the charge without decimals, commas, or dollar signs.
24G	**Mandatory**	Enter the number of units.
24I	**Mandatory**	Enter appropriate code. Y = emergency N = not an emergency
24J	**Conditional**	Enter the appropriate COB code to define the involvement of Medicare or other insurance carriers.
24K	**Conditional**	Report amount of Medicare or other insurance payment or Medicaid deductible liability.
25	**Mandatory**	Enter the provider's Federal Tax I.D. or Social Security Number.
26	**Mandatory**	Enter the patient account number assigned by the provider or supplier.
28	**Mandatory**	Enter sum of charges in 24F.
29	**Conditional**	Mandatory if entries in 24K. Enter sum of entries in 24K.
30	**Mandatory**	Enter amount in 28 less amount in 29.
31	**Mandatory**	Signature of provider or supplier and date.
32	**Conditional**	Enter name and address of facility where services were rendered.
33	**Mandatory**	Enter the provider's nine-digit Medicaid ID number next to "PIN#" for the location of service billed.

SECTION 4 - REPLACEMENT, VOID / CANCEL CLAIMS AND REFUND OF PAYMENT

4.1 REPLACEMENT CLAIMS (ADJUSTMENTS)

Replacement claims must be submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after MDCH has made payment. When replacement claims are received, MDCH deletes the original claim and replaces it with the information contained on the replacement claim. It is very important to include all service lines on the replacement claim, whether they were paid incorrectly or not. All money paid on the first claim is debited and the new payment is based on information reported on the replacement claim only. Reasons claims may need to be replaced:

- To return an overpayment (report "returning money" in Remarks section);
- To correct information submitted on the original claim (other than to correct the provider ID number and/or the beneficiary ID number). Refer to the Void/Cancel Claims subsection below;
- To report payment from another source after MDCH paid the claim (report "returning money" in Remarks section); and
- To correct information that the scanner misread (except a provider ID number or a beneficiary ID number). State reason in the Remarks section.

All claim completion instructions apply to completing a replacement claim. The provider ID number and beneficiary ID number on the replacement claim must be the same as on the original claim. Replacement claims must also include resubmission code 7 in the left side of Item 22 and the ten-digit Claim Reference Number (CRN) of the previously paid claim in the right side of Item 22. If the resubmission code of 7 is missing the claim cannot be processed as a replacement claim.

If all service lines of a claim were rejected, the services must be resubmitted as a new claim, not a replacement claim.

4.2 VOID / CANCEL CLAIMS (ADJUSTMENTS)

Void/cancel claims must be submitted when a claim was paid under an incorrect provider ID number or under an incorrect beneficiary ID number. When void/cancel claims are received, MDCH deletes the original claim and all money paid on the first claim is debited. Reasons a claim may need to be voided/cancelled include but are not limited to:

- Wrong Beneficiary ID Number.
- Wrong Provider ID Number.

All claim completion instructions apply for completing a void/cancel claim except as noted below. The provider ID number and beneficiary ID number on the void/cancel claim must be the same as on the original claim. A void/cancel claim must also include resubmission code 8 in the left side of Item 22 and the ten-digit CRN of the previously paid claim in the right side of Item 22.

If the resubmission code of 8 is missing the claim cannot be processed as a void/cancel claim.

Exceptions to claim completion instructions are:

- If payment is received under the wrong beneficiary ID number, submit a void/cancel claim using the same beneficiary ID as the original claim, complete one service line and enter zero dollars (000) in all money fields. The entire payment made on the first claim will be debited. A new claim may then be submitted using the correct beneficiary ID.
- If payment is received under an incorrect provider ID number, submit a void/cancel claim using the same provider ID number as the original claim, complete one service line and enter zero dollars (000) in all money fields. The entire payment made on the first claim will be debited. A new claim may then be submitted for the correct provider ID number.

After the void/cancel claim is submitted, a new claim containing the correct beneficiary ID number and/or provider ID number is submitted.

If all service lines of a claim were rejected, the services must be resubmitted as a new claim, not a replacement claim. No void/cancel claim is submitted.

4.3 Refund of Payment

Return of overpayments made by MDCH, due to either payment from a third party resource or due to an error, must be done through the use of a replacement claim or void/cancel claim. This process will result in a debit against future payment.

This requirement does not apply to inactive providers or monies being returned to MDCH due to settlements or lawsuits. In these situations, checks must:

- be made payable to the State of Michigan in the amount of the refund
- include the provider EIN (tax) number
- be sent to MDCH Cashier's Unit. (Refer to the Directory Appendix for contact information.)

SECTION 5 - CHANGES IN ELIGIBILITY ENROLLMENT (FFS/MHP/CSHCS)

It is the provider's responsibility to determine eligibility/enrollment status of beneficiaries at the time services are provided and obtain the appropriate authorizations for payment.

Medicaid, Adult Benefits Waiver (ABW) or Children's Special Health Care Services (CSHCS) beneficiaries may lose eligibility or change enrollment status on a monthly basis. Enrollment status changes include beneficiaries changing from FFS (Fee-For-Service Medicaid or CSHCS) to a MHP, from one health plan to another health plan, or from a health plan to FFS. Normally the change occurs at the beginning of a month; however, some changes may occur during the month. It is important that providers check beneficiary eligibility before each service is provided to determine who is responsible for payment and whether authorization is necessary. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.

5.1 INPATIENT HOSPITAL ADMISSIONS AND SERVICES

The following guidelines are intended to assist providers and health plans regarding authorization of services and payment responsibility, particularly when a change in enrollment status has occurred.

- All admissions (other than emergency admissions) require authorization. All medical/surgical (nonpsychiatric) admissions must be authorized by MDCH or its Admissions and Certification Review Contractor (ACRC) or by the Heath Plan the beneficiary is enrolled in at the time of the admission. The local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Service Program (CMHSP) must authorize all psychiatric admissions.
- Services provided during the admission may also require authorization for health plan enrollees. Providers must be aware of the beneficiary's enrollment status and of health plan requirements and processes for authorization. Consultations, surgical procedures, and diagnostic tests may not be reimbursed unless a health plan's authorization process is followed.
- If a beneficiary is admitted by the local PIHP/CMHSP, the admission and all psychiatric services are the responsibility of the PIHP/CMHSP. However, any nonpsychiatric medical/surgical services needed during a psychiatric admission are the responsibility of the health plan and must be authorized by the health plan. This includes transportation to another facility for medical/surgical services. If a beneficiary is admitted for medical/surgical services authorized by the health plan and needs psychiatric consultation or care, the PIHP/CMHSP must be contacted for authorization and is then responsible for payment for the psychiatric services once authorization has been obtained.
- If a beneficiary is admitted to an inpatient hospital facility and the enrollment status changes during the admission, payment for all services provided until the date of discharge are the responsibility of the payer at the time of admission. Services provided after discharge are the responsibility of the new payer. Discharge planning should include the new payer for authorization of any medically necessary services or treatments required after discharge from the hospital.
- If a beneficiary is transferred from one inpatient hospital to another inpatient hospital, this does not constitute a discharge. The payer at admission is the responsible party until the beneficiary is discharged from the inpatient hospital setting to a nonhospital setting.

The following examples illustrate payment responsibilities:

FFS to Health Plan	A FFS beneficiary is admitted to the hospital on September 15, enrolled in a health plan on October 1, and was discharged from the hospital on October 5. The health plan is not responsible for services until October 5, after discharge. FFS is responsible for the entire admission and physician services provided during the admission. The health plan must be contacted at discharge to transition care needs and authorize services needed after discharge such as rental of equipment, ongoing medical supply needs, ongoing treatment (e.g., home health care, physical therapy, chemotherapy, IV infusion), etc.
Health Plan to Health Plan	If a beneficiary is in health plan "A" during September and changes to health plan "B" for October, health plan "A" is responsible for the admission. Health plan "B" must be contacted during the discharge planning process and is responsible for authorizing all services needed after discharge.
Health Plan to Health Plan with Transfer to a Tertiary Hospital	A beneficiary enrolled in health plan "A" is admitted for authorized surgery in June. The beneficiary is enrolled in health plan "B" on July 1. After surgery, the patient develops complications necessitating a transfer to a tertiary hospital on July 2. The beneficiary is subsequently discharged to home on July 6. Plan "A" is responsible for all hospital and physician services through July 6, and plan "B" is responsible for all services needed after discharge.
Hospitalization for Medical Reasons During an Inpatient Psychiatric Stay	A health plan beneficiary is admitted for inpatient psychiatric care by a PIHP. During the admission, the beneficiary requires surgery for medical reasons at another facility. The beneficiary's health plan must authorize the surgery and is responsible for paying for transport between the facilities and for charges related to the surgery.

CSHCS Exception: Beneficiaries with CSHCS coverage are excluded from enrollment in a MHP when:

- A beneficiary becomes enrolled in CSHCS, he is disenrolled from the MHP.
- Upon review, MDCH may initiate a retroactive disenrollment from the MHP effective the first day of the month in which CSHCS medical eligibility was determined.
- Responsibility of payment transfers from the MHP to FFS on the effective date of the disenrollment.
- Providers are advised to check the Eligibility Verification System (EVS) for changes of enrollment status prior to billing. (Refer to Directory Appendix for contact information.)

MHP beneficiaries who gain CSHCS coverage are disenrolled from the MHP retroactively. Responsibility of payment for the inpatient care during the retroactive time period transfers from the MHP to FFS.

5.2 Ongoing Services and Extended Treatment Plans

Providers are responsible for verifying a beneficiary's eligibility/enrollment status before each service is rendered, particularly on the first day of a new month. Even though a beneficiary may be involved in an ongoing treatment or care plan, a change in enrollment status requires new authorization from the new responsible party. Enrollment in a health plan always triggers an authorization process through the new

or "current" health plan. There is no requirement for a new health plan to reimburse providers for services that were authorized under a previous health plan. The new health plan must assess the need for continuing services and authorize as appropriate. Health plans should facilitate the transition between providers to ensure continuity of care for the beneficiary.

The following are examples of situations that may occur while providing care to an eligible beneficiary.

FFS to Health Plan	A beneficiary is in FFS in June. On June 15, the MDCH authorizes a breast reconstruction after mastectomy for breast cancer. The surgery is scheduled for July 20. On July 1, the beneficiary is enrolled in a health plan with the same primary care provider and surgeon. The surgeon must follow the health plan process for authorization of the reconstructive surgery, as the plan is now the payer, not FFS. The MDCH authorization would be void.
Voluntary Health Plan Change During a Course of Treatment	A beneficiary is in health plan "A" in July and is involved in a course of physical therapy (PT). The therapy program was authorized for six weeks. On August 1, the beneficiary changes enrollment to health plan "B" and still has two more scheduled weeks of PT. Before PT can continue, the provider must obtain a new authorization from health plan "B." Ideally, as a plan-to-plan change occurs at the request of the beneficiary, the provider would coordinate the transition to the new plan, maintain continuity of care and have an authorization in place from plan "B" so the ongoing PT is not interrupted. However, if PT continues without new plan "B" authorization, plan "A" is not responsible and plan "B" may or may not honor the treatment. The provider cannot bill the beneficiary as the services are covered and it is the provider's responsibility to verify eligibility/enrollment changes and obtain any necessary authorization.

5.3 Durable Items or Equipment

MDCH policy directs providers to bill the date of delivery for durable items or equipment. However, when a beneficiary has a change in enrollment status and the responsible payer is different on the date of delivery than on the date of order, providers must bill the date of order and specify the date of delivery in the Comments/Remarks box on the claim. This is especially important when a beneficiary changes from FFS to a health plan.

In situations where a change in enrollment status occurs during a hospital admission, physician services provided during the admission are the responsibility of the payer for the admission.

SECTION 6 – SPECIAL BILLING

For professional claims, many of the coding conventions described in the CPT manual apply when submitting claims to MDCH. Additionally, CMS guidelines apply in many instances. Some services may require additional billing information in order to receive correct reimbursement from Medicaid, CSHCS, and ABW.

Do not send documentation with the claim unless it is a MDCH requirement for processing the claim. The use of modifiers replaces documentation requirements in many instances.

If you have unusual circumstances to report, contact Provider Inquiry for assistance. (Refer to the Directory Appendix for contact information.)

6.1 GENERAL INFORMATION

Coding	All unlisted or not otherwise classified (NOC) codes require documentation of the services provided for payment consideration. Do not recode procedure codes submitted to Medicare or other insurers to unlisted or NOC codes when billing Medicaid unless MDCH does not cover the procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement. **Claims will be rejected for inappropriate recoding even if PA was issued by MDCH.**
Diagnosis Coding	Use ICD-9-CM coding conventions to report the diagnosis code(s) at the highest level of specificity. E-codes cannot be reported as a primary diagnosis. If an E-code is reported as primary, or if a code requiring a fourth or fifth digit is reported with fewer digits (truncated), the claim is not paid.
Prior Authorization	For elective services requiring PA, authorization must be obtained before providing the service. If approved, a letter approving or denying the service will be sent to the requesting provider along with a nine-digit PA number. Do not submit the letter with the claim when billing. Report the PA number in item 23.

6.2 THIRD PARTY COVERAGE

Identification of Third Party Resources	Providers must always identify third party resources and report third party payments in the appropriate field(s) on the claim. Third party resources must be identified even when the payer does not cover the services.
Medicare Services	Medicare covered services must be submitted on one claim and any excluded services must be submitted on a separate claim. Do not mix covered and excluded services on the same claim. Providers must indicate Medicare's allowable amount as the charge (item 24F) and report the actual payment and/or deductible as instructed. If the beneficiary is in a Medicare risk HMO, the fixed co-pay must be entered in item 24F and enter COB code 6 in item 24J. Refer to the Coordination of Benefits Chapter for information regarding Medicare crossover claims.
Commercial Plan with Fixed Co-pay	If the beneficiary is in a commercial plan with fixed co-pays, the co-pay must be entered in item 24F and enter COB code 2 in item 24J.
Commercial Insurance Payments	If payments are made by a commercial insurance, the amount paid, whether it is paid to the provider or the policyholder of the insurance, must be entered in item 24K on each service line as appropriate.
Medicaid Deductible	If the beneficiary's Medicaid deductible amount is met in the middle of a service so that part of the charge is the beneficiary's responsibility and part is Medicaid's responsibility, enter the full charge for the service in item 24F of the service line. Enter COB code 9 in item 24J and enter the amount of the beneficiary's liability in item 24K.
Spend-down	See Medicaid Deductible.
Evidence of Other Insurance Response	When billing on the CMS 1500 paper claim form, providers must submit evidence of other insurance responses (EOBs, denials, etc.) when billing MDCH for covered services. If billing electronically, no EOB is necessary, as all required data are part of the electronic format. However, in all cases where a provider is billing on the CMS 1500 claim form, a copy of the Medicare EOB must be submitted with the claim.
Beneficiaries in a MHP or PIHP	MDCH cannot be billed for co-pays, deductibles, or any other fee for services provided to beneficiaries enrolled in a MHP, or who are receiving services under PIHP/CMHSP capitation. Payment for services must be obtained from the MHP/PIHP/CMHSP. For detailed information related to third party billing, including Medicare and commercial insurance, refer to the Coordination of Benefits Chapter of this manual.

6.3 AMBULANCE

Referring/ Ordering Physician	All nonemergency ambulance services billed must have the referring/ordering physician's name and Medicaid ID# in items 17 and 17a.
Wait Time	No additional payment is made for the first 30 minutes of waiting time. If more than 30 minutes of waiting time occurs, report the procedure code and enter the appropriate number of time units in item 24g. Bill one time unit for each 30 minutes of waiting time over and above the first 30 minutes. Documentation regarding the circumstances must be submitted with the claim.
Mileage	When billing a mileage code, enter the number of whole miles the beneficiary was transported in item 24g. Do not use decimals.

6.4 ANCILLARY MEDICAL SERVICES [CHANGES MADE 4/1/06]

Injectable Drugs	If an injectable drug, except a vaccine, is administered on the same day as another service, the administration of the drug is considered a part of the other service and cannot be billed separately. Only the procedure code for the cost of the drug is billed. The cost of the drug must be reflected in the charge submitted to Medicaid. For example, if the drug is obtained at a lower than normal cost through the 340B Program, that lower cost must be reflected in the charge. If a nonspecific or not otherwise classified (NOC) code is billed, the dose administered and the National Drug Code (NDC) must be reported in item 19 of the CMS 1500 or in the appropriate segments of the electronic format. **(redundant sentence deleted 4/1/06)** Do not recode injectable drugs from a national procedure code covered by Medicare or other payers to a NOC code when billing Medicaid unless MDCH does not cover that procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement.
Chemotherapy Drugs	Chemotherapy drugs and the administration of the chemotherapy drugs must be billed separately. Separate payment is also made for chemotherapy administration by push and by infusion techniques on the same day. The cost of the drug must be reflected in the charge submitted to Medicaid. For example, if the drug is obtained at a lower than normal cost through the 340B Program, that lower cost must be reflected in the charge. If a chemotherapy drug is billed under a nonspecific or not otherwise classified (NOC) code, the dose administered and the NDC must be reported in item 19 of the CMS 1500 claim form or in the appropriate segments of the electronic format. Do not recode chemotherapy drugs from a national procedure code covered by Medicare or other payers to a NOC code when billing unless Medicaid does not cover that procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement.

Immunizations	Immunizations must be reported using the administration fee code(s) and the code identifying the type of vaccine given. Each vaccine/toxoid given must be reported in addition to the appropriate CPT administration code(s). Immunization administration is covered in addition to the vaccine even if an Evaluation and Management (E/M) visit is reported on the same day. Immunizations included in the Vaccine For Children (VFC) Program are free to providers so the charge for these vaccines must be reported as 0.00 (zero dollars). The cost of the vaccine (including 340B price) must be reflected in the charge submitted to Medicaid. **(added 4/1/06)**
Allergy Immunotherapy Services	For allergy immunotherapy services, only component services may be billed. Bill the number of doses of allergy extract or stinging insect venom prepared for and administered to the beneficiary on that date.
Component Billing	For diagnostic tests with global, professional and technical components, practitioners can bill the global service only in the ambulatory setting. The professional component may be billed in any setting. Practitioners cannot bill the technical component.

6.5 Anesthesia Services

Coding	Report anesthesia services with the five-digit CPT anesthesia codes. Only one primary anesthesia service should be reported for a surgical session. Use the anesthesia code related to the major surgery.
Modifiers	Every anesthesia service must have an appropriate anesthesia modifier reported on the service line.
Anesthesia Add-on Codes	Anesthesia add-on codes may be billed in addition to the primary anesthesia code when appropriate. For all nonobstetrical anesthesia add-on codes, payment for the add-on code(s) is based on established anesthesia base unit values with all time units reported under the primary anesthesia code. For obstetrical anesthesia add-on codes, report the anesthesia time in minutes associated with the add-on code separately from the anesthesia time in minutes associated with the primary anesthesia code.
Time Reporting	Report the total anesthesia time in minutes in item 24G. Convert hours to minutes and enter the total anesthesia minutes provided for the procedure. Do not include base units.
Concurrent Surgical and Anesthesia Services	If allowable surgical services are reported in addition to the anesthesia procedure, do not report time units for surgical services.

6.6 CHILDREN'S WAIVER PROGRAM

Coding	Providers must refer to the current CPT and HCPCS code books for the full descriptions of the national procedure codes and for additional explanatory information that may affect billing.
Units of Service	In many cases, the units of service for the national procedure codes differ from the units of service for the old Medicaid local procedure codes. In order to correctly bill for services, the full descriptions of the procedure codes must be referred to in conjunction with the current version of Mental Health/Substance Abuse Chapter of this manual.
Respite Services to More Than One Beneficiary	If an RN or LPN is providing respite services to more than one beneficiary at the same time, the modifier for RN or LPN must only be reported for one of the beneficiaries for any one unit of service. During that same unit of service, other beneficiaries must be billed using the same procedure code with no modifier reported. If the same RN or LPN provides both private duty nursing services and respite services to the same beneficiary, the record must clearly identify the discreet time spent on each function.
Prior Authorization	Prior authorization is required from the Children's Waiver Program for each of the following services: ▪ Home Modifications; ▪ Repair and nonroutine service for medical equipment; and ▪ Van lifts and tie downs with a cost exceeding $5,500.00 or when replacement is needed before five years have elapsed. All other vehicle modifications require prior authorization. (Refer to the Mental Health/Substance Abuse Chapter of this manual for additional information.)
Fee Screens	Information regarding fee screens and coverage parameters (when appropriate) for covered procedure codes are posted on the MDCH website. (Refer to the Directory Appendix for contact information.)

6.7 Durable Medical Equipment, Prosthetics, Orthotics and Supplies

6.7.A. Date(s) of Service

Medical Supplies	For medical supplies, the date supplied must be reported as the date of service.
Diaper and Incontinent Supplier	For the Diaper and Incontinent Supplier Contract, the date the order is transmitted by the contractor to the fulfillment house is the date of service.
DME/Prosthetics/ Orthotics	For both custom and noncustom durable medical equipment (DME) and prosthetics and orthotics (P&O) the date of delivery must be reported as the date of service. For subsequent rental months if applicable, the DOS must be the first day of the service month based on the original date of delivery.
Custom-made DME or P&O Appliances	For custom-made DME or P&O appliances, when there is a loss of eligibility or a change in eligibility status (e.g., from FFS to health plan enrollment or vice versa) between the time the item is ordered and delivered, the order date rather than the delivery date must be reported as the date of service. For payment, the item must be delivered within 30 days after loss or change in eligibility
Rented DMEPOS	For all rented DMEPOS, if a beneficiary's death occurs during a specific month in which payment has already been made, the prorating of actual days the items were used is not required.

6.7.B. Days or Units

Enteral Formulae	For enteral formulae (administered orally or by tube), the appropriate formula HCPCS code should be billed on a monthly basis with total caloric units reported as the quantity. To determine the number of caloric units, divide the total number of calories of all cans to be used by 100.
Gradient Compression Stockings/Surgical Stockings	Gradient compression stockings are considered a "one item" service. The right (RT) and left (LT) modifiers must be used for these items when reporting HCPCS codes L8100-L8150. When a gradient compression stocking is provided bilaterally, the same code is reported for both garments on one service line using modifiers LTRT with a quantity of "2". Surgical stockings and most gradient compression stockings are packaged by a pair and are billed with a quantity of "1" for each stocking. No RT or LT modifier is required for billing purposes.

Home Intravenous Infusion Therapy	For home intravenous infusion therapy, HCPCS "S" codes must be reported as a daily rate by reporting the total number of days used as units unless otherwise noted in the code description. A home infusion therapy code may be billed with modifier "SH" or "SJ" if multiple drugs are being administered concurrently (e.g., SH – 2 drugs, SJ – 3 drugs). Routine catheter care is included with the daily rate for the active infusion. For chemotherapy and pain management, the specific HCPCS code will designate either continuous or intermittent administration. If the therapy is provided without interruption for 24 hours or more, report the continuous therapy code. For less than 24 hours of therapy, use the intermittent code. For antibiotic, antiviral or antifungal therapy, report the code that best describes the frequency of administration. Only one therapy code of this series may be reported on the same date of service.
Parenteral Intravenous Infusion Therapy	For parenteral intravenous infusion therapy, the appropriate HCPCS "B" codes must be billed as a daily rate by reporting total number of days used as units. The parenteral lipids, the parenteral pre-mix solution, the infusion pump, supply kit, and the administration kit may be billed in combination with each other.
Powered Flotation Bed/Air-fluidized Bed	For a powered flotation bed or air-fluidized bed, the rental must be billed as a daily rate by reporting total number of days used as units. (Up to 10 months of rental may be considered for payment.) For a powered flotation bed or air-fluidized bed, the "MS" modifier is reported only after 10 months of rental have occurred and an additional six months of continued maintenance and servicing of the item has been provided. A quantity of "1" must be reported for the entire six-month period of service.

6.7.C. Hospital Discharge Waiver Services

To bypass the PA requirement when billing for standard DME covered under the hospital discharge waiver service, report the discharge date in item 18. (The discharge date must be entered in the eight-digit MMDDCCYY format.)

6.7.D. Converting Rental to Purchase

If the purchase of an item is requested after a previous rental month(s) has been paid, the provider must subtract this amount from the total purchase price.

6.7.E. Place of Service Codes

DMEPOS	Place of service codes acceptable to report for DMEPOS claims submitted by medical suppliers are as follows: ▪ **01** – Pharmacy ▪ **12** – Home ▪ **13** – Assisted Living Facility ▪ **14** – Group Home ▪ **31** – Skilled Nursing Facility ▪ **32** – Nursing Facility ▪ **33** – Custodial Care Facility
Nursing Facility Residents	For residents in a skilled nursing facility or a nursing facility, many medical supplies and/or items or DME are considered as a part of the facility's per diem rate. For verification of specific procedure codes that may be billed by the medical supplier, refer to the Medical Supplier Database on the MDCH website. (Refer to the Directory Appendix for additional information.)

6.8 Evaluation and Management Services

Coding	CPT E/M service guidelines apply for determining what level of care is appropriate. Generally CPT descriptions for E/M services indicate "per day" and only one E/M service may be reported per date of service (DOS).
Preventive Medicine E/M Visit and Another E/M Visit on the Same Date	A preventive medicine E/M visit and another E/M visit on the same date are billed separately if during the preventive visit, a problem or abnormality is detected which requires additional work which meets the key component requirements of a problem-oriented E/M visit. When this occurs, bill the office/outpatient E/M procedure code using modifier 25 and bill the preventive E/M visit without using a modifier. Refer to CPT guidelines for additional information. If the same level of care E/M visit is provided twice on the same day, report on one service line and use modifier 22. Indicate the time of day for each visit in item 19.
Procedures and New E/M Service	A procedure and a new patient E/M service on the same date should be reported using modifier 25 on the E/M service line.
Consultations	Consultations require the referring/ordering provider's name and Medicaid ID in items 17 and 17a.
Office Emergency Services	To report emergency services in the office, report the applicable procedure (e.g., laceration repair) or the E/M office visit that represents the level of care provided.

Hospital ED Reimbursement	E/M services provided in the hospital emergency department (ED) by the attending physician (MD, DO) are reimbursed on a two-tiered case rate based on whether the beneficiary was released or admitted. If the beneficiary was released from the ED, a single rate is used as the fee screen. If the beneficiary was admitted to the hospital or transferred to another hospital from the ED, a higher single rate is used as the fee screen. Physicians must bill the level of service identified in the CPT coding descriptions to ensure proper reimbursement.
Miscellaneous	Services such as telephone calls, missed appointments, interpretations of lab results cannot be billed as separate services.

6.9 HEARING AIDS

Delivery Date	The date of delivery of the hearing aid must be reported as the date of service.
Change in Eligibility	When there is a loss of eligibility or a change in eligibility status (e.g., from FFS to health plan enrollment or vice versa) between the time a custom hearing aid is ordered and delivered, the date of service should be reported as the order date rather than the delivery date.

6.10 HYSTERECTOMY

To encourage electronic billing and reduce administrative burden, MDCH allows for submission of the Acknowledgement of Receipt of Hysterectomy Information forms (MSA-2218) via fax. This form must be submitted to Medicaid before reimbursement can be made for any hysterectomy procedure. (Refer to the Practitioner Chapter of this manual for additional information.)

6.11 LABORATORY SERVICES

Panels	CPT definitions for panels apply. All services in the panel must be provided and each test must be appropriate to the diagnosis or symptom for which the test was ordered.
Blood Handling	On the CMS 1500 claim form, Box 19, Reserved for Local Use, must indicate the reason the blood was obtained as a separate service and the reason the laboratory that performed the testing could not also perform the venipuncture. For electronic claims, ANSI X12 837, Professional, documentation should be entered in the 2300 Loop, segment NTE02.
Referring/Ordering Provider	All clinical lab services billed to Medicaid must have a referring/ordering Medicaid provider name and ID in items 17 and 17a.
CLIA Number	All clinical lab services billed to Medicaid must have a CLIA number in item 23.

Repeat Tests	If it is medically necessary to repeat the same clinical lab test on the same day for the same patient, report the first test on one line with no modifier and the second test on the next line with modifier 91.

6.12 Maternity Care Services

Coding	CPT guidelines for reporting prenatal care and delivery services apply. Bill the global service as appropriate if the same physician or a single group practice provides prenatal care, delivery and postpartum care.
Prenatal Care	The individual prenatal care or delivery codes must only be billed when different physicians (not in the same group) provide the services. The number of prenatal visits may vary depending on when the beneficiary first seeks care. Typically a beneficiary has about 13 visits. For a high-risk pregnancy, report the appropriate E/M service when additional visits (beyond 13) are required for the high-risk condition. The diagnosis must be for the high-risk condition.
Postpartum Care	Postpartum care is only billed as a separate service when provided by a physician or group practice that did not perform the delivery services.
Multiple Gestation	For twin gestation, report the service on two lines with no modifier on the first and modifier 51 on the second. If all maternity care was provided, report the global obstetric (OB) service for the first infant, and report the appropriate delivery-only code for the second infant using modifier 51. If multiple gestation for more than twins is encountered, report the first service on one line and combine all subsequent deliveries on the second line with modifiers 51 and 22. Provide information in item 19 or submit an attachment to the claim explaining the number of babies delivered.

6.13 Newborn Care

When billing for medical services provided to the newborn, providers must use the newborn's Medicaid ID number, **except** if the delivering physician performs the newborn care and circumcision during the mother's inpatient stay, the delivering physician may bill for the newborn care and circumcision on the same claim as the delivery under the mother's Medicaid ID number.

6.14 Private Duty Nursing (PDN)

6.14.A. MI AuthentiCare

MI AuthentiCare is an Interactive Voice Response (IVR) system that allows a PDN provider to check-in by calling a toll-free telephone number when arriving at a beneficiary's home and check-out when care is completed. Information captured through the IVR is validated against MDCH prior authorization (PA) files, provider files, beneficiary eligibility files, and other insurance files to verify that the service should be paid. Once validated, MI AuthentiCare automatically submits a HIPAA compliant 837 claim to Medicaid.

Except as detailed in the Direct Billing to MDCH subsection below, private duty nursing services are billed through the MI AuthentiCare system.

All workers (RN or LPN) providing PDN services must have a seven-digit worker ID number registered in MI AuthentiCare. For Medicaid-enrolled RNs and LPNs (Provider Type 10), this is their seven-digit Medicaid provider ID number. The MI AuthentiCare Manual, which contains information regarding the MI AuthentiCare system and detailed instructions for the use of the system, is available on the MDCH website. (Refer to the Directory Appendix for website information.) Newly enrolled PDN providers will receive instructions on how to obtain a Personal Identification Number (PIN) (necessary for accessing the MI AuthentiCare system via the web) as part of their enrollment package.

Failure to provide timely, accurate worker information can result in delayed or rejected claims.

6.14.B. DIRECT BILLING TO MDCH

Providers must bill MDCH directly (either paper or electronically) if the beneficiary has other insurance, the other insurance made a payment, and the provider is billing Medicaid for the balance due. If the provider is not billing for the balance due, no claim is to be submitted to Medicaid.

When direct billing to MDCH, note the following:

Place of Service	The Place of Service Code on the claim must indicate Home.
Service Dates	Each date of service must be reported on a separate service line.
Hours/Units	Each service line must contain the number of units of care in the Days or Units item for that date of service.
Prior Authorization	The PA number listed on the Medicaid authorization letter must be recorded on the claim.
Authorization Letter	The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter must not be mailed with the claim when billing.
Plan of Care	A plan of care is not to be attached to the CMS 1500 or otherwise submitted to Medicaid unless specifically requested to do so by MDCH.
Billable Units	The total number of units reported must not exceed the total units that were authorized for that month.

Adjustments	Adjustments to claims are made through a total claim replacement or void/cancel process.
Multiple Beneficiaries Seen At Same Location	The appropriate procedure codes must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. These procedure codes must be used for **each** beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, the multiple beneficiary code must be used for both children. Procedure codes to be used for billing private duty nursing are available on the MDCH website in the Private Duty Nursing Reimbursement Rates Database.
Holidays	Additional reimbursement for holidays on which private duty nursing services are provided is allowed. Current recognized holidays are: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving, and Christmas Day.

6.14.C. Payment in 15-Minute Increments

Private duty nursing is paid in 15-minute increments. In the event an increment of service is less than 15 minutes, the following rule applies.

Duration of Service	Units Billed
Less than 8 minutes	0
8 – 15 minutes	1

Example: 53 minutes of service = 4 units

42.5 minutes of service = 3 units

6.15 Radiology Services

Bilateral	If bilateral x-rays are performed on extremities, report on two service lines with modifier RT on one and modifier LT on the other.
Multiple X-Rays	If the same x-ray is performed multiple times on the same beneficiary on the same day, (e.g., before and after fracture care) report the appropriate quantity in item 24G.
Component Billing	For radiology services with global, professional and technical components, practitioners can bill the global service in the nonhospital setting or professional component service in any setting. Practitioners cannot bill the technical component only.

6.16 School Based Services

Units/Time	Procedure codes that specify time intervals cannot be billed until and unless the time unit specified is reached. Providers cannot bill less than a full unit or a partial unit and cannot round up to the next unit of service. For procedure codes billed by time units, such as per 15 minutes, the time specified in the procedure code description equals one unit of service. Procedure codes that are not billed by time units are billed per encounter.
Coding	Qualified staff may bill for assessments, tests and evaluations performed for the Individuals with Disabilities Education Act (IDEA) assessment using the appropriate procedure code with the HT modifier. The date of service is the date of the determination of eligibility for special education or early-on services. The determination date must be included in the assessment, test or evaluation.
IEP/IFSP	Qualified staff may bill for the multidisciplinary team assessment to develop, review and revise an IEP/IFSP treatment plan using the appropriate procedure code and the TM modifier. The date of service is the date of the multidisciplinary team assessment.
Evaluations/ Assessments	Evaluations/assessments may be provided that are not related to the IDEA assessment or IEP/IFSP development, review, and revision. When this occurs, bill the appropriate evaluation/assessment procedure code for that profession with no modifier. The date of service is the date the evaluation/assessment is completed.
Multiple Disciplines on Same DOS	The psychologist, counselor, and social worker can bill for their evaluations/assessments using the same procedure code for the same date of service. When this occurs, bill on one service line and indicate the total number of units provided for that date of service. The evaluations/assessments that are performed on the same day for the same student must be for different purposes and not duplicative. The date of service is the date the evaluations/assessments are completed.

6.17 Surgery

Coding	CPT surgery guidelines for add-on codes, separate procedures, and bilateral services generally apply.
Global Surgery	CMS's global surgery guidelines apply. Use the appropriate modifiers to identify the service provided.
Post-0perative Care	When reporting post-operative care only for surgical procedures with 10-day or 90-day global periods, the provider assuming the post-operative care must bill the date of the surgery and the appropriate surgical code with modifier 55. The claim cannot be submitted until after the patient is seen. Report the date care was assumed/relinquished in item 19.

Multiple Surgery	For multiple surgical procedures performed during the same surgical session, report the primary surgery on the first service line with no modifier. Report the subsequent procedures performed during the same surgical session with modifier 51.
Identical Surgery/ Procedures on Same DOS	If two identical surgical or procedural services are provided on the same day to the same beneficiary, and cannot be reported as a bilateral procedure, bill on two service lines with no modifier on the first line and modifier 51 on the second line. Multiple surgery rules apply. If more than two identical services are provided on the same day, the second and subsequent identical services must be combined on the second line. Report modifiers 51 and 22 and provide an explanation of the circumstances.
Bilateral Procedures	If a bilateral procedure is performed, report the bilateral code if available. When there is no code describing bilateral services, report the service on one line and use modifier 50.
Sterilization and Hysterectomy Consent Forms	Sterilization and hysterectomy consent forms may be faxed to MDCH for acknowledgement of proper completion and signatures before the service is billed. (Refer to the Directory Appendix for contact information.) If completed properly, there is no need to submit a copy of the form with the claim. Indicate "consent on file" in item 19. For MHP enrollees, providers must contact that health plan for specific requirements related to these consent forms.

6.18 VISION

Routine Eye Examination	A routine eye examination includes, but is not limited to: ▪ Case history ▪ Determination of visual acuity (each eye) ▪ Ophthalmoscopy ▪ Biomicroscopy ▪ Ocular motility ▪ Tonometry ▪ Refraction ▪ Diagnosis ▪ Treatment program ▪ Disposition Ophthalmologists and optometrists must use appropriate CPT/HCPCS code(s) for the service
Nonroutine Eye Examination	Nonroutine eye examinations for the purpose of evaluation and treatment of chronic, acute, and/or sudden onset of abnormal ocular symptoms must be billed using the appropriate CPT/HCPCS codes.

Glaucoma Screening	Glaucoma screening must be billed with the appropriate CPT/HCPCS procedure codes. This screening entails a dilated eye examination, tonometry, and direct ophthalmoscopy or slit lamp examination. If this screening is provided as part of another billable service, separate reimbursement for this screening is not allowed. If the beneficiary presents with a visual or ocular complaint, the glaucoma screening procedure code should not be used. A procedure code that best describes the encounter should be selected from the E/M or General Ophthalmological codes.
CPT/HCPCS Codes/Modifiers	Covered CPT/HCPCS codes are listed in the Vision Services Database on the MDCH website and, where noted by status code "P", prior authorization is required. (Refer to the Directory Appendix for information.)
Eyeglass Dispense Date	Report the date eyeglasses are dispensed as the date of service in item 24A. If eligibility or enrollment status changes after eyeglasses are ordered but before they are delivered, the order date of the eyeglasses must be reported as the date of service in item 24A.

SECTION 7 - MODIFIERS

Procedure codes may be modified under certain circumstances to more accurately represent the service or item rendered. MDCH recognizes two levels of modifiers:

- Level I modifiers are those included in CPT and updated annually by the American Medical Association (AMA).
- Level II modifiers are recognized nationally and updated annually by CMS.

Definitions and use of Level I modifiers can be found in the annual edition of the CPT manual. Definitions of Level II modifiers are found in the annual edition of the HCPCS procedure coding manual. Providers should refer to these manuals and MDCH provider manuals for specific information on the use of these modifiers.

The modifiers listed below must be reported when applicable. Modifiers affect the processing and/or reimbursement of claims billed to MDCH for Medicaid, CSHCS, and ABW beneficiaries. Other Level I and Level II modifiers may be used to provide additional information about the service or may be required by other payers but do not affect the processing of the Medicaid claim.

7.1 GENERAL BILLING

Modifier	Description	Special Instructions
22	Unusual Procedural Services	Report/remarks required.
99	Multiple Modifiers	Identifies that more modifiers are necessary than allowed by the format (2 on paper claims or 4 in the electronic format). The second or fourth modifier must be "99" and the additional modifiers must be indicated in item 19 or the appropriate electronic remark area.
EP	Service provided as part of Medicaid EPSDT program	Used with procedure code T1028 to determine reimbursement.
GC	Service performed by resident under direction of teaching physician	Report to identify services provided by resident in presence of teaching physician.
GE	Service performed by resident under primary care exception	Report to identify primary care services provided by a resident without the presence of the teaching physician under the primary care exception.
LT	Left side (used to identify procedures performed on the left side of the body)	Allows appropriate multiple line reporting of select procedures performed on the right and left side of the body on the same day.

Modifier	Description	Special Instructions
Q5	Service furnished by substitute physician under a reciprocal billing arrangement	The name of the physician providing the service must be reported in item 19.
Q6	Service furnished by a locum tenens physician	The name of the physician providing the service must be reported in item 19.
RT	Right side (used to identify procedures performed on the right side of the body)	Allows appropriate multiple line reporting of select procedures performed on the right and left side of the body on the same day.
TS	Follow-up service	Used with procedure code T1029 to determine reimbursement.

7.2 AMBULANCE

7.2.A. ORIGIN AND DESTINATION MODIFIERS

When billing for ambulance services, appropriate origin and destination modifies must be included on any service line when billing for mileage. The first character of the modifier is the origin code and the second character of the modifier is the destination code (e.g., use modifier RH for a transport from the residence to the hospital).

Modifier	Description
D	Diagnosis or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential domiciliary custodial facility (other than a Medicare/Medicaid facility)
G	Hospital based dialysis facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of transportation
J	Nonhospital-based dialysis facility
N	Skilled Nursing Facility (SNF) (Medicare/Medicaid facility)

Modifier	Description
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at a physician's office on the way to the hospital

7.2.B. Multiple Patients Transport

When billing for a transport when more than one patient is transported at one time, the appropriate modifier must be reported on the service line for the transport for the second or subsequent patient being transported.

Modifier	Description	Special Instructions
GM	Multiple patients on one ambulance trip	Enter on the transport service line for second or subsequent patient when more than one patient is transported. Reduces reimbursement for the second or subsequent patient transported. Do not report for the first patient.

7.3 Anesthesia

Anesthesia services billed without an appropriate modifier are rejected.

Modifier	Description	Special Instructions
47	Anesthesia by Surgeon	Anesthesia procedure codes billed with this modifier are not paid. General anesthesia provided by the surgeon is not covered.
AA	Anesthesia Services Performed Personally By Anesthesiologist	Determines reimbursement for anesthesia services reported with codes 00100-01999.
AD	Medical Supervision By A Physician: More Than Four Concurrent Anesthesia Procedures	Determines reimbursement for anesthesia services reported with codes 00100-01999.

Modifier	Description	Special Instructions
QK	Medical Direction Of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QX	Certified registered nurse anesthetist (CRNA) service with medical direction by a physician	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QY	Medical direction of one CRNA by an anesthesiologist	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QS	Monitored anesthesia care service	Report in addition to the appropriate anesthesia modifier to identify monitored anesthesia care (MAC) services reported with codes 00100-01999.
QZ	CRNA service: without medical direction by a physician	Determines reimbursement for anesthesia services reported with codes 00100-01999.

7.4 CHILDREN'S WAIVER PROGRAM

Modifier	Description	Special Instructions
TD	RN	Report in addition to the appropriate procedure code for respite when a registered nurse provides the service.
TE	LPN/LVN	Report in addition to the appropriate procedure code for respite when the service is provided by a licensed practical nurse.
TT	Individualized service provided to more than one patient in the same setting	Report in addition to the appropriate procedure code for respite when more than one beneficiary is receiving the service at the same time from the same provider.

7.5 Component Billing

Certain procedures are a combination of a professional component and a technical component and must be reported to receive reimbursement.

Modifier	Description	Special Instructions
26	Professional Component	Must be reported when billing only the professional component of a procedure. Providers are limited to billing the professional component for certain services in a facility setting.
TC	Technical Component	Reserved for facility billing. Practitioners should not report.

7.6 DMEPOS

7.6.A. Surgical Dressings

For surgical dressings, report modifiers A1 through A9 depending on number of wounds being treated.

Modifier	Description	Special Instructions
A1	Dressing for one wound	Use to report surgical dressings
A2	Dressing for two wounds	Use to report surgical dressings
A3	Dressing for three wounds	Use to report surgical dressings
A4	Dressing for four wounds	Use to report surgical dressings
A5	Dressing for five wounds	Use to report surgical dressings
A6	Dressing for six wounds	Use to report surgical dressings
A7	Dressing for seven wounds	Use to report surgical dressings
A8	Dressing for eight wounds	Use to report surgical dressings

Modifier	Description	Special Instructions
A9	Dressing for nine or more wounds	Use to report surgical dressings

7.6.B. NEW / USED DME

For DME items, the new equipment modifier NU or the used equipment modifier UE must be reported for all applicable procedure codes. For rented equipment, use the equipment modifier RR.

Modifier	Description	Special Instructions
KH	DMEPOS item, initial claim, purchase or first month rental	Use with HCPCS code E0604 for first month of rental only.
NU	New DME equipment	Use for the purchase of a new DME item.
UE	Used durable medical equipment	Use for the purchase of used DME equipment that is not over 3 years old and meets the Medicaid requirements for equipment.
RR	Rental (use the "RR" modifier when DME is to be rented)	For monthly rental rate of DME items.

7.6.C. Lower Extremity Prostheses

For all lower extremity prostheses, modifiers "K0" through "K4" must be reported to designate the potential functional ability of a beneficiary (before a prosthesis is furnished) based on the reasonable expectations of the prosthetist and treating physician.

Modifier	Description	Special Instructions
K0	Lower extremity prosthesis functional level 0 – does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility	Use to report functional level capability of beneficiary
K1	Lower extremity prosthesis functional level 1 – has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.	Use to report functional level capability of beneficiary
K2	Lower extremity prosthesis functional level 2 – has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator	Use to report functional level capability of beneficiary

Modifier	Description	Special Instructions
K3	Lower extremity prosthesis functional level 3 – has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to transverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion	Use to report functional level capability of beneficiary
K4	Lower extremity prosthesis functional level 4 – has the ability or potential for prosthetic ambulation that exceeds the basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete	Use to report functional level capability of beneficiary

7.6.D. ORTHOTIC AND PROSTHETIC

For orthotic and prosthetic items, the "LT" or "RT" modifier is required to designate either the left or right side of the body if applicable. Refer to the Medical Supplier Database for additional information. When reporting bilateral orthotic or prosthetic items on the same DOS, the "LT" and "RT" modifiers must be listed on the same service line with the combined quantities of both items. To verify the specific HCPCS codes that require these modifiers, refer to the Medical Supplier Database on the MDCH website.

Modifier	Description	Special Instructions
LT	Left Side of the Body (used to identify procedures performed on the left side of the body)	Must be reported with select prosthetic and orthotic items to identify the left side of the body for use. Also allows payment of bilateral RT and LT devices placed on the same date of service.

Modifier	Description	Special Instructions
RT	Right Side of the Body (used to Identify Procedures performed on the right side of the body)	Must be reported with select prosthetic and orthotic items to identify the right side of the body for use. Also allows payment of bilateral RT and LT devices placed on the same date of service.

7.6.E. DME AND PROSTHETIC/ORTHOTIC ITEMS

For DME and prosthetic/orthotic items, the "RP" modifier is required when billing the repair of an item involving the replacement of a component part. The reimbursement includes the cost of the part and the labor associated with its removal, replacement and finishing.

Modifier	Description	Special Instructions
RP	Replacement and repair, "RP" may be used to indicate replacement of DME, orthotic and prosthetic devices which have been in use for some time. The claim shows the code for the part, followed by the "RP" modifier and the charge for the part	Replacement of a component part of a DME, orthotic or prosthetic item includes the cost of the part and the labor associated with its removal, replacement and finishing. When billing this service, report the "RP" modifier with the specific HCPCS code.

7.6.F. POWERED FLOTATION/AIR-FLUIDIZED BED

For a powered flotation bed or air-fluidized bed, the "MS" modifier is reported only after 10 months of rental have occurred and an additional six months of continued maintenance and servicing of the item has been provided. A quantity of 1 must be reported for the entire six-month period of service.

Modifier	Description	Special Instructions
MS	Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty	Use with HCPCS codes E0193 or E0194 after six months of continued maintenance and servicing following the initial 10 months of rental.

7.6.G. Enteral Nutrition

Modifier	Description	Special Instructions
BO	Orally administered nutrition, not by feeding tube	Use to report oral administration of enteral nutrition
U3	Low Profile	Use with HCPCS code B4086 for low profile gastrostomy tube only.

7.6.H. Infusion Therapy

Modifier	Description	Special Instructions
SH	Second concurrently administered insulin therapy	Must be reported with HCPCS "S" home infusion codes to specify two concurrently administered drugs.
SJ	Third or more concurrently administered insulin therapy	Must be reported with HCPCS "S" home infusion codes to specify three or more concurrently administered drugs.

7.6.I. Miscellaneous Supplies

Modifier	Description	Special Instructions
U4	Pediatric supply item	Use with HCPCS code A7520 for pediatric neonatal tracheostomy tubes. Use with HCPCS codes A4351 or A4352 for hydrophilic coated intermittent urinary catheters.

7.7 Evaluation and Management (E/M) Services

Modifier	Description	Special Instructions
21	Prolonged Evaluation and Management Services	Use to report a service that is greater than that usually required for the highest level of an evaluation and management service. A report or remarks explaining the service is required.

Modifier	Description	Special Instructions
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	E/M services unrelated to the surgery and billed by the surgeon during the postoperative period of a global surgery are not payable without this modifier.
25	Significant, Separately Identifiable Evaluation and Management Services by Same Physician on Same Day of the Procedure	E/M services reported without modifier 25 and billed in addition to other procedures/services on the same day are not payable. Allows significant separately identifiable E/M services to be paid without review. Subject to post payment audit.
57	Decision for Surgery	Required for an E/M service provided the day of or the day before a procedure with a 90-day global period to indicate that the service was for the decision to perform the procedure.
UA	Admitted or transferred to inpatient hospital	Required for ED case rate paid to attending ED physician when beneficiary is admitted or transferred from the ED to the inpatient hospital.
UD	Released/Discharged from Emergency Department	Required for ED case rate paid to attending ED physician when beneficiary is treated and released/discharged from the ED.

7.8 LABORATORY

Modifier	Description	Special Instructions
90	Reference Lab	Identifies that services were referred to specialty lab.
91	Repeat Clinical Diagnostic Laboratory Test	Use to identify a medically necessary repeat test done on same date.
QW	CLIA waived test	Identifies CLIA waived tests as required.

7.9 MEDICARE

Any service reported to Medicaid for a Medicare/Medicaid eligible beneficiary that is an excluded or noncovered Medicare benefit, must be identified with modifier GY or GZ on the service line.

Modifier	Description	Special Instructions
GY	Excluded Medicare Benefit	Report this modifier to identify services that are excluded from Medicare coverage. Also report to identify services for aliens 65 years old and older.
GZ	Medicare denied as not reasonable or necessary	Report this modifier to identify services determined not reasonable or necessary by Medicare.

7.10 PRIVATE DUTY NURSING

Modifier	Description	Special Instructions
TT	Individualized service provided to more than one patient in same setting	Use this modifier with procedure codes S9123 and S9124 when private duty nursing services are being provided to more than one beneficiary at one time.

7.11 SCHOOL BASED SERVICES

Modifier	Description	Special Instructions
HT	Multi-disciplinary team	Use this modifier with the appropriate evaluation procedure codes to identify participation by each qualified profession in the Individuals with Disabilities Education Act (IDEA) assessment.
TM	Individualized Educational Program (IEP)	Use this modifier with the appropriate procedure codes to identify participation by each qualified staff in the development, review and revision of the IEP.

7.12 SURGICAL ASSISTANCE

Modifier	Description	Special Instructions
80	Assistant Surgeon	Reimbursement for services at the assistant surgeon rate. If reported with modifiers 54, 55, 58, 59, 78, 79 the claim is not paid.

Modifier	Description	Special Instructions
81	Minimum Assistant Surgeon	Use modifier 80 or 82 to bill surgical assistance. Claims billed with modifier 81 are rejected.
82	Assistant Surgeon (when qualified resident surgeon not available)	Reimbursement for services at the assistant surgeon rate. If reported with modifiers 54, 55, 58, 59, 78, 79 the claim is not paid.
AS	PA, NP, or CNS services for assistant at surgery	Reimbursement for services adjusted to CMS limits for reimbursement for these practitioners.

7.13 Surgical Services

Modifier	Description	Special Instructions
50	Bilateral Procedure	Report to identify that bilateral procedures were performed during the same operative session. Reimbursement is 150% of the fee for the procedure or the provider's charge if bilateral reporting is appropriate.
51	Multiple Procedure	Use to report multiple procedures during the same operative session. Report on each additional procedure, not on the primary procedure. Determines payment at 100%, 50%, 50%, etc. when appropriate.
52	Reduced Services	Report if a service or procedure is partially reduced or eliminated at the physician's discretion. A report or remarks are required to determine reimbursement.
53	Discontinued Procedure	Report if a surgical or diagnostic procedure is terminated after it was started. A report or remarks are required to determine reimbursement.
54	Surgical Care Only	Reported by the surgeon for surgical procedures with 10 or 90 day global periods when all or part of the post op care is relinquished to a physician who is not a member of the same group. Reimbursement is reduced to the surgical care rate only.
55	Postoperative Management Only	Reported by the physician furnishing post-op management only. Report the surgical procedure with the date of surgery and the date care was relinquished/assumed in Box 19.
56	Preoperative Management Only	Do not report. Preoperative management is part of the surgical care and is not covered separately. Claims billed with modifier 56 are rejected.

Modifier	Description	Special Instructions
58	Staged or Related Procedure Or Service By The Same Physician During The Postoperative Period	Allows payment for subsequent surgical procedures performed during the global surgery period that meet certain requirements. Do not use in place of modifier 78.
59	Distinct Procedural Service	Report/remarks required. Do not report if another modifier is more appropriate.
62	Two Surgeons	Determines reimbursement when two surgeons were involved in the same surgery.
66	Surgical Team	Determines reimbursement for complex surgery requiring a surgical team. A report or remarks are required.
76	Repeat Procedure by Same Physician	Report when a procedure or service is repeated by the same physician subsequent to the original service.
78	Return to the Operating Room for a Related Procedure During the Postoperative Period	When appropriate, allows payment for related services (complications) requiring a return to OR during the postoperative period. Payment is reduced to operative care only.
79	Unrelated Procedure or Service by Same Physician During Postoperative Period	When appropriate allows payment for services during the postoperative period unrelated to the original surgery.

7.14 VISION

Modifier	Description	Special Instructions
U1	Polycarbonate lenses	Determines payment rate to contractor.
U2	High index lenses	Determines payment rate to contractor.
VP	Aphakic patient	Report to identify that service is for aphakic patient.

55	Postoperative management only	Reported by an optometrist (with Therapeutic Pharmaceutical Agent (TPA) certification) for select services when a physician performs the surgical procedure and relinquishes the follow-up care to the optometrist.

SECTION 8 - REMITTANCE ADVICE

A Remittance Advice (RA) is produced to inform providers about the status of their claims. RAs are available in paper and electronic formats, and utilize the HIPAA-compliant national standard claim adjustment group codes, claim adjustment reason codes, and remarks codes, as well as adjustment reason codes, to report claim status. Code definitions are available from the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

8.1 PAYMENTS / CLAIM STATUS

MDCH processes claims and issues payments (by check or EFT) every week unless special provisions for payments are included in the provider's enrollment agreement. A Remittance Advice (RA) is issued with each payment to explain the payment made for each claim. If no payment is due, but claims have pended or rejected, an RA is also issued. If claims are not submitted for the current pay cycle, no action is taken on previously pended claims, or no payment gross adjustments are processed in the pay cycle, an RA is not generated.

If the total amount approved for claims on any one RA is less than $5.00, a payment is not issued for that pay cycle. Instead, a balance is held until approved claims accumulate to an amount equal to or more than $5.00. Twice a year (usually June and December) all amounts of less than $5.00 are paid.

If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider ID number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment.

Payments to providers are issued by Tax Identification Number (TIN). All payments due to all providers enrolled with MDCH under a specific TIN are consolidated and issued as one check or EFT.

Providers who would like to receive payments from MDCH through EFT must register through the Department of Management and Budget's (DMB) website. (Refer to the Directory Appendix for contact information.)

8.2 ELECTRONIC REMITTANCE ADVICE

The electronic RA is produced in the HIPAA-compliant ANSI X12N 835 version 4010A1 format. Providers opting to receive an electronic RA receive all information regarding adjudicated (paid or rejected) claims in this format. Information regarding pended claims is reported electronically in the 277 Unsolicited Claim Status format.

The electronic RA has many advantages:

- It can serve to input provider claim information into the provider's billing and accounting systems;
- It includes a MDCH trace number to identify the associated warrant or electronic transfer (EFT) payment;

- It returns the provider's internal medical record number, line item control number, and patient control number when submitted on the original claim; and
- It contains additional informational fields not available on the paper RA.

The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835 and/or 277U, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835/277U transaction must identify a primary service bureau to receive the 835/277U. All providers under the same corporate TIN must utilize the same primary service bureau. An addition of and/or change in the identification of the primary service bureau must be submitted to Provider Enrollment. The primary service bureau is the only one to receive the 835/277U remittance information for all claims regardless of submission source. No other service bureau submitting claims for that provider/group TIN receives information regarding claims submitted.

For more information regarding the 835 and 277U transactions issued by the MDCH, refer to the MDCH Companion Guides on the MDCH website. For general information about the 835 and 277U, refer to the Implementation Guides for these transactions. The guides are available through the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

8.3 Paper Remittance Advice

All providers with approved or pended claims receive a paper RA, even if they opt to receive the 835/277U transactions.

The following information is supplied on the paper RA Header:

Provider ID# and Provider Type	This is the Medicaid Provider ID from the provider's claim. The first two digits of the Provider ID appear in the Provider Type box and the last seven digits appear in the Provider number box.
Provider Name	This is from the MDCH provider enrollment record for the Provider ID# submitted on the claim.
Pay Cycle	This is the pay cycle number for this RA.
Pay Date	This is the date the RA is issued.
Page No.	Pages of the RA are numbered consecutively.
Federal Employer ID# (EIN) or Social Security Number (SSN)	This is in small print in the upper right corner and is unlabeled. The number on the provider's claim must match the billing provider ID# on file with the MDCH and it must be a valid number with the Michigan Department of Treasury. MDCH cannot issue a check if there is a discrepancy between the number on file with the MDCH and the Michigan Department of Treasury. (Incorrect information should be reported to the Provider Enrollment Unit. Refer to the Directory Appendix for contact information.)

Claims appear on the RA in alphabetical order by the beneficiary's last name. If there is more than one claim for a beneficiary, they appear in Claim Reference Number (CRN) order under the beneficiary's name. The table below explains the fields of the RA:

Field Name	Explanation
Claim Header	Patient ID Number: Prints the beneficiary's Medicaid ID number that the provider entered on the claim. Claim Reference Number (CRN): A 10-digit CRN is assigned to each claim. If the claim has more than one service line, the same CRN is assigned to each line. The first four digits are the Julian Date the claim was received by MDCH. The fifth through tenth digits are the sequential claim number assigned by MDCH. Example: In CRN 3223112345, 3 is the year 2003, 223 is the Julian day of the year (August 11), and 112345 is the sequence number. The combination of Julian day and sequence makes a unique number that is assigned to each claim. When asking about a particular claim, the provider must refer to the CRN and Pay Date. The 10-digit CRN is following by a two-character input IN (3223223445-XX). If a service bureau submitted the claim, this is the service bureau ID. If the provider submitted a paper claim, this is a scanner identifier.
Line No.	This identifies the line number where the information was entered on the claim.
Invoice Date	This identifies the date the provider entered on the claim or, if left blank, the date the claim was processed by the system.
Service Date	This identifies the service date entered on the claim line (admit date for inpatient service).
Procedure Code	This identifies the procedure code or revenue code entered on the service line.
Qty	This identifies the quantity entered on the service line. If MDCH changed your quantity, an informational edit appears in the Explanation Code column.
Amount Billed	This identifies the charge for the entire claim.
Amount Approved	This identifies the amount MDCH approved for the service line (amount approved for DRG represents the entire claim and it is not approved by claim line). Pended and rejected service lines show the amount approved as zero (.00). Zero also prints when no payment is due from MDCH. For example, when other resources made a payment greater than MDCH's usual payment.
Claim Adjustment Reason Code	Claim adjustment reason codes communicate why a claim or service line was paid differently than was billed. If there is no adjustment to a claim line, then there is no adjustment reason code.

Field Name	Explanation
Claim Remark Code	Claim remark codes relay service line specific information that cannot be communicated with a reason code.
Invoice Total	Totals for the Amount Billed and the Amount Approved print here.
Insurance Information	If Medicaid beneficiary files show other insurance coverage, the carrier name, policy number, effective dates and type of policy (e.g., vision, medical) print below the last service line information.
History Editing	Certain edits compare the information on the claim to previously paid claims. In some cases, information about the previous claim prints on the RA. This information prints directly under the service line to which it relates.
Page Total	This is the total Amount Approved for all service lines on the page. If a claim has service lines appearing on two RA pages, the page total includes only the paid lines printed on each RA page. Amounts for pended service lines and rejected service lines are not included on the page total. All hospitals on the Medicaid Interim Payment (MIP) program have "MIP" PROGRAM printed on the bottom of each page.

8.4 Gross Adjustments

Gross adjustments are initiated by MDCH. A gross adjustment may pertain to one or more claims. Providers are notified in writing when adjustments are made to claims. Notification should be received before the gross adjustment appears on your RA.

The paper RA indicates gross adjustments have been made by:

- **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes are used and defined in the 835 Implementation Guide.
- **Gross Adjustment Code:** This is the MDCH gross adjustment code that corresponds to the gross adjustment description.

Code	Name	Explanation
GACR	Gross Adjustment Credit	This appears when the provider owes MDCH money. MDCH subtracts the gross adjustment amount from approved claims.
GADB	Gross Adjustment Debit	This appears when MDCH owes the provider money. MDCH adds the gross adjustment amount to approved claims on the current payroll.

Code	Name	Explanation
GAIR	Gross Adjustment Internal Revenue	MDCH prints this code when the provider has returned money to MDCH by check instead of submitting a replacement claim. The amount is subtracted from the provider's YTD (Year To Date) Payment Total shown on the summary page of the RA.

8.5 Remittance Advice Summary Page

The Summary Page is the last page of the RA and gives totals on all claims for the current payroll and year-to-date totals from previous payrolls. The table below explains the fields of the Summary Page:

Field Name	Explanation
This Payroll Status	The total number of claims and the dollar amount for the current payroll. This includes new claims plus pended claims from previous payrolls that were paid, rejected, or pended on the current payroll.
Approved	Number of claims from this payroll with a payment approved for every service line. The dollar amount is the total approved for payment.
Pends	Number of claims from this payroll that are pending. The dollar amount is the total charges billed.
Rejected	Number of claims from this payroll with a rejection for every service line. The dollar amount is the total charges billed.
App'd/Rejected	Number of claims from this payroll with a combination of paid and rejected service lines. The amount next to App'd Claim Lines is the total approved. The amount next to Rejected Claim Lines is the total charge billed.
Total Pends in System	Number of new and unresolved pended claims in the system and related total charges.
Previous YTD (Year to Date) Payment Total	The total amount paid for the calendar year before any additions or subtractions for this payroll.
Payment Amount Due This Payroll to Provider	This amount is the Payment Amount Approved plus any balance due to the provider minus any balance owed by the provider to MDCH.

Field Name	Explanation
Payment Made This Payroll	The amount of the provider's check or EFT issued for this payroll.
New YTD Payment Total This Payroll	Total payment for the calendar year including payments made on this payroll.
Balance Owed or Balance Due	One or more of the following messages prints if there is a balance owed or a balance due: ▪ **Balance Due to Provider by MDCH -** This appears if the payment amount approved is less than $5.00 or a State account is exhausted. ▪ **Balance Owed by provider to MDCH -** This appears when money is owed to MDCH, but the provider does not have sufficient approved claims from a particular State account (e.g., CC or ABW) to deduct what is owed. ▪ **Previous Payment Approved, Not Paid -** This appears if a balance is due from MDCH on the previous payroll. ▪ **Previous Payment owed by Provider to MDCH -** This appears when a balance is due from the provider on a previous payroll.
Pay Source Summary	Identifies the dollar amounts paid from the designated State accounts.

8.6 Pended and Rejected Claims

When a claim is initially processed the Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid, rejected or pended and lists edits which apply.

- **Rejections**: If a service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. The provider should review the definition of the codes to determine the reason for the rejection.
- **Pends**: If any service line pends for manual review, PEND prints in the Claim Adjustment Reason/Remark column of the RA. An explanation code(s) followed by a P (e.g., 936P) prints in the explanation code column of the RA. These pended claims do not print again on the provider's RA until the claim:
  - Is paid or rejected;
  - Is pended again for another reason; or
  - Has pended for 60 days or longer.

When a claim is pended, wait until it is paid or rejected before another claim is submitted for the same service(s).

After a claim initially pends it may pend again for a different reason. In that case, a # symbol prints in front of the CRN on the RA to show that it is pending again for further review. CRNs may also appear with a # symbol if they have pended 60 days or longer.

SECTION 9 - JULIAN CALENDAR

Day Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	- -	88	119	149	180	210	241	272	302	333	363
30	30	- -	89	120	150	181	211	242	273	303	334	364
31	31	- -	90	- - -	151	- - -	212	243	- - -	304	- - -	365

For leap year, one day must be added to number of days after February 28. The next three leap years are 2008, 2012, and 2016.

Example: claim reference # 3351203770-59
3 = year of 2003
351 = Julian date for December 17
203770 = consecutive # of invoice
59 = internal processing

ADULT BENEFITS WAIVER

Until further notice, an enrollment freeze is in effect for this program.

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers.

The Adult Benefits Waiver(ABW), formerly known as the State Medical Program (SMP), provides health care benefits for Michigan's childless adult residents (age 18 through 64) with an annual income at or below 35 percent of the Federal Poverty Level (FPL). Covered services and maximum co-payments for beneficiaries in this eligibility category are detailed in the following sections. Unless noted in Medicaid provider-specific chapters, service coverage and authorization requirements for the fee-for-service (FFS) beneficiaries enrolled in the ABW program mirror those required for Medicaid. Only those providers enrolled to provide services through the Michigan Medicaid Program may provide services for FFS ABW beneficiaries.

The Department of Human Services (DHS) may also refer to the ABW as the Adult Medical Program.

1.1 COUNTY-ADMINISTERED HEALTH PLANS

ABW beneficiaries enrolled in County-Administered Health Plans (CHPs) are subject to the requirements of the respective CHP. In those counties operating nonprofit CHPs, all covered services for ABW beneficiaries must be provided through the health plan. CHPs administering the ABW program are required to provide the services noted in the Coverage and Limitations Section of this chapter to ensure that benefits are consistent for all ABW beneficiaries across the FFS and CHP programs.

An up-to-date list of CHPs is maintained on the Michigan Department of Community Health (MDCH) website. (Refer to the Directory Appendix for website information.) CHPs may:

- Require that services be provided through their contracted provider network and may institute prior authorization (PA) requirements beyond those required for the FFS ABW program.
- Require beneficiaries to obtain certain services from the Local Health Departments (LHDs) or other community resources. When such referrals are made, the CHP is responsible for the beneficiary's share of the fee minus any applicable co-payments.

CHP providers rendering services to ABW beneficiaries enrolled in a CHP are not required to enroll as providers in the Medicaid program, but they must comply with all Medicaid provider requirements as detailed in this manual. This includes the prohibition on balance billing beneficiaries for the difference between the provider's charge and the CHP reimbursement.

1.2 ABW ELIGIBILITY DETERMINATION AND VERIFICATION

The local office of the DHS determines eligibility for the ABW beneficiaries who are identified with a scope/coverage code 3G or 3M. Level of Care (LOC) code 11 identifies ABW beneficiaries enrolled in a CHP. No LOC code is used to identify the FFS ABW beneficiary. Once eligibility is determined, the beneficiary is issued a **mihealth** card. CHPs may also issue membership cards to their enrollees.

Before providing service, providers must verify eligibility using the Eligibility Verification System (EVS). (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.) Individuals with scope/coverage code 3E are eligible only for emergency services and are not enrolled in a CHP.

Medical authorization from the local DHS office for individual services is not required for ABW beneficiaries.

Questions regarding ABW coverage and FFS billing should be directed to MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

1.3 Reimbursement

Services provided to beneficiaries enrolled in CHPs are billable to the CHP except for:

- H7Z class psychotropic drugs
- Anti-retroviral classes
- Anti-psychotic classes

A list of the specific medications is maintained on the MDCH pharmacy benefit manager's website and is subject to change without notice. (Refer to the Directory Appendix for website information.) These medications should be billed through the MDCH pharmacy benefit manager's point-of-sale reimbursement system for all ABW beneficiaries. Providers billing for these services must be Medicaid enrolled.

Reimbursement for services rendered to FFS ABW beneficiaries is the current Medicaid fee screens or the provider's charge, whichever is less. Services for ABW beneficiaries enrolled in a CHP are reimbursed at a rate negotiated by the CHP with its network providers. Services provided to ABW beneficiaries by Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) are not subject to the prospective payment reimbursement rate.

FFS ABW beneficiaries may not be billed for services except in the following situations:

- A co-payment is required. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required co-payment on the date of service.
- If the beneficiary requests a service not covered by the ABW, the provider may charge the beneficiary for the service if the beneficiary has been told prior to rendering the service that it was not covered by the ABW. If the beneficiary is not informed of the ABW noncoverage until after the services have been rendered, the provider cannot bill the beneficiary.
- The provider chooses not to accept the beneficiary as an ABW beneficiary and the beneficiary had prior knowledge of the situation. The beneficiary is responsible for payment.

It is recommended that providers obtain the beneficiary's written acknowledgement of payment responsibility prior to rendering any nonauthorized or noncovered service the beneficiary elects to receive. For additional information about billing the beneficiary, refer to the Billing Beneficiaries Section of the General Information for Providers Chapter.

1.4 Notification and Appeal

ABW applicants or beneficiaries must be provided written notice for each proposed action to deny, reduce, suspend or terminate any ABW covered benefit. Applicants and beneficiaries must be offered the opportunity to appeal the action whether they are enrolled in a CHP or receiving services through the FFS program.

The notice of proposed action must include:

- Statement of the action to be taken;
- Reasons for the intended action;
- Specific regulations supporting the action;
- An explanation of the individual's right to a hearing; and
- The circumstances under which assistance or service is continued if a hearing is requested.

Appeals related to such action are subject to the CHP complaint/grievance process and/or the Administrative Hearing process administered by MDCH's Administrative Tribunal and Appeals Division. Information pertaining to the Administrative Hearing process can be found on the MDCH website in the Administrative Tribunal Policy and Procedures Manual. (Refer to the Directory Appendix for website information.)

1.5 Co-Payment

FFS ABW beneficiaries are charged a co-payment for some covered benefits as specified in the Coverage and Limitations section of this chapter. No co-payments are required for family planning or pregnancy related services or prescriptions.

The respective CHPs may elect to use different co-payment amounts, but the co-pays may not exceed those listed nor may co-payments exceed the Medicaid fee screen for a specific service.

SECTION 2 – COVERAGE AND LIMITATIONS [CHANGE MADE 4/1/06]

The table below outlines beneficiary coverage under ABW. Special instructions for CHP beneficiaries are noted when applicable.

Service	Coverage
Ambulance	Limited to emergency ground ambulance transport to the hospital Emergency Department (ED).
Case Management	Noncovered
Chiropractor	Noncovered
Dental	Noncovered, except for services of oral surgeons as covered under the current Medicaid physician benefit for the relief of pain or infection.
Emergency Department	Covered per current Medicaid policy. For CHPs, PA may be required for nonemergency services provided in the emergency department.
Eyeglasses	Noncovered
Family Planning	Covered: Services may be provided through referral to local Title X designated Family Planning Program.
Hearing Aids	Noncovered
Home Health	Noncovered
Home Help (personal care)	Noncovered
Hospice	Noncovered
Inpatient Hospital	Noncovered
Lab & X-Ray	Covered if ordered by an MD, DO, or NP for diagnostic and treatment purposes. PA may be required by the CHP.

Service	Coverage
Medical Supplies/ Durable Medical Equipment (DME)	Limited coverage. ▪ Medical supplies are covered except for the following noncovered categories: gradient surgical garments, formulas and feeding supplies, and supplies related to any noncovered DME item. ▪ DME items are noncovered except for glucose monitors.
Mental Health Services	Covered: Services must be provided through the PIHP/CMHSP. (Refer to the Mental Health/Substance Abuse Coverage section of this chapter.)
Nursing Facility	Noncovered
Optometrist	Noncovered
Outpatient Hospital (Nonemergency Department)	Covered: Diagnostic and treatment services and diabetes education services. PA may be required for some services. A $3 co-payment for professional services is required. * Noncovered: Therapies, labor room and partial hospitalization.
Pharmacy	Covered: ▪ Products included on the Michigan Pharmaceutical Products List (except enteral formulas) that are prescribed by an MD, DO, NP or type 10-enrolled oral surgeon. PA may be required. Products must be billed to MDCH or CHP, as appropriate. ▪ Psychotropic medications are provided under the FFS benefit. See the MDCH Pharmacy Benefits Manager (PBM) website for a list of psychotropic drug classes to be billed to MDCH. (Refer to the Directory Appendix for website information.) The list of drugs covered under the carveout is updated as necessary. Drugs are added and deleted on a regular basis so it is imperative that the provider review this website frequently. Noncovered: Injectable drugs used in clinics or physician offices. Co-payment: $1 per prescription

* Professional services requiring a co-payment are defined by the following Evaluation and Management (E&M) procedure codes. 92002-92014, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397. No co-payment may be charged for family planning or pregnancy related services.

Service	Coverage
Physician **Nurse Practitioner (NP)** **Oral Surgeon** **Medical Clinic**	The following services are covered per current Medicaid policy: ▪ Annual physical exams (including a pelvic and breast exam, and pap test). Women who qualify for screening/services under the Breast and Cervical Cancer Program administered by the LHD may be referred to that program for services as appropriate. ▪ Diagnostic and treatment services. May refer to LHD for TB, STD, or HIV-related services, as available. ▪ General ophthalmologic services (procedure codes 92002-92014) ▪ Immunizations per current Advisory Committee on Immunization Practices (ACIP) guidelines. May be referred to LHD. Travel immunizations are excluded. ▪ Injections administered in a physician's office per current Medicaid policy. Psychotropic injectable drugs administered to CHP enrollees must be billed to the CHP. **(added 4/1/06)** CHPs may require PA for some injections. PA may be required for some services. A $3 co-payment is required for office visits (professional services). * Noncovered: Services provided in an inpatient hospital setting.
Podiatrist	Noncovered
Prosthetics/ Orthotics	Noncovered
Private Duty Nursing	Noncovered
Substance Abuse	Covered through the Substance Abuse Coordinating Agencies (CAs). (Refer to the Mental Health/Substance Abuse Coverage section of this chapter.)
Therapies	Occupational, physical, and speech therapy evaluations are covered when provided by physicians or in the outpatient hospital setting. Therapy services are not covered in any setting.
Transportation (nonambulance)	Noncovered
Urgent Care Clinic	Professional services provided in a freestanding facility are covered. CHPs may require authorization by the primary care physician or plan administrator. A $3 co-payment is required. *

* Professional services requiring a co-payment are defined by the following Evaluation and Management (E&M) procedure codes. 92002-92014, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397. No co-payment may be charged for family planning or pregnancy related services.

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SECTION 3 - MENTAL HEALTH/SUBSTANCE ABUSE COVERAGE

Mental health and substance abuse services for ABW beneficiaries are the responsibility of the Prepaid Inpatient Health Plans (PIHPs) and the Community Mental Health Services Programs (CMHSPs) as outlined in this section.

ABW mental health and substance abuse coverage is limited both in scope and amount to those that are medically necessary and conform to professionally accepted standards of care consistent with the Michigan Mental Health Code. Utilization control procedures, consistent with the medical necessity criteria/service selection guidelines specified by MDCH and in best practice standards, must be used.

3.1 MENTAL HEALTH SERVICES

PIHPs/CMHSPs are responsible for the provision of the following mental health services to ABW beneficiaries when medically necessary and within applicable benefit restrictions:

- Crisis interventions for mental health-related emergency situations and/or conditions.
- Identification, assessment and diagnostic evaluation to determine the beneficiary's mental health status, condition and specific needs.
- Inpatient hospital psychiatric care for mentally ill beneficiaries who require care in a 24-hour medically-structured and supervised licensed facility.
- Other medically necessary mental health services:
  - Psychotherapy or counseling (individual, family, group) when indicated;
  - Interpretation or explanation of results of psychiatric examination, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the beneficiary;
  - Pharmacological management, including prescription, administration, and review of medication use and effects; or
  - Specialized community mental health clinical and rehabilitation services, including case management, psychosocial interventions and other community supports, as medically necessary, and when utilized as an approved alternative to more restrictive care or placement.

Any beneficiary liability for the cost of covered services shall be determined by each CMHSP, according to the ability-to-pay provisions of the Michigan Mental Health Code and applicable administrative rules.

3.2 Substance Abuse Services

Substance Abuse Coordinating Agencies (CAs) are responsible for the following substance abuse services for ABW beneficiaries when medically necessary and within applicable benefit limitations:

- Initial assessment, diagnostic evaluation, referral and patient placement;
- Outpatient Treatment;
- Intensive Outpatient Treatment;
- Federal Food and Drug Administration (FDA) approved pharmacological supports for Levo-Alpha-Acetyl-Methadol (LAAM) and Methadone only; or
- Other substance abuse services that may be provided, at the discretion of the CA, to enhance outcomes.

AMBULANCE

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SECTION 1 - INTRODUCTION

1.1 GENERAL INFORMATION

This chapter applies to Ambulance providers (Provider Type 18).

The Michigan Department of Community Health (MDCH), which administers the Medicaid Program, reimburses for ambulance services as medically necessary and appropriate when:

- Medical/surgical or psychiatric emergencies exist; and/or
- No other effective and less costly mode of transportation for medical treatment can be used because of the beneficiary's medical condition.

Services that have been excluded from direct reimbursement to ambulance providers are:

- Services that are not medically necessary.
- Services that are included as a part of the base rate.
- Services for beneficiaries in a nursing facility (NF) that are reimbursed as part of the facility's per diem or are billed separately by the facility.
- Services reimbursed as part of the Diagnosis Related Groups (DRG) rate for beneficiaries who are inpatients at a hospital and are sent to another facility for services and returned to the originating hospital without being discharged from the originating hospital.
- Services to Medicaid Health Plan (MHP) enrollees, except for medically necessary ambulance transports related to dental, substance abuse, and community mental health services.
- Nonambulance, nonemergency medical transportation that is provided by a MHP.
- Nonambulance, nonemergency medical transportation where the Department of Human Services (DHS) reimburses the beneficiary or the transportation provider directly.

The Covered Services Section of this chapter describes, in alphabetical order, the coverages and limitations for payment of ambulance services by Medicaid.

Special billing instructions follow coverage sections, where applicable. These instructions assist the ambulance provider in obtaining reimbursement and must be used in conjunction with the completion instructions found in the Billing & Reimbursement for Professionals Chapter of this manual and the Health Care Financing Administration Common Procedure Coding System (HCPCS) manual.

1.2 COMMON TERMS

The following terms have specific meanings in the Ambulance Program:

Ambulance	A motor vehicle, watercraft, or aircraft that is primarily used or designated as available to provide transportation and basic life support or advanced life support.
Continuous or Round Trip	An ambulance service in which the patient is transported to the hospital, the physician deems it medically necessary for the ambulance to wait, and the beneficiary is then transported to a more appropriate facility for care or back to the place of origin.
Cooperating Hospital	A licensed hospital which supports an advanced mobile emergency care service as required by sections 20761(a) and 20763(b) of Public Act 368 of 1978, as amended.
Emergency Medical Condition	An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: ▪ Placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy, ▪ Serious impairment to bodily functions, or ▪ Serious dysfunction of any bodily organ or part.
Emergency Patient	An individual whose physical or mental condition is such that it meets the definition of "emergency medical condition".
Emergency Response	A response that, at the time the ambulance provider is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that in the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary's health in serious jeopardy; in impairment to bodily functions; or in serious dysfunction to any bodily organ or part.
Emergency Transport	An emergency, pre-hospital service in which no physician has yet seen the patient, e.g., a transport from the scene of an accident to an emergency department.
Fixed Wing Air Ambulance	Transportation by a fixed wing aircraft that is certified as a fixed wing air ambulance, and such ancillary services as may be medically necessary.
Helicopter (Rotary Wing) Air Ambulance	Transportation by a helicopter that is certified as an ambulance and such ancillary services as may be medically necessary.
Loaded Mileage	The number of miles for which the Medicaid beneficiary is transported in the ambulance vehicle.

Medically Necessary Transport	An ambulance transport which is required because no other effective and less costly mode of transportation can be used due to the patient's medical condition. The transport is required to transfer the patient to and/or from a medically necessary service not available at the primary location.
Psychiatric Emergency	Any condition that must be treated to prevent the patient from inflicting injury to self or others.
Transfer	A non-emergency transport in which the patient is moved from one facility to another for care that is not available at the originating facility.

1.3 Ambulance Services

MDCH recognizes different levels of medical services provided by qualified ambulance staff according to the standards established by law and regulation through Michigan Public Act 368 of 1978 as amended. The standards established for each level of service are detailed in the Base Rate subsection of this chapter.

A physician must order all covered medically necessary services and a copy of the physician's order must be retained in the beneficiary's medical record. The physician's order must contain, at a minimum, the following information:

- Beneficiary's name and Medicaid Identification (ID) number;
- An explanation of the medical necessity for ambulance transport; and
- Physician's signature and Medicaid Provider ID number.

Emergency services do not require a physician's order, but the ambulance provider must retain all documentation in the beneficiary's file supporting the emergency nature of the service.

1.4 Medical Necessity

The medical care personnel in attendance, including the Emergency Medical Technician (EMT) at the scene of an emergency, determine medical necessity and appropriateness of service within the scope of accepted medical practice and Medicaid guidelines. Medical necessity for nonemergency transports must be substantiated with a physician's written order. Ambulance providers must maintain documentation of the medical necessity and appropriateness of service in the beneficiary's file.

1.5 Diagnosis Coding

Providers must enter the appropriate diagnosis code on all ambulance claims using the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM). Providers must report the most specific diagnosis code available that identifies the reason for the service. When billing for emergency transports, refer to the Covered Services Section, Emergency subsection of this chapter and the MDCH Ambulance Services Database located on the MDCH website. (Refer to the Directory Appendix for website information.)

Documentation supporting the diagnosis code must be retained in the ambulance provider's records for audit purposes.

1.6 Usual and Customary Charges

Providers must bill MDCH the usual and customary (U&C) fee charged to the public. If the public receives a service without charge, an ambulance provider cannot bill MDCH for the same service. If one charge is made to tax-paying residents in a given township, and a higher charge is made to nonresidents, the same charge formula should be applied for Medicaid beneficiaries.

Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits chapters of this manual when the beneficiary also has Medicare or other insurance.

1.7 Medicare/Medicaid Coverage

MDCH reimburses the ambulance provider for the coinsurance and deductible amounts subject to Medicaid's reimbursement limitations on Medicare approved claims, even if Medicaid does not normally cover the service.

Refer to the Billing & Reimbursement for Professionals Chapter of this manual for instructions on completing the claim after Medicare has approved the services.

SECTION 2 - COVERED SERVICES

2.1 AIR AMBULANCE

MDCH reimburses air ambulance providers who are licensed by the State of Michigan and properly enrolled with MDCH. Providers must indicate on the enrollment application that they are requesting either fixed-wing air ambulance or helicopter air ambulance status.

2.1.A. FIXED-WING AIR AMBULANCE

Fixed-wing air ambulance providers must submit a copy of their Aircraft Transport Operation license with the enrollment application to verify that their aircraft is registered as an Aircraft Transport Vehicle. Since all equipment standards must equate to current Basic Life Support (BLS) or Advanced Life Support (ALS) criteria, as appropriate for the transported patient, providers must also submit a copy of their Commission on Accreditation of Air Medical Services (CAAMS) accreditation or an affidavit of substantial CAAMS accreditation compliance to document that the fixed wing aircraft is suitable for air ambulance transport. The Medicaid Provider Enrollment file reflects enrollment as a fixed wing air ambulance provider.

Air ambulance transport provided by fixed wing aircraft must be prior authorized. (For details regarding prior authorization [PA] for out of state services, refer to the Out of State Nonborderland Transports subsection in this chapter.) The following requirements must be met:

- The transport, including ancillary services (e.g., flight nurse), is ordered by a physician;
- The written physician order is maintained in the beneficiary's file;
- Transport by a ground vehicle would endanger the beneficiary's life due to time and distance from the hospital;
- Necessary care and medical services for the beneficiary's condition cannot be provided by the local facility; and
- Transport is for medical or surgical procedures only and not for diagnostic purposes.

2.1.B. HELICOPTER AIR AMBULANCES

Helicopter air ambulance providers must submit a copy of their license with their enrollment application. The Medicaid Provider Enrollment file reflects enrollment as a helicopter air ambulance provider.

MDCH covers helicopter air ambulance services only under the following circumstances:

- Time and distance in a ground ambulance would be a hazard to the life of the patient.
- Necessary care and services for the beneficiary's needs are not available at the local hospital.
- Transport is for medical or surgical procedures only and not for diagnostic purposes.

(Refer to the Ambulance Services subsection of this chapter for documentation requirements for emergency and medically necessary services.)

Coverage of helicopter air ambulance services includes the helicopter base rate, mileage, and waiting time:

- **Base Rate:** Reimbursement for the helicopter air ambulance base rate includes oxygen, equipment and supplies essential for the provision of services and accompanying personnel.
- **Mileage:** Mileage may only be billed for loaded air miles.
- **Waiting time:** Waiting time which exceeds 30 minutes is reimbursable as detailed in the Waiting Time subsection of this section.

The ambulance company must bill any ground ambulance transportation ordered to and from the airport in the normal manner.

2.2 Base Rate

The ambulance provider may bill one base rate procedure code:

- Basic Life Support (BLS) Nonemergency;
- BLS Emergency;
- Advanced Life Support 1 (ALS 1) Nonemergency;
- ALS 1 Emergency;
- Advanced Life Support 2 (ALS 2);
- Neonatal Emergency Transport;
- Helicopter Air Ambulance; or
- Fixed Wing Air Ambulance Transport.

The base rate must reflect the level of service rendered, not the type of vehicle in which the beneficiary was transported, except in those localities where local ordinance requires ALS as the minimum standard of service. Ambulance providers in these localities may bill the ALS rate which most closely fits the services rendered for all emergency transports, regardless of the level of service rendered. For transfers in these localities, the base rate billed must reflect the level of service rendered, not the type of vehicle in which the beneficiary was transferred.

If an ambulance provider has only ALS vehicles, but operates in a locality where both BLS and ALS are available, the base rate billed must reflect the level of service rendered rather than the type of vehicle used.

Reimbursement for the base rate covers all services rendered except mileage that may be billed separately.

When treatment is rendered and no other care or transport is necessary, ambulance providers may bill the base rate procedure code for the level of service performed but not for mileage. (Refer to the Special Situations Section of this chapter for instructions regarding intercept situations.)

2.3 Advanced Life Support

Ambulance operations and ambulance staff must be licensed to render advanced life support (ALS) services by the State and properly enrolled with MDCH. MDCH recognizes two levels: ALS 1 and ALS 2.

2.3.A. ALS 1 Nonemergency

When medically necessary, the ALS 1 base rate may be billed when an advanced life support provider (minimum level of EMT-Intermediate or Paramedic) renders an assessment or furnishes one or more ALS interventions or in those localities where ALS has been mandated as the minimum level of service.

2.3.B. ALS 1 Emergency

When medically necessary and ALS 1 services, as specified above, are provided in the context of an emergency response.

2.3.C. ALS 2

When medically necessary, the ALS 2 base rate may be billed when an advanced life support provider (minimum level of EMT-Intermediate or Paramedic) renders an assessment and the administration of at least three different medications, and furnishes one or more of the following ALS procedures:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line

Reimbursement for the ALS base rates includes those services listed under BLS and is the same whether or not special services were performed.

2.4 Basic Life Support

Ambulance operations and ambulance staff must be licensed to render BLS services by the State and properly enrolled with MDCH. Medicaid coverage of the BLS base rate includes transportation and medical services that an EMT is routinely trained to provide (e.g., the provision of oxygen and resuscitation). Reimbursement for accompanying personnel, suctioning, delivery/labor, emergency first aid, emergency/night call services, oxygen, and resuscitation is included in the BLS base rate. BLS also

includes equipment and supplies essential to providing such services (e.g., splints, backboards, obstetrical kits).

2.4.A. BLS Nonemergency

When medically necessary, the BLS base rate may be billed when a BLS or ALS provider renders basic life support services as defined above.

2.4.B. BLS Emergency

When medically necessary, the BLS emergency transport base rate may be billed when a BLS or ALS provider renders basic life support services as defined above.

2.5 Drugs and Solutions

Drugs, intravenous solutions and needles, and syringes and hypodermic needles carried in ambulances require replacement by a cooperating hospital pharmacy and under the supervision of a licensed pharmacist. Only the hospital is reimbursed for these items.

2.6 Emergency

Claims may be made to MDCH for emergency transports that meet the criteria specified in the definitions of BLS Emergency, ALS 1 Emergency and ALS 2 transports in this section.

Claims for emergency ambulance transports must be coded with both an emergency procedure code and an appropriate ICD-9-CM diagnosis code whenever the service results in transport to an emergency department, or assessment and treatment/stabilization determines that no further transport is necessary. Claims for emergency transports without this information will be rejected. Documentation supporting the emergency diagnosis code must be retained in the ambulance provider's records for audit purposes.

To assure appropriate coverage and reimbursement for emergency ambulance services, MDCH maintains a database of diagnosis codes for emergency ambulance transport. The MDCH Ambulance Services Database is located on the MDCH website and is routinely updated. (Refer to the Directory Appendix for website information.)

2.7 Mileage

Mileage reimbursement is a Medicaid benefit in the following circumstances:

- Only when a transport occurs.
- Only when the beneficiary is in the vehicle (loaded mileage only).
- When billed with the appropriate origin and destination modifier combination:
  - Refer to the Billing & Reimbursement for Professionals chapter of this manual for a list of origin and destination modifiers.
  - Modifier 22 is not an appropriate origin and destination modifier.

When billing for mileage greater than 100 miles, enter the origin and destination addresses in the Remarks section.

2.8 NEONATAL

Coverage of neonatal transport includes neonatal base rate, loaded mileage, and waiting time. The cost of the transfer isolette use is included in the neonatal base rate.

The intensive care transport of critically ill neonates (i.e., newborns) to approved, designated neonatal intensive care units (regional centers) is covered, providing the designated carrier is approved by the regional center to which the provider renders service.

A hospital medical team must accompany the newborn in the ambulance for Medicaid to reimburse the services. The hospital team usually consists of a physician, nurse, and respiratory therapist. The hospital team has primary responsibility for the newborn and the hospital is reimbursed for these services. The designated ambulance provider may bill the neonatal base rate and mileage for the transport.

A return trip of a newborn from a regional center to a community hospital (after the newborn's condition is stabilized) is covered. A physician's order indicating the medical necessity of the return trip must be retained in the beneficiary's file as detailed in the Ambulance Services subsection of this chapter.

Waiting time that exceeds 30 minutes is reimbursable and must be billed as detailed in the Waiting Time subsection of this section.

2.9 NONEMERGENCY

A claim may be made to MDCH for medically necessary nonemergency transport only when it is provided in a licensed BLS or ALS vehicle. Ambulance providers must obtain appropriate documentation of the medical necessity of the transport (a copy of the physician's written order or signed certification statement from the attending physician) and retain it in their files. A copy of the physician's order for nonemergency ambulance transport in the patient's medical record is acceptable documentation. A physician may write a single prescription for nonemergency ambulance transport of a beneficiary with a chronic condition to a planned treatment that covers up to one month of treatment. The prescription must contain information that would indicate:

- The type of transport necessary;
- Why other means of transport could not be used;
- Frequency of needed transport;
- Origin;
- Destination;
- Diagnosis; and
- Medical necessity.

For all other nonemergency transport, a separate physician's order is required for each individual transport.

If the ambulance provider is unable to obtain the required written documentation of medical necessity within 21 days following the date of service, the ambulance provider must document a minimum of two attempts to obtain the physician's order/documentation of medical necessity. Acceptable documentation must include a signed return receipt from the U.S. Postal Service, or other similar delivery service, as well as a copy of the request itself. Such a return receipt serves as proof that the ambulance provider attempted to obtain the required documentation of medical necessity from the attending physician.

Nonemergency transport in a Medi-van or other wheelchair-equipped vehicle is not a covered service for ambulance providers. However, Medicaid beneficiaries or transportation providers may receive reimbursement for this type of transport directly from the DHS caseworker or the MHP, if the beneficiary is enrolled in a MHP.

MDCH pays for MHP enrolled beneficiaries on a fee-for service (FFS) basis only if the nonemergency transport was medically necessary and was for Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) related services. When submitting claims, providers are to enter in the Remarks section that the ambulance transport was to receive PIHP/CMHSP services.

2.10 Unlisted Ambulance Service

If a service is rendered that is not included in the coverages defined under the existing procedure codes, the ambulance provider may bill the procedure under the Unlisted Ambulance Service procedure code. The claim pends for manual review to determine whether the service is reimbursable under Medicaid guidelines.

Additional considerations:

- Items included in the base rate are not separately reimbursable.
- If no transport was provided, refer to the base rate billing instructions.
- A complete description of the service must be included in the Remarks section or as an attachment to the claim.

2.11 Waiting Time

Waiting time is reimbursable after the first 30 minutes when a physician deems it medically necessary for the ambulance provider to wait at a hospital while the beneficiary is being stabilized, with the intent of continuing transport to a more appropriate hospital for care or back to the point of origin.

The maximum number of hours allowed for waiting time is four hours. If more than four hours of waiting time is involved, providers must request individual consideration and provide documentation. Providers should refer to the Billing & Reimbursement for Professionals Chapter of this manual for instructions.

The appropriate number of time units must be reflected in the Quantity box. One time unit represents each 30 minutes of waiting time after the first 30 minutes (e.g., total waiting time of 1 hour, 30 minutes = 2 time units).

The usual and customary charge (U&C) must be entered.

The Remarks section, or an attachment to the claim, must include the following documentation:

- Total length of waiting time, including the first 30 minutes;
- The physician's name that ordered the wait; and
- The reason for the wait.

2.12 Water Ambulance

Nonemergency ambulance services provided by marine craft must be prior authorized. Providers should refer to the General Information for Providers Chapter of this manual for information on the PA process.

Emergency ambulance services provided by marine craft do not require PA.

Claims are to be submitted to MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

SECTION 3 - SPECIAL SITUATIONS

3.1 INTERCEPTS

In situations where a BLS vehicle intercepts with an ALS vehicle, each provider may bill for the appropriate base rate and for the loaded mileage they provided (if any).

3.2 BRIDGE/TUNNEL TOLL

Bridge and tunnel toll charges are reimbursable to the ambulance provider, both loaded and return trip.

Billing Instructions:

- The Unlisted Ambulance Service code must be used.
- All toll charges must be combined on one claim line.
- The Remarks section must contain the bridge or tunnel name and the number of times used.

3.3 CONTINUOUS OR ROUND TRIP TRANSPORT

This type of transport is considered to be one run. The base rate code for the highest level of service performed during transport should be billed on one claim line. Loaded mileage is also billed on one claim line with the total number of whole (loaded) miles indicated as the quantity.

Refer to the Waiting Time subsection of this chapter in cases where waiting time exceeds 30 minutes.

3.4 NURSING FACILITIES

Routine, nonemergency medical transportation provided for NF residents in a van or other nonemergency vehicle is included in the facility's per diem rate. This includes transportation for medical appointments, dialysis, therapies or other treatments not available in the facility but located in the county or the normal service delivery area.

When the resident's attending physician orders nonemergency transportation by ambulance (due to the need for a stretcher or other emergency equipment), the ambulance provider may bill MDCH directly. The ambulance provider must maintain the physician's written order as documentation of medical necessity.

If the resident's attending physician does not order nonemergency ambulance transport, arrangements for payment must be between the facility and the ambulance provider, and cannot be charged to the resident, the resident's family, or used to offset the patient-pay amount. This cost may not be claimed as a routine cost on Michigan's Medicaid cost report. The cost of nonemergency ambulance transports not ordered by the resident's physician must be identified and removed on Worksheet 1-B by the NF.

For direct reimbursement by MDCH to an enrolled ambulance provider for services provided to a Medicaid beneficiary who is a resident of a NF, refer to the Ambulance Quick Reference Guide Section of this chapter.

3.5 Multiple Arrivals

When multiple units respond to a call for services, only the entity that actually provides services for the beneficiary may bill and be paid. The entity that rendered service/care should bill for all services furnished.

3.6 Multiple Beneficiaries Per Transport

When more than one eligible beneficiary is transported at the same time, the only acceptable duplication of charges is half of the base rate.

Separate claims must be submitted for each beneficiary. The first claim is completed in the usual manner and the base rate billed must reflect the highest level of service performed.

Claims for additional beneficiaries must indicate the U&C base rate charge. The appropriate modifier must be reported. Providers should refer to the Billing & Reimbursement for Professionals chapter of this manual for a list of modifiers. Payment is made at 50 percent of Medicaid's reimbursement rate or 50 percent of the provider's charge (whichever is less).

No mileage or waiting time is to be charged for additional beneficiaries. These services are included in the reimbursement of the first claim.

3.7 Multiple Transports Per Beneficiary

More than one transport per beneficiary on the same date of service is covered when the following conditions apply:

- The beneficiary received a different level of service on each transport (e.g., ALS1 and BLS): enter the appropriate code for each base rate on the claim.
- The beneficiary received the same level of service on each transport: enter the appropriate code for each base rate on one claim line with the appropriate combined base rate charge. A quantity of "1" must be reported and individual consideration (Modifier 22) requested.
- Other services duplicated from the multiple transports must be combined and billed on one claim line (e.g., the total loaded mileage is combined and billed on one claim line).
- Other services not duplicated are billed on separate claim lines.
- The Remarks section of the claim, or an attachment to the claim, must detail the following information:
  - Number of transports.
  - Originating and terminating locations.
  - Ambulance requestor's name(s).
  - Reason for multiple transports on the same day.

- Number of times each base rate was provided.
- If transport is for any reason other than further treatment, the reason for the transport must be provided in addition to the diagnosis.

Return trips are considered multiple transports if a break in service has occurred (i.e., the ambulance is available to respond to other requests for service).

3.8 Out of State Nonborderland Transports

Except for emergencies, out of state, nonborderland transports require PA. (Refer to the General Information for Providers chapter of this manual for additional information.)

The ambulance provider, home health agency (HHA), hospital, NF, physician, or social worker may request this authorization. The ambulance provider must retain documentation of medical necessity (physician's order) in the beneficiary's file to support the need for ambulance transportation. To request authorization, the requestor must submit a letter to MDCH before services are rendered. The request must include:

- Point of pick-up
- Beneficiary's name and Medicaid ID number
- Diagnosis
- Service to be provided
- Destination point
- Reason why the ambulance transport was medically necessary
- Reason why the beneficiary cannot be transported by any other means
- Name and address of the ambulance provider
- Requestor's name

The authorization may be obtained by calling or writing to MDCH Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

Based on the authorization requested, MDCH approves or disapproves the request. The ambulance provider may render the service upon receipt of verbal approval. A copy of the approval authorization letter is mailed to the ambulance provider following the verbal authorization. The ambulance provider may not bill Medicaid until he has received the authorization letter. The ambulance provider must keep a copy of the authorization letter in the beneficiary's file. Documentation of medical necessity (physician's order) must also be retained in the beneficiary's file to support the need for ambulance transportation.

The requestor must notify the Prior Authorization Division of any changes to the approved PA (e.g., change in service date or ambulance provider, etc.).

When seeking reimbursement for out of state transports, the PA number must be entered on the claim, except in the case of emergency transports.

Claims are to be submitted to MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

3.9 Pronouncement of Death

There are three rules that apply to ambulance services and the pronouncement of death:

- If the beneficiary was pronounced dead by an individual who is licensed to pronounce death (coroner/physician) prior to the time that the ambulance is called, no payment is made.
- If the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment for an ambulance trip is made at the BLS rate, but no mileage is paid.
- If the beneficiary is pronounced dead after being loaded into the ambulance, payment is made following the established program policies (that is, the same level of payment is made as if the beneficiary had not died).

SECTION 4 – AMBULANCE COVERAGE EXCLUSIONS

Circumstances under which Medicaid does not pay for ambulance transportation include, but are not limited to:

- Medi-car, Medi-van, or wheelchair transports.
- Transport to a funeral home.
- Trips made for services, such as drawing blood and catheterization that could have been provided at the beneficiary's location.
- Transportation of a beneficiary pronounced dead before the ambulance was called.
- Round trips when a beneficiary is taken from a hospital to another facility and returned to the same hospital. As long as the beneficiary is an inpatient, all ancillary services are the responsibility of the hospital.
- Transport of correctional facility inmates to and from the correctional facility.
- Transports that are not medically necessary.

SECTION 5– AMBULANCE QUICK REFERENCE GUIDE

Transports rendered in an emergency situation are covered in all settings. Use the following table to determine if the service is covered, not covered or if covered but to be billed to another facility/entity.

	To Inpatient	To Emergency Room Outpatient	To Nursing Facility	To Ambulatory Setting (i.e., Lab, Office, Clinic, Therapy, Dialysis)	To Home
From Inpatient	If Medically Necessary	Emergency Only	If Medically Necessary	If Medically Necessary	If Medically Necessary
From Emergency Room Outpatient	If Medically Necessary	Emergency Only	If Medically Necessary	If Medically Necessary	If Medically Necessary
From Nursing Facility	If Medically Necessary	Emergency Only	If Medically Necessary	If Medically Necessary	If Medically Necessary
From Ambulatory Setting (i.e., lab, office, clinic, therapy, dialysis)	If Medically Necessary	Emergency Only	If Medically Necessary	If Medically Necessary	If Medically Necessary
From Home	Emergency Only	Emergency Only	If Medically Necessary	If Medically Necessary	Not Covered
From At Large (Example: Scene of accident)	Emergency Only	Emergency Only	Not Covered	Emergency Only	Not Covered

CHILDREN'S SPECIAL HEALTH CARE SERVICES PROGRAM

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SECTION 1 – GENERAL

This chapter applies to all providers.

Children's Special Health Care Services (CSHCS) is a program within the Michigan Department of Community Health (MDCH) created to find, diagnose, and treat children in Michigan who have chronic illnesses or disabling conditions. Title V of the Social Security Act, Michigan Public Act 368 of 1978, and the annual MDCH Appropriations Act mandate CSHCS. CSHCS promotes the development of service structures that offer specialty health care for the CSHCS qualifying condition that is family centered, community based, coordinated, and culturally competent.

MDCH covers medically necessary services related to the CSHCS qualifying condition for individuals who are enrolled in the CSHCS Program. Medical eligibility must be established by MDCH before the individual is eligible to apply for CSHCS coverage. Based on medical information submitted by providers, a medically eligible individual is provided an application for determination of nonmedical program criteria.

An individual may be eligible for CSHCS and eligible for other medical programs such as Medicaid, Adult Benefits Waiver (ABW), Medicare, or MIChild. To be determined dually eligible, the individual must meet the eligibility criteria for CSHCS and for the other applicable program(s).

SECTION 2 – APPROVED PROVIDERS

Physicians and hospitals approved as CSHCS providers must be authorized per client in the CSHCS system in order to be reimbursed for services.

2.1 PHYSICIANS

Physicians desiring to be CSHCS approved specialty care providers must:

- Be licensed to practice as a doctor of medicine (MD) or osteopathy (DO) by the state where the service is performed.
- Have successfully completed medical residency.
- Possess Specialty Board Certification. (Board eligible physicians in the process of completing certification requirements may be provisionally approved).
- Be enrolled in the Michigan Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)
- Have clinical privileges in a CSHCS approved hospital/facility.
- Have documented clinical training or experience with children who have diagnoses eligible for CSHCS services. A physician not having experience treating infants and young children may be conditionally approved to supervise the care of children over 12 years of age.

2.2 HOSPITALS

Hospitals desiring to be CSHCS approved must:

- Be approved by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO);
- Be enrolled in the Michigan Medicaid program;
- Have an organized Pediatrics Unit with an average daily census of 6 or greater; and
- Have a medical staff structure, including an organized Pediatrics Department headed by a board certified pediatrician.

To request approval as a CSHCS provider, the physician or hospital must contact MDCH. (Refer to the Directory Appendix for contact information.)

SECTION 3 – MEDICAL ELIGIBILITY

CSHCS covers approximately 2,600 medical diagnoses that are handicapping in nature and require care by a medical or surgical subspecialist. A current list of covered diagnoses is maintained on the MDCH website. (Refer to the Directory Appendix for contact information.) Diagnosis alone does not guarantee medical eligibility for CSHCS. To be medically eligible, the individual must:

- Have at least one of the CSHCS qualifying diagnoses.
- Be within the age limits of the program:
  - Under the age of 21; or
  - Age 21 and above with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.
- Meet the medical evaluation criteria during the required medical review period as determined by a physician subspecialist regarding the level of severity, chronicity and need for treatment. (Refer to the Medical Renewal Period subsection of the Coverage Period Section of this chapter.)

A MDCH medical consultant conducts the medical determination by reviewing the written report of a subspecialist physician. The medical information may be provided to CSHCS in the form of a comprehensive letter, hospital consultation or summary, or the Medical Eligibility Report Form (MERF), (MSA-4114). (A copy of the form is available in the Forms Appendix). Medical information is reviewed in the context of current standards of care, as interpreted by a MDCH medical consultant. All of the criteria described below must be met for the individual to be considered medically eligible:

Diagnosis	The individual must have a CSHCS qualifying diagnosis where his activity is or may become so restricted by disease or deformity as to reduce his normal capacity for education and self-support. Psychiatric, emotional and behavioral disorders, attention deficit disorder, developmental delay, mental retardation, autism, or other mental health diagnoses are not conditions covered by the CSHCS Program.
Severity of Condition	The severity criteria is met when it is determined by the MDCH medical consultant that specialty medical care is needed to prevent, delay, or significantly reduce the risk of activity becoming so restricted by disease or deformity as to reduce the individual's normal capacity for education and self-support.
Chronicity of Condition	A condition is considered to be chronic when it is determined to require specialty medical care for not less than 12 months.
Need for Treatment by a Physician Subspecialist	The condition must require the services of a medical and/or surgical subspecialist at least annually, as opposed to being managed exclusively by a primary care physician.

CSHCS covers diagnostic evaluations for individuals when symptoms and history indicate the possibility of a CSHCS qualifying condition but the appropriate medical information cannot be obtained from their current provider(s). Diagnostic evaluations are to determine whether an individual meets the medical eligibility criteria for CSHCS, not for providing treatment. The local health department (LHD) assists in obtaining these diagnostic evaluations. Treatment is not a CSHCS benefit until a qualifying diagnosis is established and the individual has enrolled in the CSHCS Program. Individuals currently enrolled in a commercial Health Maintenance Organization (HMO), Medicaid Health Plan (MHP), or with other commercial insurance coverage must seek an evaluation by an appropriate physician subspecialist through their respective health plan or health insurance carrier to provide medical documentation of a CSHCS qualifying diagnosis.

Medical information submitted for the purpose of renewing CSHCS eligibility is generally considered current when it is no more than 12 months old. Initial determination of medical eligibility may require reports that are more current to document the individual's current medical status.

Covered medical diagnostic categories include, but are not limited to:

- Cardiovascular Disorders
- Certain chronic conditions peculiar to newborn infants
- Congenital anomalies
- Digestive Disorders
- Endocrine Disorders
- Genito-Urinary Disorders
- Immune Disorders
- Late effects of injuries and poisonings
- Musculoskeletal Disorders
- Neoplastic Diseases
- Neurologic Disorders
- Oncologic and Hematologic Disorders
- Respiratory Disorders
- Special Senses (e.g., vision, hearing)

CSHCS does not cover acute/specialty care that is not related to the CSHCS qualifying diagnosis. CSHCS also does not cover mental health care, primary care, well-child visits, or immunizations. Examples of diagnoses, conditions or procedures not covered include, but are not limited to:

- Acne
- Allergies, without anaphylaxis
- Anorexia Nervosa
- Appendicitis
- Attention Deficit Disorder
- Autism
- Behavioral Problems
- Bronchitis (acute), croup
- Childhood Illnesses (measles, mumps, chicken pox, scarlet fever, etc.)
- Cosmetic Surgery
- Depression
- Developmental Delay
- Headache, migraines
- Hernia (inguinal or umbilical)
- In utero treatment
- Pneumonia
- Refractive Errors and Astigmatism
- Sinusitis
- Tonsillitis, strep throat

SECTION 4 – APPLICATION PROCESS

When the MDCH medical consultant determines the individual is medically eligible for CSHCS, MDCH sends the individual a Children's Special Health Care Services Application (MSA-0737). The individual must complete the application and return it to MDCH to be considered for enrollment in the program. (Refer to the Directory Appendix for contact information.) Applications submitted by the family cannot be processed until medical eligibility has been determined by MDCH.

Applications must be signed by the medically eligible individual (when legally responsible for self), or the person(s) who is legally responsible for the individual. Verification of legal guardianship may be required.

Foster parents and stepparents are not considered the legally responsible persons to sign the application unless the following criteria are met:

- The foster parent is the child's court-appointed guardian; or
- The stepparent is in the legal process of adopting the child or is the child's court-appointed guardian.

The application must be completed and submitted to MDCH as directed on the application form. MDCH will notify the individual by mail if the application is incomplete and cannot be processed. The individual has 30 calendar days from the date of MDCH's letter to submit the required information in order to preserve the initial coverage date. Failure to submit the required information within the required time frame may result in the coverage date being delayed.

SECTION 5 – FINANCIAL DETERMINATION

MDCH reviews the CSHCS Income Review/Payment Agreement (MSA-0738) submitted by all individuals to evaluate the individual/family financial resources. The review serves to:

- Determine whether the individual/family income is sufficient to establish a payment agreement to pay toward the costs of the medical care received through CSHCS.
- Aid in identifying additional services or benefits for which the individual/family may be eligible.

5.1 FINANCIAL DETERMINATION PROCESS [CHANGE MADE 4/1/06]

Individuals/families are exempt from a payment agreement if at least one of the following applies:

The individual to be covered:

- Has full Medicaid coverage;
- Is enrolled in Women, Infants and Children (WIC);
- Is enrolled in MIChild.
- Is a ward of the county or state;
- Lives in a foster home or a private placement agency;
- Has a legal guardian;
- Is under age 18 and was adopted with a pre-existing CSHCS eligible medical condition;
- Has a family income at or below 200 percent of the Federal Poverty Level (FPL); or
- Is deceased (retroactive coverage).

The MSA-0738 must be completed and submitted, either indicating the individual/family status is exempt from a payment agreement, or with **(added 4/1/06)** the responsible party's income and family size as reported on the federal income tax return (Form 1040, 1040A, or 1040EZ) from the previous year. If no federal income tax return is available, families may contact the local health department (LHD) or the CSHCS Family Phone Line for further assistance. (Refer to the Directory Appendix for contact information.)

5.2 VERIFICATION OF INCOME

Individuals/families self declare income at the time of CSHCS application and renewal. Periodic reviews of randomly selected individual/family financial documentation are conducted. When the information submitted is problematic to completing the payment participation determination, or when an individual/family is randomly selected for verification of income, their federal income tax return may be requested. When the federal income tax return is not available, the individual/family may contact the LHD or CSHCS Family Phone Line for further assistance. (Refer to the Directory Appendix for contact information.)

5.3 Payment Agreement

CSHCS is required to determine an individual's/family's ability to pay toward the cost of the individual's care through the financial determination process. Those determined to be exempt from payment participation as described in the Financial Determination Process subsection are not required to pay toward the cost of care covered by CSHCS. The individual/family payment amount is established based on the income and family size reported by the responsible party on their most recent federal income tax return as indicated on the CSHCS Payment Agreement Guide (MSA-0738-B). The income is applied to a tiered scale to determine the amount of the payment agreement. The MSA-0738-B is updated at least annually.

Financial reviews occur and new payment agreements are redetermined annually and implemented (if still applicable) according to the client's CSHCS coverage period.

The MSA-0738 must be signed by the responsible party for CSHCS coverage to be implemented. The amount of the payment agreement is the total client/family financial obligation for one year, regardless of the number of children in the family with CSHCS coverage. Payments may be distributed equally over a 12-month period for ease of financial responsibility of the client/family, even if the client/family chooses to end CSHCS coverage during the year.

Unpaid balances may be forgiven and CSHCS coverage continued, if needed, under the following circumstances:

- Death of the client
- Client has acquired Medicaid coverage;
- Client's/family's financial circumstances have changed and the income level no longer requires a payment agreement (at or below 200% of the FPL).

A client/family may have no more than two outstanding years of incomplete or unpaid payment agreements. The client/family will not receive CSHCS coverage under a third year of a payment agreement until the oldest payment agreement obligation has been met.

When the client reaches the age of majority, or otherwise becomes emancipated, outstanding payment agreements remain with the family who entered into the original agreements. Further payments on the current year payment agreement are terminated for the family within 30 days of notification to the CSHCS that the client has reach age 18.

SECTION 6 – OTHER ELIGIBILITY CONSIDERATIONS

6.1 CITIZENSHIP STATUS

The parent, or legal guardian of the individual must be a citizen of the U.S. or a noncitizen lawfully admitted for permanent residence. Any individual born in the United States, or a child or individual who is a noncitizen lawfully admitted migrant who meets all other program eligibility criteria, is deemed eligible regardless of the citizenship status of the parents/legal guardian.

- Noncitizens who have been granted admission to the U.S. for a temporary or specific period of time are not eligible for CSHCS coverage other than as specified below.
- MDCH requires a statement of citizenship status from the family if the information is unclear from the application.

There are some exceptions by the Bureau of Citizenship and Immigration Services (formerly known as Immigration and Naturalization Services [INS]) that allow legal status for individuals with specific reasons for nonpermanent entry in the U.S who are recognized as potentially eligible for full Medicaid coverage (as opposed to Emergency Services Only coverage). CSHCS recognizes the same individuals for coverage when all other CSHCS qualifying criteria are met.

- MDCH may request verification of citizenship or permanent resident status.

6.2 RESIDENCY

The individual, parent, legal guardian, or foster parent of the individual must be:

- A Michigan resident(s);
- Working or looking for a job in Michigan, and living in Michigan (including migrant status);
- In Michigan with the clear intent to make Michigan their home; or
- A Michigan resident who is temporarily absent from the state (due to out-of-state college attendance or, being a member of a family stationed out-of-state for military service or other extenuating circumstances allowed by MDCH) and agrees to return to Michigan at least annually for subspecialty medical treatment of the qualifying diagnosis(es).

CSHCS does not issue or maintain coverage when the individual/client is known to be out-of-state (except for the circumstances listed above) for an extended period of time even if the parent, legal guardian or foster parent meets the criteria for residency. An extended period of time is defined as more than 12 consecutive months.

CSHCS does not issue or maintain coverage when the individual/client is known to reside in a long term care facility whose rate of payment includes medical care and treatment (e.g., nursing facility, ICF/MF, inpatient psychiatric hospitals, etc.). The individual/client can re-apply for CSHCS coverage or have CSHCS coverage reinstated when the living arrangement changes and all other eligibility criteria are met.

SECTION 7 – EFFECTIVE DATE

Once the application is complete, the effective date of CSHCS coverage is dependent upon the individual's other health care coverage. When the individual has:

- Commercial insurance coverage or no other health care coverage - The CSHCS effective date is the day the application was signed when submitted* within 30 days of the signature. Applications submitted later than 30 days of the signature are made effective on the submission date.*
- Medicaid, Transitional Medicaid Assistance (TMA), TMA-Plus, ABW, or MIChild - The CSHCS effective date is prospective to the first day of the first available month after the CSHCS application has been processed, according to the Medicaid card cut-off processing time frames. This could result in the CSHCS effective date for coverage being as early as two weeks or as late as six weeks from the time of processing.

When information is missing, the individual has 30 days from the date of the letter sent from MDCH requesting the missing information to submit* the information in order to preserve the initial effective date of coverage. Failure to submit the required information within the timeframe indicated results in the effective date of coverage being delayed until the date that all necessary information has been submitted to MDCH. Individuals/families are required to provide complete and accurate information at the time of application and as circumstances change. At a minimum, changes in address and insurance must be reported as they occur.

* Submission date is considered the date the document is received by MDCH.

SECTION 8 – COVERAGE PERIOD

Upon completion of the application or renewal process requirement (as specified below), CSHCS coverage is typically issued in 12-month increments.

Clients/families are required to provide updated financial information during the annual renewal of the coverage period to determine financial participation with the CSHCS Program. Those with Medicaid, MIChild, WIC or adopted with a pre-existing CSHCS qualifying diagnosis are determined as complete in the annual financial review each year those circumstances remain true. Clients are requested to provide updated information during the annual renewal of the coverage period regarding current providers, address, other insurance, etc.

8.1 MEDICAL RENEWAL PERIOD

CSHCS medical renewal period is established according to the following time frames:

- One year for those receiving the Private Duty Nursing (PDN) benefit regardless of the CSHCS qualifying diagnosis and a limited group of additional CSHCS qualifying diagnoses; or
- Two years, three years, or five years, depending upon the CSHCS primary diagnosis.

Medical reports for renewal of coverage (refer to the Renewal of Coverage subsection) are required consistent with the time frames indicated by the CSHCS medical renewal period.

When the client has more than one CSHCS qualifying diagnosis, the diagnosis determined by MDCH to be primary is used to determine the time interval for required medical information to be submitted for all covered diagnoses. This results in a single periodic medical review process per client. When the medical review process results in the elimination of one of the qualifying diagnoses while maintaining another diagnosis, the new coverage period is based on the time frame associated with the new primary diagnosis.

Example: Client has three diagnoses, each related to a different medical review period. All new medical information is required according to the medical renewal time period of the primary diagnosis.

A change of primary diagnosis during the medical renewal period does not change the time period unless and until the current medical renewal period has been completed and a new one is established.

All coverage periods end on the last day of a month, or the client's 21st birthday if the client does not have a qualifying diagnosis that is covered beyond age 21.

8.2 RETROACTIVE COVERAGE

In some instances, the client's coverage may be retroactive up to three months when requested by the family. This may occur if, during that time:

- All CSHCS medical and nonmedical eligibility requirements were met; and
- Medical services related to the qualifying diagnosis(es) were rendered and remain unpaid with no other responsible payer (e.g., Medicaid, private insurance, etc.).

Coverage does not guarantee that providers of services already rendered will accept CSHCS payment. CSHCS does not reimburse families directly for payments made to providers.

8.3 Partial Month Coverage

If a client enters or leaves a facility that is not a covered facility (e.g., nursing home, or intermediate care facility) during a month of eligibility, the client remains a CSHCS client for the remainder of that month. However, services provided to the client while in the facility are not covered (i.e., reimbursable) by CSHCS, as these facilities are responsible for providing the medical care. (Refer to the General Information for Providers Chapter in this manual for additional information for clients who also have Medicaid coverage.)

8.4 Renewal of Coverage

The client's coverage may be renewed as needed if all eligibility criteria continue to be met and the family completes the renewal process. Medical review reports are required according to the time frames established based on the primary diagnosis for the client. An annual financial review is also required. If all of the criteria continue to be met for CSHCS coverage, a new coverage period is typically issued in 12-month increments.

SECTION 9 – BENEFITS

CSHCS covers services that are medically necessary, related to the client's qualifying diagnosis(es), and ordered by the client's CSHCS authorized specialist(s) or subspecialist(s). Services are covered and reimbursed according to Medicaid policy unless otherwise stated in this chapter.

The primary CSHCS benefits may include:

- Ambulance
- Care Coordination*
- Case Management*
- Dental (Specialty and General, Refer to the Dental Sections)
- Dietary Formulas (limited)
- Durable Medical Equipment (DME)
- Emergency Department (ED)
- Hearing and Hearing Aids
- Home Health (intermittent visits)
- Hospice*
- Hospital at approved sites (Inpatient/Outpatient)
- Incontinence Supplies
- Laboratory Tests
- Medical Supplies
- Monitoring Devices (Nonroutine)
- Office Visits to CSHCS Authorized Physicians
- Orthopedic Shoes
- Orthotics and Prosthetics
- Parenteral Nutrition
- Pharmacy
- Physical/Occupational/Speech Therapy
- Radiological Procedures
- Respite*
- Transplants and Implants
- Vision

(* Refer to the information and authorization requirements stated in this Section.)

Private Duty Nursing (PDN) may be available for CSHCS clients who also have Medicaid coverage.

9.1 SPECIALTY DENTAL BENEFITS

Refer to the Dental chapter of this manual for details regarding dental service coverage and limitations.

Specialty dentistry is limited to specific CSHCS qualifying diagnoses and refers to services routinely performed by dental specialists. Examples include: orthodontia, endodontia, prosthodontia, oral surgery and orthognathic surgery. CSHCS diagnoses covered for specialty dental services include:

- Amelogenesis imperfecta, Dentinogenesis imperfecta

- Anodontia which has significant effect of function
- Cleft palate/cleft lip
- Ectodermal dysplasia or epidermolysis bullosa with significant tooth involvement
- Juvenile periodontosis
- Juvenile rheumatoid arthritis and related connective tissue disorders with jaw dysfunction secondary to tempromandibular joint arthritic involvement
- Post-operative care related to neoplastic jaw disease
- Severe malocclusion requiring orthognathic surgery
- Severe maxillofacial or cranialfacial anomalies that require surgical intervention
- Traumatic injuries to the dental arches

To request approval as a CSHCS provider, dentists must contact MDCH. (Refer to the Directory Appendix for contact information.)

9.2 General Dental Benefits

General dentistry refers to diagnostic, preventive, restorative and oral surgery procedures. MDCH may determine a client eligible for certain general dentistry services when the CSHCS qualifying diagnosis is related to conditions eligible for this coverage as identified below:

- Chemotherapy or radiation which results in significant dental side effects
- Cleft lip/ palate/ facial anomaly
- Convulsive disorders with gum hypertrophy
- Cystic Fibrosis
- Dental care that requires general anesthesia in an inpatient or outpatient hospital facility for those with certain CSHCS diagnoses
- Hemophilia and/or other coagulation disorders
- Pre- and post-transplant

To request approval as a CSHCS provider, dentists must contact MDCH. (Refer to the Directory Appendix for contact information.)

9.3 Care Coordination Benefit

Clients enrolled in CSHCS with identified needs may be eligible to receive Care Coordination services.

Care Coordination services may be provided by the local health department. LHD staff includes registered nurses (RNs), social workers, or paraprofessionals under the direction and supervision of RNs. Staff must be trained in the service needs of the CSHCS population and demonstrate skill and sensitivity in communicating with children with special needs and their families.

Care Coordination is not reimbursable for clients also receiving Case Management services during the same LHD billing period, which is usually a calendar quarter. In the event Care Coordination services are no longer appropriate, and Case Management services are needed, the change in services may only be made at the beginning of the next billing period.

Clients/families can contact the LHD for assistance in obtaining care coordination services.

9.4 Case Management Benefit

CSHCS clients may be eligible to receive Case Management services if they have complex medical care needs and/or complex psychosocial situations which require that intervention and direction be provided by an outside, independent professional. Eligible clients include, but are not limited to, the Private Duty Nursing (PDN) population. LHDs or their contractors may provide Case Management services. Case Management requires the development of a comprehensive plan of care (POC) meeting the minimum elements as determined by MDCH. All services must relate to objectives/goals documented in the POC.

Case Management requires that services be provided in the home setting or other noninstitutional settings based on family preference, and be provided face-to-face. Clients are eligible for a maximum of six billing units per eligibility year. Services above the maximum of six would require prior approval by MDCH. To request approval, the Case Management provider must send a detailed request including documentation and the rationale for additional services to MDCH. (Refer to the Directory Appendix for contact information.)

Each case manager must be licensed to practice as a registered professional nurse in the State of Michigan and be employed as a Public Health nurse at the entry level or above by a LHD, or be able to demonstrate to MDCH that comparable qualifications are met.

Case Management is not reimbursable for clients also receiving Care Coordination services during the same LHD billing period, which is usually a calendar quarter. In the event Case Management services are no longer required, but Care Coordination services would be of assistance, the change may only be made at the beginning of the next billing period.

Clients/families can contact the LHD for assistance in obtaining case management services.

9.5 Hospice Benefit

Hospice provides assistance to the family when palliative care and treatment are appropriate services for the client. Hospice is intended to maximize quality of life when there is no reasonable expectation of recovery. To be eligible and authorized for hospice, MDCH must receive a medical report for review that includes:

- A statement that the client has reached the terminal phase of illness where the physician deems palliative measures necessary and appropriate rather than the ongoing aggressive treatment typically engaged for curative measures;
- Documentation from the treating specialty physician, indicating the need to pursue the palliative measures;
- A statement of limited life expectancy (approximately six months or less); and
- A proposed plan of care for services that are consistent with the philosophy/intent of hospice and are clinically and developmentally appropriate to the client's needs and abilities.

Requests for hospice care must address the criteria above and be made in writing to MDCH. (Refer to the Directory Appendix for contact information.) MDCH responds to all requests for hospice services in writing.

9.6 Respite Benefit

Respite services provide limited and temporary relief for families caring for clients with complex health care needs when the care needs require nursing services in lieu of the trained caregivers. Services are provided in the family home by hourly skilled and licensed nursing services as appropriate. To be eligible and authorized for respite, MDCH must determine the CSHCS client to have:

- Health care needs that meet the following criteria:
  - That skilled nursing judgments and interventions to be provided by licensed nurses in the absence of trained and/or experienced parents/caregivers responsible for the client's care;
  - That the family situation requires respite; and
  - That no other community resources are available for this service.
- No other publicly or privately funded hourly skilled nursing services in the home.
- Service needs which can reasonably be met only by the CSHCS Respite benefit, not by another service benefit.

A maximum of 180 hours of CSHCS Respite services may be authorized per family during the 12-month eligibility period. When there is more than one respite-eligible client in a single home, the respite service is provided by one nurse at an enhanced reimbursement rate for the services provided to multiple clients. Allotted respite hours may be used at the discretion of the family within the eligibility period. Unused hours from a particular eligibility period are forfeited at the end of that period and cannot be carried forward into the next eligibility period.

Clients receiving services through any of the following publicly funded programs and benefits are not eligible for the CSHCS Respite benefit:

- Private Duty Nursing Benefit
- Children's Waiver
- Habilitation/Support Services Waiver
- MI Choice Waiver

Requests for respite must be made in writing to MDCH (refer to the Directory Appendix for contact information), and include the following information:

- The health care needs of the child;
- The family situation that influences the need for respite; and
- Other community resources or support systems that are available to the family (e.g., CMH services, DHS services, adoption subsidy, SSI, trust funds, etc.).

MDCH responds to all requests for respite in writing.

9.7 Insurance Premium Payment Benefit

Clients may lose private insurance coverage due to a change in family circumstances (loss of job, etc.) or have difficulty continuing to pay the insurance premium. In some cases, CSHCS may consider paying the cost of the insurance premium or Medicare Part B if requested and if it is deemed by MDCH to be cost-effective. The LHD assists families who would like to be considered for this benefit.

SECTION 10 – OUT-OF-STATE MEDICAL CARE

CSHCS covers out-of-state **emergency** medical care when services are related to the qualifying diagnosis. Emergency medical care is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the client;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Nonemergency medical care related to the qualifying diagnosis is defined as not meeting the definition of emergency medical care and is covered out-of-state only when comparable care cannot be provided within the State of Michigan and:

- The service is prior authorized by MDCH;
- Medicare has paid part of the service and the provider is billing for the coinsurance and/or deductibles; or
- The service has been determined medically necessary by MDCH (either pre- or post-service) because the client's health would be endangered if he were required to travel back to Michigan for services.

Medical care provided in borderland areas is allowed without application of the Out-of-State Medical Care criteria if the provider is enrolled in the Michigan Medicaid Program. Borderland is defined as counties outside of Michigan that are contiguous to the Michigan border and the major population centers (cities) beyond the contiguous line as recognized by MDCH. (Refer to the General Information for Providers Chapter of this manual for more information.)

The LHD CSHCS offices authorize and assist families with travel for care received in borderland areas in the same manner as for travel in state.

SECTION 11 – TRAVEL ASSISTANCE [CHANGE MADE 4/1/06]

CSHCS reimburses for travel to assist clients in accessing and obtaining authorized specialty medical care and treatment (in-state and out-of-state, **(corrected 4/1/06)** as appropriate) when the family's resources for the necessary travel poses a barrier to receiving care. Travel assistance is allowed for the client and one adult to accompany the client. The treatment must be related to the qualifying medical diagnosis and provided by a CSHCS approved provider. The travel benefit is not intended to assume the entire cost for the expenses incurred.

11.1 IN-STATE TRAVEL

Requests for transportation assistance must be made as follows:

- Clients who are not covered by Medicaid, must request travel assistance from the LHD.
- Clients who have Medicaid coverage can request travel assistance from the LHD when travel assistance from DHS is unavailable. Travel must be related to the CSHCS qualifying diagnosis. If the request for travel is not related to the CSHCS qualifying diagnosis, but is a Medicaid covered service, the LHD will refer the family to the local DHS for assistance.

To be eligible and authorized for CSHCS in-state travel assistance, the client must be determined by MDCH to meet the following criteria:

- The client has CSHCS coverage at the time of the travel*;
- The Travel Assistance is for obtaining CSHCS specialty medical care and treatment from a CSHCS approved provider for the CSHCS medically-eligible diagnosis;
- The client/family lacks the financial resources to pay for all or part of the travel expenses;
- Other travel/financial resources are unavailable or insufficient; and
- The mode of travel to be used is the least expensive and most appropriate mode available.

Travel to borderland providers is considered the same as travel to in-state providers and follows the same requirements and rules.

Clients who meet the criteria outlined in this policy are eligible for transportation assistance through CSHCS and are reimbursed according to the allowable amount established by MDCH. Rates are reviewed at least annually and published on the MDCH website. (Refer to the Directory Appendix for website information.)

Reimbursement for CSHCS clients with Medicaid coverage, who request in-state travel assistance from their local DHS office, is provided in accordance with the Medicaid/DHS transportation policy.

* Travel assistance may be authorized for individuals who do not have CSHCS, but need travel assistance to participate in a diagnostic evaluation that is performed for the purpose of determining CSHCS eligibility. There must be verification that no other resources are available and the individual is otherwise unable to access the site of the diagnostic evaluation

11.2 Out-of-State Travel

Requests for transportation for out-of-state travel assistance must be made as follows:

- Clients who are not covered by Medicaid, must request travel assistance from the LHD or by calling the CSHCS Family Phone Line. (Refer to the Directory Appendix for contact information.)
- Clients who have Medicaid coverage can request travel assistance from the LHD. Travel must be related to the CSHCS qualifying diagnosis. If the request for travel is not related to the CSHCS qualifying diagnosis, but is a Medicaid covered service, the LHD will refer the family to the local DHS for assistance.

To be eligible and authorized for CSHCS out-of-state travel assistance, the client must be determined by MDCH to meet the following criteria:

- The client has CSHCS coverage at the time of the travel;
- Comparable medical care is not available to the client within the State of Michigan or borderland areas;
- The travel assistance is for obtaining CSHCS specialty medical care and treatment from a CSHCS approved provider for a CSHCS medically-eligible diagnosis(es);
- Prior approval for the out-of-state medical care and treatment was obtained from MDCH before the travel assistance was requested;
- Prior approval for travel assistance has been obtained;
- The client/family lacks the financial resources to pay for all or part of the travel expenses;
- Other travel/financial resources are unavailable or insufficient; and
- The mode of travel to be used is the least expensive and most appropriate mode available.

Travel assistance consists of reimbursement up to the allowable amount established by MDCH. Rates are reviewed at least annually and published on the MDCH website. (Refer to the Directory Appendix for website information.)

11.3 Travel Reimbursement for CSHCS Only Clients

Transportation	▪ Actual mileage by private car to and from the health care service. Mileage is reimbursed according to the rate established by MDCH. ▪ Parking costs and highway, bridges, and tunnel tolls require original receipts. ▪ Bus or train fare, when it is the least expensive, most appropriate mode of transportation available and supported by original receipts. ▪ Air travel must be arranged by MDCH through the State-approved travel. The family cannot be reimbursed for airline tickets they have booked themselves, unless prior approval to purchase the tickets was obtained from MDCH.

Lodging	The client must be required to stay overnight to obtain in-patient or out-patient treatment related to the CSHCS covered diagnosis, performed by a CSHCS approved provider and at a CSHCS approved medical facility in order for the family to be reimbursed for lodging. ▪ Inpatient Requirements: Reimbursement is for the accompanying adult as needed. ▪ Outpatient Requirements: Reimbursement is for the client and the accompanying adult as needed. MDCH reimburses lodging up to the allowable amount established by MDCH, regardless of cost. Original receipts are required.
Meals	Meal expenses are only reimbursable for out-of-state travel when they have occurred as the result of a necessary and prior approved daily or overnight stay(s). The stay must be for an inpatient or an outpatient treatment that is related to the CSHCS covered diagnosis, performed by a CSHCS approved provider, and at a CSHCS approved facility. Meals are not reimbursed for in-state or borderland travel. ▪ Inpatient Requirements: ➢ Meal reimbursement is for the client and accompanying adult during travel time if applicable, and only for the accompanying adult during the period of client hospitalization. ➢ Meals are reimbursed up to the allowable amount established by MDCH or the actual cost submitted on a receipt, whichever is less. ▪ Outpatient Requirements: ➢ Meal reimbursement is for the accompanying adult and the CSHCS client. ➢ Meals are reimbursed up to the allowable amount established by MDCH or the actual cost submitted on a receipt, whichever is less.

11.4 NONEMERGENCY MEDICAL TRANSPORTATION

Nonemergency Medical Transportation (e.g., Ambu-cabs, Medi-Vans, etc.) must be prior approved by the LHD. Payment is made directly to the transportation provider by MDCH. The client/family should not pay the provider directly since the client/family cannot be reimbursed.

To be eligible and authorized for the Nonemergency Medical Transportation service, the client must be:

- Wheelchair bound;
- Bed bound; or
- Medically dependent on life sustaining equipment which cannot be accommodated by standard transportation

11.5 Emergency and Special Transportation Coverage

CSHCS follows the same policies and procedures regarding emergency and special medical transportation coverage as the Medicaid Program. Coverage must be related to the CSHCS qualifying diagnosis. (Refer to the Ambulance Chapter of this manual for additional information.)

An additional person, such as a donor related to the medical care of the client, may be considered for the travel assistance when approved by a MDCH medical consultant. The treating specialist must provide CSHCS with documentation of the relationship between the client and the additional person.

SECTION 12 – INTERACTION WITH OTHER PROGRAMS

Clients may have coverage through CSHCS and another program simultaneously.

12.1 MEDICAID

Clients may have both Medicaid and CSHCS coverage. For services not covered by CSHCS and covered by Medicaid (primary care, other specialty services, etc.), the client must comply with Medicaid requirements.

12.2 MICHILD

Clients may have both MIChild and CSHCS coverage. For services not covered by CSHCS and covered by MIChild, the client must comply with MIChild requirements. CSHCS is not considered health insurance for purposes of MIChild eligibility.

12.3 TRANSITIONAL MEDICAL ASSISTANCE (TMA AND TMA-PLUS)

Clients may have both TMA and CSHCS or TMA-Plus and CSHCS coverage. For services not covered by CSHCS and covered by TMA or TMA-Plus, the client must comply with TMA and TMA-Plus requirements.

12.4 MATERNAL OUTPATIENT MEDICAL SERVICES

Clients may have both MOMS and CSHCS coverage. For services not covered by CSHCS and covered by MOMS, the client must comply with MOMS requirements.

12.5 ADULT BENEFITS WAIVER

Clients may have both Adult Benefits Waiver (ABW) and CSHCS coverage. CSHCS is not considered health coverage for purposes of ABW eligibility. For services not covered by CSHCS and covered by ABW, the client must comply with ABW requirements.

12.6 COURT-ORDERED MEDICAL INSURANCE

CSHCS cannot be used as court-ordered medical insurance.

12.7 DEPARTMENT REVIEWS

CSHCS clients without Medicaid coverage are entitled to appeal MDCH negative actions, and to a Department Review when they have been denied CSHCS eligibility or services, or when established CSHCS services have been reduced, changed, or terminated. The client will be notified in writing of the negative action and the right to appeal. CSHCS follows the same appeal and request for hearing policies and procedures as established by MDCH for all MDCH programs.

12.8 Administrative Hearings

CSHCS clients who also have Medicaid coverage have a right to an Administrative Hearing when services have been denied, reduced, changed or terminated. The client will be notified in writing of the negative action and the right to appeal. The requesting client may receive an Administrative Hearing if the circumstances suggest that Medicaid reimbursement is involved in the coverage or service in question. The requesting client may receive a Department Review if the circumstances indicate that Medicaid reimbursement is in no way involved in the coverage or service in question. The MDCH Administrative Tribunal determines which hearing is appropriate once a client has requested a hearing.

CHIROPRACTOR

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Chiropractors (Provider Type 14).

1.1 MEDICAL NECESSITY

Determination of medical necessity and appropriateness of service is the responsibility of chiropractors within the scope of accepted medical practice and Medicaid limitations. Chiropractors are held responsible if excessive or unnecessary services are ordered, regardless of who actually renders these services (e.g., x-rays), or if reimbursement is received for the service. Chiropractors are subject to any corrective action related to these services, including recovery of funds.

1.2 BENEFICIARY CO-PAYMENT

Beneficiaries age 21 and older are required to pay a $1.00 co-payment for each Medicaid reimbursable chiropractic visit. Beneficiaries who reside in a nursing facility (NF) are exempt from the co-payment.

When more than one reimbursable service is provided during one visit (e.g., spinal manipulation and x-ray on the same date of service [DOS]), only a single $1.00 co-payment may be charged to the beneficiary.

Providers may not refuse to render service if a beneficiary is unable to pay the co-payment amount at the time the service is provided. However, the uncollected co-payment is considered a bad debt which allows the provider to refuse to provide future services according to Michigan's State Plan. Providers who elect not to provide services based on a history of bad debt, including unpaid co-payments, must give beneficiaries appropriate verbal notice and a reasonable opportunity for payment.

When billing Medicaid for the service, chiropractors should bill their usual and customary (U&C) charge (i.e., without any adjustment for the co-payment). Upon approval of the service, the Michigan Department of Community Health (MDCH) automatically deducts the co-payment. If the chiropractor deducts the co-payment from the charge billed, an underpayment may result.

1.3 OTHER INSURANCE AND MEDICARE SERVICES

It is the chiropractor's responsibility to question the beneficiary regarding Medicare and other insurance coverage prior to providing the service. Medicaid is the payer of last resort. Payment must be sought from other third party payers before submitting claims to MDCH. (Refer to the Coordination of Benefits Chapter of this manual for additional information.)

1.4 NURSING FACILITY

Chiropractors may render manual spinal manipulations to beneficiaries in a NF as an ancillary service. The attending physician (MD or DO) must order all ancillary services, including chiropractic services. The chiropractor must keep and make available complete records of the services provided.

SECTION 2 – COVERED SERVICES

2.1 MANUAL SPINAL MANIPULATION

Medicaid covers medically necessary chiropractic services rendered by a chiropractor for the treatment of a diagnosed condition of subluxation of the spine. The subluxation must be demonstrable on x-rays.

Spinal manipulation is the only covered chiropractic procedure. (Refer to the Codes Section of this chapter for additional information.) Only one of the spinal manipulation procedure codes is billable per day, per beneficiary. Clinical signs and symptoms must be consistent with the level of subluxation.

If documentation other than x-rays supports the medical necessity of spinal manipulation for children, the x-ray requirement may be waived. Medicaid reserves the right to request x-ray documentation if deemed necessary.

Medicaid reimburses up to 18 chiropractic visits per calendar year.

2.2 PRIOR AUTHORIZATION INSTRUCTIONS

If additional visits during the calendar year are medically necessary, providers must submit a prior authorization (PA) request before performing manipulations that exceed the 18-visit limit. Submit a written request to the MDCH Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

The letter requesting PA must:

- Provide beneficiary name and Medicaid identification (ID) number;
- Specify height;
- Specify weight;
- Provide the date of onset of current complaint and the frequency of visits to date; including a brief history of complaint, initial symptoms and significant symptom characteristics;
- Indicate level of subluxation and associated diagnosis; including complications or predisposing conditions, if present;
- Specify physical and objective findings;
- Specify radiographic findings, including significant findings in support of diagnosis;
- Indicate the patient's response to current treatment (improvement to date, if any);
- Provide an estimate of continued treatment necessary for current complaint;
- Provide expected and anticipated benefit of continued treatment; and
- Include any additional details, comments, etc. that may be of assistance in the evaluation.

The PA request is reviewed and a notice is returned to the provider stating the approval or denial of the request. If approved, the provider is notified of the number of additional visits granted. Providers are also given a nine-digit PA number that must be placed in the PA field on the claim form when billing for the additional services. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for claim completion instructions.)

2.3 X-Ray Services

A chiropractor may order, and be reimbursed for, no more than one set of spinal x-rays per beneficiary, per year. If more than two procedures are provided for the beneficiary on the same date of service, the service must be combined and billed as one inclusive procedure code, such as the entire radiologic examination of the spine with survey study, anteroposterior and lateral.

SECTION 3 – CODES

3.1 DIAGNOSTIC CODES

Chiropractors must use at least one diagnosis code in conjunction with the procedure codes when billing chiropractic services. MDCH follows the Medicare diagnosis coding requirements for chiropractic services.

3.2 PROCEDURE CODES

Chiropractors must use at least one appropriate procedure code from the Current Procedure Terminology (CPT) and Health Care Financing Administration Common Procedure Coding System (HCPCS) coding manuals. A list of procedure codes covered by MDCH is maintained on the MDCH website. (Refer to the Directory Appendix for website information.)

SECTION 4 – NONCOVERED SERVICES

Chiropractic services excluded from Medicaid coverage are all services other than manual manipulation of the spine and spinal x-rays. Medicaid does not cover the following services when rendered by a chiropractor:

- Consultations
- Fracture care
- Home visits
- Injections
- Laboratory tests
- Maintenance therapy
- Medical supplies
- Evaluation and management services
- Plaster casts
- Inpatient hospital visits

DENTAL

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Dentists/Dental Clinics (Provider Types 12, 74).

The primary objective of Medicaid is to ensure that essential medical/dental services are made available to Medicaid beneficiaries. Medicaid goals are aimed at making the best use of Medicaid resources and assuring the quality of medically necessary health care services provided to Medicaid beneficiaries.

Determination of medical necessity and appropriateness of services is the responsibility of the dentist, within the scope of current accepted dental practice and the limitations of Medicaid (e.g., the prior authorization [PA] process).

In cases where the Michigan Department of Community Health (MDCH) determines that the dentist did not provide a service within the scope of current accepted dental practice or the service was not provided within the limitations of Medicaid, MDCH may:

- Require the service to be immediately provided;
- Require the dentist to repeat the service at no additional charge;
- Refuse payment to the dentist for the service; or
- Recover from the dentist reimbursement made for the service.

Dental services that may be provided to all Medicaid beneficiaries include emergency, diagnostic, preventive, and therapeutic services for dental disease which, if left untreated, would become acute dental problems or cause irreversible damage to teeth or supportive structures.

Dental benefits are available to beneficiaries under 21 years of age through Medicaid, which provides Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Upon completion of a well-child visit (EPSDT), providers must refer beneficiaries to a dental provider for a thorough dental examination. It is recommended that a dental appointment be made every six months and that it include a complete dental examination, appropriate x-rays, and preventive care such as a prophylaxis and fluoride treatment. If additional treatment is needed, follow-up dental visits are to be scheduled at the end of the examination so dental treatment can be completed.

Beneficiaries age 21 and older receive dental benefits that are more limited in coverage. Dental benefits are provided through the Medicaid fee-for-service (FFS) Program. Medicaid Health Plans (MHPs) are not responsible for the coverage of dental benefits for their enrolled beneficiaries.

Dentists providing specialty dental services to Children's Special Health Care Services (CSHCS) Program beneficiaries should refer to CSHCS Dental Services Section of this chapter and the Dental Procedure Code Database on the MDCH website for coverages and limitations. (Refer to the Directory Appendix for website information.)

SECTION 2 - PRIOR AUTHORIZATION

Prior authorization (PA) must be obtained for certain services identified in this chapter and those dental services identified as requiring PA in the Dental Procedure Code Database posted on the MDCH website. (Refer to the Directory Appendix for website information.) PA request is needed only for those services requiring PA.

2.1 PRIOR AUTHORIZATION REQUIREMENTS IN CASES OF OVER-UTILIZATION

MDCH may require a dentist found to be misutilizing services to obtain PA for all or selected dental services separate from those generally requiring authorization. MDCH is required to explain to the dentist, in writing, the reasons for applying this requirement.

2.2 COMPLETION INSTRUCTIONS

The Dental Prior Approval Authorization Request form (MSA-1680-B) is used to obtain authorization. (Refer to the Forms Appendix for instructions for completing the form.) When requesting authorization for certain procedures, dentists may be required to send specific additional information and materials. Based on the MSA-1680-B and the documentation attached, staff approves or disapproves the request and returns a copy to the dentist. Approved requests are assigned a PA number. For billing purposes, the PA number must be entered in the appropriate field on the claim form. An electronic copy of the MSA-1680-B is available on the MDCH website. (Refer to the Directory Appendix for website information.)

2.3 TOLL-FREE PHONE NUMBER

MDCH has a toll-free telephone number for dentists to call the Dental Prior Authorization Unit. (Refer to the Directory Appendix for contact information.). Dentists and their staff may call this number for information on previous PA requests, status of their current requests, and to update PA requests. To assist in the efficient use of this service, providers and their office staffs are encouraged to have the beneficiary's file, including all necessary data and information, ready for immediate reference each time a call is made.

All other inquiries, such as billing problems, should be directed to Provider Inquiry. (Refer to the Directory Appendix for contact information.)

2.4 APPROVED PRIOR AUTHORIZATION REQUESTS

An approved PA request confirms that the beneficiary meets Medicaid's established medical criteria for the services and that the services are Medicaid-covered benefits. **This approval does not guarantee eligibility nor verify a beneficiary's age. It is also not to be considered an authorization for payment.**

The dentist is responsible for verifying the beneficiary's Medicaid eligibility and age by checking the Eligibility Verification System (EVS). Eligibility should be verified prior to each appointment. (Refer to the Beneficiary Eligibility Chapter for additional information and the Directory Appendix for contact information.)

PA is granted to the dentist requesting authorization. It may be transferred or used by another dentist within the same group at the same address without contacting the Dental Prior Authorization Unit. When the patient will be treated at a different location, a new PA request must be submitted to the Prior Authorization Unit.

If a MSA-1680-B is approved under a given provider identification (ID) number and, in the course of providing the approved services the dentist's provider ID number is changed by the Provider Enrollment Unit, he must contact the Dental Prior Authorization Unit regarding the change and affected PA request(s).

While a beneficiary is eligible, all treatment authorized must be completed within 180 days from the date of authorization. If treatment is not completed within the 180 days, the PA request must be updated before continuing treatment.

Providers may update the PA request by contacting the Dental Prior Authorization Unit by phone or fax if there are no treatment plan changes. (Refer to the Directory Appendix for contact information.)

If a change in the treatment plan is necessary, dentists should submit a new MSA-1680-B with appropriate films and information to the Dental Prior Authorization Unit.

If a PA request is denied, the dentist receives a denial notice. The beneficiary also receives a notice of denial for the requested service along with their notice of appeal rights.

2.5 Loss or Change in Eligibility

No service is covered after loss of eligibility except for Root Canal Therapy, Complete and Partial Dentures, and Laboratory-Processed Crowns. Reimbursement is only made if the following specific conditions exist:

- Services must have been started prior to the loss of eligibility. For complete or partial dentures and laboratory-processed crowns, impressions must have been taken prior to the loss of eligibility.
- Services must be completed within 30 days of change and/or loss of eligibility.
- For complete or partial dentures and laboratory-processed crowns after loss of eligibility, the date of service on the claim should be the date of the initial impression.
- This does not apply to immediate dentures.

If a beneficiary's Medicaid eligibility is terminated after extractions have been performed, the extractions themselves do not qualify the beneficiary for dentures.

In the case of a beneficiary's death where denture services have commenced but have not been delivered, the dentist should use the Not Otherwise Classified (NOC) procedure code, include a copy of the lab bill, and an explanation in the Remarks section of the claim. Providers are paid a reduced rate to cover the lab costs that have incurred.

SECTION 3 - CO-PAYMENT

Beneficiaries age 21 and older are required to pay a $3.00 co-payment for each separately reimbursable visit:

Beneficiaries under the age of 21 and those who reside in a long term care nursing facility are exempt from co-payments.

- When more than one reimbursable service is provided during a visit, only one $3.00 co-payment may be charged.
- Where several visits are required to complete a service, such as dentures, only one $3.00 co-payment may be charged.
- Beneficiaries cannot be charged a co-payment for infection control, sterilization or for other routine procedures that are considered part of normal office operations.

Providers may not refuse to render service if a beneficiary is unable to pay the co-payment amount at the time the service is provided. However, the uncollected co-payment is considered a bad debt which allows the provider to refuse to provide future services according to Michigan's State Plan. Providers who elect not to provide services based on a history of bad debt, including unpaid co-payments, must give beneficiaries appropriate verbal notice and a reasonable opportunity for payment.

SECTION 4 - PLACE OF SERVICE

All dental services must be performed in the dental office, public health department dental clinic, dental school, dental hygiene program or by state, county or Federally Qualified Health Centers (FQHCs). Special situations may necessitate the provision of services at a different site such as a hospital or nursing facility.

4.1 HOSPITAL SETTING

4.1.A. PROVISION OF CARE IN THE INPATIENT OR OUTPATIENT SETTING

Admission to an inpatient or outpatient hospital setting for any **nonemergency dental service** is covered for beneficiaries for the following conditions:

- The patient has a concurrent hazardous medical condition;
- The nature of the procedure requires it to be performed in a hospital setting; or
- Other contributing factors, such as age, behavioral problems due to mental impairment, etc., necessitate hospitalization.

The dentist/physician must document in the beneficiary's medical record the condition that required the dental service to be done in the hospital setting.

Hospitalization is not a benefit for the convenience of the dentist or beneficiary or because of apprehension on the part of the beneficiary.

4.1.B. AUTHORIZATION INSTRUCTIONS

For FFS beneficiaries, no special authorization is needed for dental services performed in the outpatient setting. For elective inpatient admissions, the dentist must call the Pre-Admission and Certification Evaluation Review (PACER) system for a PACER number. The PACER number is placed in the Remarks Section of the Dental Invoice. (Refer to the Directory Appendix for contact information.)

For beneficiaries enrolled in a MHP, the dentist must contact the appropriate MHP to receive authorization to perform dental services in the hospital setting. The MHP provides authorization when determined medically necessary based on the contributing factors identified above. The name and telephone number of the MHP that the beneficiary is enrolled in can be obtained by calling the EVS.

4.1.C. SERVICES PERFORMED IN THE OPERATING ROOM SETTING

For services performed in the Operating Room (OR) setting, the dentist should use the usual and customary (U & C) fee for the service as performed in an office setting. In addition, the procedure code **Hospital Call** may also be billed if services are provided in the OR setting. This code may be billed in addition to the appropriate dental procedure code for the actual service performed. This procedure code is not for administrative purposes, such as arranging appointment times, gathering signatures for release forms, etc.

4.2 Nursing Facility

Dental services that may be provided to a beneficiary in a nursing facility are the same as those identified in the Covered Services Section of this chapter.

Dental services (including dental examinations) provided to a beneficiary in a nursing facility must be upon the written order of a licensed physician (MD, DO). The order must be signed and dated by the physician, and the facility must retain a copy in the beneficiary's medical record.

When an oral examination is provided in a nursing facility, a notation must be made in the beneficiary's medical record of the chief complaint, current oral health status, appropriate health history and services to be rendered.

4.3 Other Sites

All other sites must be prior approved and will only be approved if the patient's medical condition precludes the ability to travel. In order to receive prior authorization (PA), the dental provider must complete the Dental Prior Approval Authorization Request form (MSA-1680-B) for each individual and submit it to the Prior Authorization Section. (Refer to the Forms Appendix for a copy of the form.) Providers should follow the same instructions for submission of the PA request for site of service as they do requests for procedures.

At a minimum, equipment to be present at the site for the service delivery must include a focused light, portable dental chair and portable x-ray equipment. The minimum amount of time for a prophylaxis to be completed is 20 minutes for a child and 40 minutes for an adult.

SECTION 5 - ANCILLARY SERVICES

5.1 PHARMACY SERVICES

Medicaid has a list of covered drugs that include selected legend and over-the-counter drugs. The intent is to maintain coverage of economical products for most drugs. Medicaid does not reimburse dentists for drugs dispensed in the office setting. For those beneficiaries enrolled in a MHP, dentists should refer to the MHP's formulary for the list of approved drugs.

Prescribed quantities should be limited to an amount necessary to keep the beneficiary supplied during the therapeutic regimen. In certain cases and conditions, more than a month's supply is appropriate while, for other conditions, more frequent monitoring is essential. However, in no instance may the dentist prescribe a drug for more than a 100-day supply.

Dentists should include their Drug Enforcement Agency (DEA) number on prescriptions written for Medicaid beneficiaries.

5.2 MEDICAL LABORATORY SERVICES

Medically necessary laboratory services ordered by dentists are a Medicaid benefit. Only the provider who performs the service may bill for the service.

Dentists should use their nine-digit Medicaid provider ID Number on medical laboratory service orders written for Medicaid beneficiaries. (The laboratory is required to provide this information when billing.)

SECTION 6 - COVERED SERVICES

This section provides information on Medicaid covered services and is divided into the following subsections that correspond to the categories of services in Current Dental Terminology (CDT) as published by the American Dental Association.

- Diagnostic Services
- Preventive Services
- Restorative Treatment
- Endodontics
- Periodontics
- Prosthodontics (Removable)
- Oral Surgery
- Adjunctive General Services

Providers must use the current CDT procedure codes published by the American Dental Association (ADA) when completing both the claim and PA form. Procedure codes covered by MDCH are listed in the Dental Procedure Code Database on the MDCH website. (Refer to the Directory Appendix for website information.) PA must be obtained for certain services identified in this section.

6.1 DIAGNOSTIC SERVICES

6.1.A. CLINICAL ORAL EVALUATION (EXAMINATIONS)

A periodic, comprehensive or problem-focused evaluation is considered a benefit for all beneficiaries only if detailed written documentation of medical and dental findings (both negative and positive) and tests are included in the beneficiary's dental record. (Refer to the General Information for Providers Chapter for additional information.) Typically, it should include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, periodontal conditions, occlusal relationships, hard and soft tissue anomalies, oral cancer screening, prosthesis condition and usage, etc. Examinations without this documentation are not a covered benefit.

6.1.B. COMPREHENSIVE ORAL EVALUATION

A comprehensive oral evaluation must include a documented medical and dental history, a thorough evaluation and recording of the condition of extraoral and intraoral hard and soft tissues, including a complete charting of the condition of each tooth and supporting tissues, occlusal relationships, periodontal conditions, including periodontal charting, oral cancer screening, and appropriate radiographic studies (which are separately reimbursable). The comprehensive oral evaluation is a covered benefit for all beneficiaries. In addition, a complete treatment plan must be included that addresses the beneficiary's needs.

6.1.C. Periodic Oral Evaluation

A periodic oral evaluation is an examination to determine any changes in a beneficiary's dental and medical health status since a previous comprehensive or periodic examination. The periodic oral evaluation must include a written update of the beneficiary's dental and medical history, clinically appropriate charting necessary to update and supplement the comprehensive oral examination data, including periodontal screening and appropriate radiographs (which are separately reimbursable) as necessary to update previous radiograph surveys. A periodic oral evaluation is a covered benefit once every six months for all beneficiaries. In addition, a complete treatment plan must be included that addresses the beneficiary's needs.

6.1.D. Limited Oral Evaluation - Problem Focused

A limited oral evaluation-problem focused exam consists of an examination for diagnosis and observation of a specific oral health problem or complaint, such as injuries to teeth and supporting structures. A limited oral evaluation must include appropriate recording of the beneficiary's medical and dental history, charting that is clinically appropriate for the particular problem. In addition, the findings, diagnosis, and treatment plan for the diagnosis must be included in the beneficiary's chart.

A limited oral evaluation can be billed in conjunction with radiographs and/or extractions (simple or surgical) and considered as a covered benefit. Routine restorative procedures, root canal therapy, elective surgery, and denture services are not considered emergency procedures and cannot be billed in conjunction with a limited oral evaluation. Limited oral evaluation-problem focused is a covered benefit for all ages.

6.1.E. Consultation

A consultation provided by another dentist or a physician (MD, DO) is a benefit for all beneficiaries. Medicaid defines a consultation as a service rendered by a physician/dental specialist whose opinion or advice is formally requested by another appropriate practitioner (e.g., physician, certified nurse-midwife [CNM], dentist) for the further evaluation and/or management of the beneficiary. The consultant does not render patient care or treatment. If a consultant assumes responsibility for any patient management or treatment, then all services subsequent to the consultation must be billed under the appropriate procedure code (e.g., exams, procedures). If a dentist provides a consultation, the only separately reimbursable services that may be provided in addition to the consultation are radiographs.

A consultation service includes examination and evaluation of the beneficiary, documentation of history and physical examination findings, recommendations, and submission of a written formal consultation report to the requesting practitioner. The dentist requesting the consultation cannot bill the consultation procedure code.

A consultation related to routine dental treatment (e.g., caries) is not a covered benefit.

6.1.F. Radiographs [Change Made 4/1/06]

Radiographs are benefits for all beneficiaries and are limited to that number medically necessary to make a diagnosis (other limitations apply to radiographs – see below). The Dental Procedure Code Database available on the MDCH website lists the radiographic codes for single, multiple or combination radiographs. (Refer to the Directory Appendix for website information.)

6.1.F.1. Complete Series

A full mouth or complete series is a covered benefit only once every five years for all beneficiaries.

A full mouth series consists of:

- A minimum of 10 intraoral films in conjunction with a minimum of two bitewings; or
- An intraoral/extraoral series of a panoramic film in conjunction with a minimum of two bitewings.

If any combination of intraoral films total 10 or more films, or the fee submitted for any set of radiographs exceeds the full mouth series fee, it is considered a full mouth series.

6.1.F.2. Bitewings

Bitewing radiographs are a covered benefit only once in a 12-month period for all beneficiaries.

6.1.F.3. Panoramic Radiographs

A panoramic radiograph is a covered benefit only once every five years for all beneficiaries.

Panoramic radiographs may be submitted as a separate reimbursable service for PA requests for replacement of existing complete dentures (i.e., the beneficiary is edentulous, has worn dentures for years and needs replacement dentures). In this case, the dentist may submit radiographs if they deem them necessary in the evaluation of the beneficiary's oral condition.

A panoramic film is not acceptable as a diagnostic tool for caries determination, periapical pathology or periodontal pathology. It is not covered for extractions in other than full mouth extraction cases or third molar extractions performed by an oral surgeon.

6.1.F.4. Copies of Full Mouth Series

When a beneficiary changes dental providers and has had a full mouth series of radiographs taken within the previous 12 months, the expectation is that the dental provider provides a copy of the radiographs to the new dental provider.

6.1.F.5. Radiograph Submission Requirements for Prior Authorization [Change Made 4/1/06]

In some cases, pre-op radiographs are necessary to document the presence and/or absence of teeth, related tooth structure, or related chronic pathology within the alveolar process(es).

A full mouth radiograph series must be submitted with PA requests for complete dentures in cases where beneficiaries are receiving their first denture. A full mouth radiograph series is optional for PA requests for replacement of existing complete dentures (i.e., the beneficiary is edentulous, has worn dentures for years and needs replacement dentures). In this case, the dentist may submit radiographs if they deem them necessary in the evaluation of the beneficiary's oral condition.

A full mouth radiograph series must be submitted with all PA requests for partial dentures.

A periapical film is required when submitting teeth that require PA for crown coverage.
(added 4/1/06 for clarification)

When requesting PA for procedures, the dentist may be required to send radiographs along with the request. (Information regarding the completion of the PA request and the submission of radiographs is contained in the Billing & Reimbursement for Dental Providers Chapter of this manual.)

6.1.F.6. Technical Considerations For Radiographs

Radiographs must meet the following technical considerations:

- All teeth or areas that are indicated on the PA form must be visible on the radiographs.
- Density and clarity of the radiograph must be such that radiographic interpretation can be made without difficulty by use of a conventional view box.
- On a periapical view, the apex of the tooth must be demonstrated clearly, as well as a minimum of one-eighth of an inch of surrounding bone.
- Where pathologic change is in question, healthy bone must be seen surrounding the questionable area.
- Interproximal bone must be visible without the overlapping of interproximal surfaces of teeth under consideration.
- Posterior teeth areas (e.g., demonstrated impactions, developing third molars) must be completely visible.

All radiographs submitted with the PA form must be mounted in an x-ray mount and identified with:

- The beneficiary's name and Medicaid ID Number;
- The date the radiograph was taken;

- The dentist's name, provider ID Number, and address; and
- "Right" and "Left" labels.

6.1.F.7. RETURNED RADIOGRAPFS

Technically unacceptable radiographs are returned to the dentist for replacement with no additional reimbursement provided.

Radiographs are returned to the dentist with the PA form.

6.1.F.8. PHOTOGRAPHS

Photographs are not reimbursed under Medicaid, but they may be submitted with the PA form as documentation to make the beneficiary's condition clearly visible.

For CSHCS beneficiaries, photographs are not separately reimbursable. They are part of the pretreatment records for orthodontic services.

6.1.F.9. OCCLUSAL FILM

An occlusal radiograph is a covered benefit for beneficiaries under age 21. Providers must use the occlusal film if billing the procedure. It is not the type of view that determines the procedure, it is the type of film used.

6.2 PREVENTIVE SERVICES

6.2.A. PROPHYLAXIS

Oral prophylaxis is a benefit for all beneficiaries. It includes routine scaling and debridement, as well as stain removal and polishing of the tooth surface.

Prophylaxis is a covered benefit once every six months.

If prophylaxis is provided, it must be billed only once, regardless of the number of visits necessary to complete it. If more than one visit is necessary to complete the service, the date of service used on the claim must be the date of the final visit.

6.2.B. TOPICAL APPLICATION OF FLUORIDE

Topical application of fluoride is a benefit for beneficiaries under age 16. It must be preceded by a complete oral prophylaxis on the same date of service and is covered only once every six months. The ADA Council on Dental Therapeutics must approve the fluoride. The topical application of fluoride via tray application or fluoride varnish are the methods covered.

The following types of fluoride treatment are not covered as a dental benefit:

- Treatment that incorporates fluoride with the polishing compound (this is considered to be part of the prophylaxis procedure and is not separately reimbursable);
- Topical application of fluoride to the prepared portion of a tooth prior to restoration;
- Fluoride rinses;
- The use of self or home fluoride application procedures; or
- Fluoride tablets or capsules prescribed by the dentist (may be covered as a pharmacy benefit for beneficiaries under the age of 10).

6.2.C. SEALANTS

Coverage is limited to fully erupted permanent first molars (#3, 14, 19, 30) and second molars (#2, 15, 18, 31) for children ages 5 through 15.

Conditions for coverage for eligible beneficiaries include:

- Prevention of pit and fissure caries.
- Occlusal surfaces free from any caries.
- Occlusal surfaces must be free of any restorations.

Medicaid does not cover sealants applied on beneficiaries with:

- Rampant decay.
- Previous restoration on identified tooth.

Coverage for sealants is limited to once every three years and the fee includes repair and replacement for three years. Application of sealants may be by a dentist or dental hygienist.

6.2.D. SPACE MAINTAINERS

Coverage is limited to beneficiaries under age 13. They are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost primary tooth.

Only one space maintainer is covered for a quadrant. Frequency limitations are once every two years.

6.3 RESTORATIVE TREATMENT

Restorative treatment is a benefit for all beneficiaries. Amalgam or Resin-based Composite materials to restore carious lesions or fractured teeth are a covered benefit.

Restorative treatment is limited to those services necessary to restore and maintain adequate dental health.

No reimbursement is made for any surface more than once in two years. The replacement of restorations, or any other restorative treatment, within two years of placement is the treating dentist's responsibility.

Core build-up or post and core substructures are allowed for permanent teeth only.

6.3.A. Amalgam Restorations

Cement bases, adhesives, liners, local analgesia and anesthesia are not separate benefits and must be included in the total fee for the restoration.

For any restorations that extend to more than one surface of a tooth, dentists must use the multiple surface procedure code. For example, a restoration that extends from the occlusal surface of a permanent molar to the mesial surface of the molar must be billed using the two-surface procedure code, **not** two one-surface procedure codes. The dentist's fee for any restoration must include **all** the surfaces in which the restoration encompasses. If pins are used they are to be reported separately.

Double occlusal restorations, or combinations of surfaces involving double occlusal restoration on any tooth, including tooth numbers 2, 3, 14, 15, 21 and 28, is not separately reimbursed. Payment is made for a given surface one time, irrespective of the number or combination of restorations placed on that surface.

Restorations are not covered for deciduous teeth where exfoliation is expected to occur within 180 days. Restorations of deciduous cuspids and molars for beneficiaries age 12 or older and of deciduous incisors for beneficiaries age five or older are **not** benefits where exfoliation is reasonably imminent.

6.3.B. Resin-based Composite Restorations – Direct

The requirements for procedure coding and limitations for reimbursement for amalgam restorations apply to resin-based composite restorations.

Resin-based composite restorations are covered for all beneficiaries. Anterior resin-based crown is covered only for beneficiaries under age 21.

6.3.C. Crowns

Crowns are benefits only for beneficiaries under age 21.

Only the following crowns are considered as covered benefits for beneficiaries under age 21:

- Stainless steel crown – allowed only for primary teeth and permanent molars.
- Stainless steel crown with resin window – allowed only for anterior primary teeth.
- Laboratory-processed resin crown (indirect) – allowed only for anterior permanent teeth; **requires PA**.

6.4 Endodontics

Endodontics is a benefit only for beneficiaries under age 21.

6.4.A. Root Canal Therapy

Program coverage for root canal therapy is solely for the professionally accepted, conventional root canal treatment modalities. These involve complete removal of pulpal tissue to the tooth apex, canal enlargement and debridement, and the obliteration of the entire root canal by the permanent insertion of an inert, nonresorbable filling material. The Sargenti technique is not a covered benefit.

Root canal therapy is a benefit only where otherwise sound teeth can be reasonably restored under Program coverages and the condition of the rest of the mouth supports this method of treatment.

The root canal therapy is not covered if the following conditions exist:

- Where furcation pathology exists;
- In unopposed posterior teeth; or
- Where teeth are not restorable under Medicaid guidelines.

6.4.B. Pulpotomy

A therapeutic pulpotomy is a benefit for beneficiaries under age 13 if it is performed on primary teeth or permanent teeth with open apices. It is not considered the first stage of root canal therapy. If exfoliation appears imminent, a pulpotomy is not a covered benefit.

6.4.C. Pulpectomy

Endodontic therapy on primary teeth is a benefit for beneficiaries under age eight when the tooth is non-vital or hemostasis cannot be established by conventional pulpotomy.

6.4.D. Pulpal Debridement

Pulpal debridement is a benefit for beneficiaries under age 13 if it is performed on primary teeth or permanent teeth prior to conventional root therapy. It is not covered when root canal therapy is completed on the same day.

6.4.E. Apexification

This service is covered for beneficiaries under age 13 and is limited to permanent teeth when the apex has not completely closed.

6.4.F. Apicoectomy

An apicoectomy is a benefit for beneficiaries **under age 21**.

6.5 Periodontics

Full mouth debridement is performed as a therapeutic, not preventive, treatment for beneficiaries to aid in the evaluation and diagnosis of their oral condition. It is the removal of subgingival and/or supragingival plaque and calculus.

Full mouth debridement is a benefit for beneficiaries age 14 and over once every 365 days. It is not covered when a prophylaxis is completed on the same day.

No other periodontal procedures are considered to be covered benefits.

6.6 Prosthodontics (Removable) [Change Made 4/1/06]

6.6.A. General Instructions

Complete and partial dentures are benefits for all beneficiaries**.** All dentures require PA. Providers must assess the beneficiary's general oral health and provide a five-year prognosis for the prosthesis requested. An upper partial denture PA request must also include the prognosis of six sound teeth.

Complete or partial dentures are authorized:

- If there is one or more anterior teeth missing;
- If there are less than eight posterior teeth in occlusion (fixed bridges and dentures are to be considered occluding teeth) **(added 4/1/06 for clarification)**; or
- Where an existing complete or partial denture cannot be made serviceable through repair, relining, adjustment, or duplicating (rebasing) procedures. If a partial denture can be made serviceable, the dentist should provide the needed restorations to maintain use of the existing partial, extract teeth, add teeth to an existing partial, and remove hyperplastic tissue.

Before final impressions are taken and any construction begun on a complete or partial denture, healing adequate to support a prosthesis must take place following the completion of extractions or surgical procedures. This includes the posterior ridges of any immediate denture. An exception is made for the six anterior teeth (cuspid to cuspid) only when an immediate denture is authorized.

Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, and duplications within six months of insertion. This includes such services for an immediate upper denture when authorized.

If a complete or partial denture requires an adjustment, reline, repair, or duplication within six months of insertion, but the services were not provided until after six months of insertion, no additional reimbursement is allowed for these services.

Complete or partial dentures are not authorized when:

- A previous denture has been provided within five years, whether or not the existing denture was obtained through Medicaid.
- An adjustment, reline, repair, or duplication will make it serviceable.
- Replacement of a complete or partial denture that has been lost or broken beyond repair is not a benefit within five years, whether or not the existing denture was obtained through Medicaid.

6.6.B. Complete Dentures

Only complete dentures with noncharacterized teeth (i.e., without cosmetic enhancements, such as gold denture teeth) and acrylic resin bases are a benefit of Medicaid. To be covered by Medicaid, all of the following procedures must be used to fabricate the dentures:

- Individual positioning of the teeth;
- Wax up of the entire denture body; and
- Conventional laboratory processing.

A preformed denture with teeth already mounted (i.e., teeth already set in acrylic prior to initial impressions), forming a denture module, is not a covered benefit. Overdentures or Cusil dentures are not a covered benefit.

6.6.C. Immediate Complete Denture

An immediate complete denture is a benefit only when the immediate extractions involve only the anterior teeth, whether maxillary or mandibular**.** When requesting PA, the dentist must state on the request that the denture will be an immediate denture, which teeth will be extracted at the denture insertion visit, and the reason the immediate denture is needed.

For reasons of denture stability and retention, an immediate denture is not a benefit:

- For the posterior segments of the maxillary or mandibular arch.
- Where cast metal base saddle areas are to be provided.

6.6.D. Partial Denture

Partial dentures are a covered benefit for all beneficiaries over age 16, with the following limitations:

- A one-piece cast metal partial denture is not a benefit.
- Elaborate appliance items, such as semi-precision or precision attachments, stress breakers, hinge saddle areas, or Kennedy (lingual) blankets are not benefits.

All clasps are included in the fee for the partial denture.

To ensure that eruption of the teeth is completed before a permanent appliance is placed, partial dentures are not a covered benefit for beneficiaries under age 16. To replace a lost anterior tooth on a patient under age 16, PA must be submitted for an interim partial denture.

6.6.E. Interim Complete & Partial Dentures

Interim complete dentures are authorized only in very unusual situations. For beneficiaries under the age of 16, interim partial dentures (sometimes called a "stay-plate") to replace anterior teeth are authorized. The provider must submit justification and explanation of proposed future treatment with the PA request.

6.6.F. Relines

After the initial six-month interval, relines or duplications are covered benefits only once within a two-year period. Relines may be laboratory-processed or chair side. Relines and adjustments are not payable on the same date of service.

6.6.G. Repairs

After the initial six-month interval, repairs and adjustments to complete or partial dentures are covered benefits only twice in a 12-month period. If more repairs are needed, they are the responsibility of the treating dentist. Repairs for interim partial dentures are not covered.

The allowance for a complete or partial denture repair, including a reline or rebase, does not exceed half the fee for a new denture if repairs are within six months of the replacement date for the dentures.

6.7 Oral Surgery

Oral surgical procedures are benefits for all beneficiaries.

The extraction of a permanent tooth for orthodontic purposes is not a benefit. Reimbursement for operative or surgical procedures includes local anesthesia, analgesia, and routine postoperative care.

Surgical procedures such as surgeries of the jaw or facial bones are considered a medical benefit, not a dental benefit.

6.7.A. Extractions

An extraction is not a covered benefit if exfoliation is imminent.

A surgical extraction is a benefit only when the removal of bone and the elevation of mucoperiosteal flap and/or sectioning of a tooth is required to facilitate the extraction.

Surgical extractions are not a covered benefit in cases of multiple extractions in the same quadrant for preparation of complete dentures.

The extraction of an impacted tooth is a benefit only when conditions arising from such an impaction warrant its removal. The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt pathology is not covered.

6.7.B. Tooth Replantation and Fixation

Tooth replantation and fixation is a benefit for beneficiaries **under age 21** when permanent anterior teeth are avulsed or displaced due to traumatic injury.

6.8 Adjunctive General Services [Change Made 4/1/06]

Anesthesia services are the only procedures that may be billed separately from the surgical procedure. Intravenous (IV) sedation and general anesthesia are benefits for **all beneficiaries**. **(corrected 4/1/06)**

General anesthesia is limited to situations when local anesthesia is medically contraindicated. IV sedation and/or general anesthesia are not a benefit for the convenience of the dentist or beneficiary or because of apprehension on the part of the beneficiary.

Intravenous sedation or general anesthesia cannot be billed when given in conjunction with a local anesthesia if the use of the intravenous sedation or general anesthesia is to allow the provision of the local anesthetic as the primary anesthetic agent. Neither intravenous sedation nor general anesthesia may be billed in combination with the other.

Non-intravenous conscious sedation is a benefit for beneficiaries **ages zero-five**. It includes the administration of a sedative and/or analgesic agents and appropriate monitoring in the office setting. It cannot be just the administration of nitrous oxide.

Nitrous oxide inhalation, in combination with oxygen alone, is classified as analgesia and is not a separately reimbursable procedure. It is included in the reimbursement of the procedure performed.

SECTION 7 - NONCOVERED SERVICES

The following dental services are excluded from Medicaid coverage:

- Orthodontics, unless there is a CSHCS qualifying diagnosis
- Gold Crowns, Gold Foil Restorations, Inlay/Onlay restorations
- Fixed Bridges
- Bite Splints, Mouth guards, sports appliances
- TMJ Services
- Services or Surgeries that are experimental in nature
- Dental Devices not approved by the FDA
- Analgesia, Inhalation of Nitrous Oxide

SECTION 8 - CHILDREN'S SPECIAL HEALTH CARE SERVICES DENTAL SERVICES

8.1 COVERED SERVICES

Covered CSHCS dental services are primarily for the specialty care of children with complicated congenital defects affecting the oral cavity. Refer to the CSHCS Chapter for the qualifying dental diagnosis that covers specialty dental services. Once it is determined that the qualifying diagnosis renders the child eligible for dental care, all of the dental services necessary to address the qualifying condition are covered by the CSHCS program. The range of specialty services may include treatment by an oral surgeon, orthodontist, pedodontist, and/or prosthodontist. The services of a general dentist may be authorized as supportive service to the specialty care. Service coverage determination for the multiple-handicap child or for conditions of spasticity requiring dental services in a hospital setting are made on an individual basis.

General dental services are also available for CSHCS beneficiaries with a qualifying diagnosis. Refer to the CSHCS Chapter for the qualifying diagnosis for general dental services. The general dental services are those benefits that are provided through the Medicaid Fee-For-Service (FFS) program. These services are diagnostic, preventive, restorative, and oral surgery procedures.

Basic Medicaid guidelines/policy apply to the dental services covered through the CSHCS program. For those children who are dually eligible for Medicaid and the CSHCS program, general dental services are provided through Medicaid and the specialty care is covered through CSHCS.

The CSHCS representative at the local health department should be contacted if there are questions regarding a beneficiary's eligibility for the CSHCS program.

No treatment is authorized for beneficiaries beyond age 21.

8.2 COVERED SERVICES AND GENERAL PRIOR AUTHORIZATION INFORMATION

The MDCH Dental Database, available on the MDCH website, lists the covered procedures for the CSHCS and/or Medicaid program and if PA is required. (Refer to the Directory Appendix for website information.)

The majority of dental services covered for the CSHCS program require PA. Providers must follow the PA completion instructions explained in the Prior Authorization Section of this chapter. PA requests are effective for a six-month period.

Any orthodontic PA request must be submitted and treatment started 12 months prior to the 21st birthday of the beneficiary.

8.2.A. ORTHODONTIC SERVICES

All orthodontic services, except the pre-orthodontic treatment visit and x-rays, require PA. All PA requests must be submitted prior to the initiation of treatment and placement of bands. A PA request is necessary for each state of orthodontic treatment, such as interceptive treatment and comprehensive treatment. An orthodontic treatment plan outlining the expected timeframe for completion, including information on the growth of the oral cavity and current dentition, must be included with the submission of each new

stage of orthodontic treatment. Debanding/retention is considered part of the orthodontic treatment plan.

Interceptive orthodontic treatments are procedures that lessen the severity of future effects of a malformation and to eliminate its cause. The procedures may involve nonsurgical appliance use for palatal expansion. Interceptive orthodontic treatment is a one-time PA request for the entire timeframe of treatment.

Comprehensive orthodontic treatments are procedures that are used when there are multiple phases of treatment provided at different stages of orofacial development that are nonsurgical. Comprehensive orthodontic treatment procedures are covered for a lifetime maximum of six years, with stage of dentition covered up to two years.

The submission of the first PA request for comprehensive orthodontic treatment should list the appropriate procedure code and banding/start date of treatment. For each additional six-month time period, a separate PA request for the periodic orthodontic treatment visit must be submitted indicating the proposed time period. The periodic orthodontic treatment visit procedure code may be used up to a total of four times each comprehensive orthodontic treatment stage, if needed.

Replacement of lost or broken retainers is allowed twice in a lifetime.

8.2.B. Crown and Bridge Services

Crowns and/or bridges require prior authorization.

Crowns and/or bridges covered for CSHCS beneficiaries with a diagnosis for specialty dental services will not be replaced within five years of the insertion date.

8.2.C. Additional Services

For those services for which there is no procedure code, the Not Otherwise Classified (NOC) code is used. These services also require prior authorization.

SECTION 9 - HEALTHY KIDS DENTAL

9.1 COVERAGE AND SERVICE AREA INFORMATION

MDCH contracts for the administration of the Medicaid dental benefit called ***Healthy Kids Dental*** in 37 counties. The contractor administers the Medicaid dental benefit to all Medicaid beneficiaries under age 21 in the participating counties. The dental services provided through the contractor mimic the dental services provided through the FFS Medicaid program. (Refer to the Directory Appendix for contact information.)

Medicaid beneficiaries have access to dentists through the contractor's participating dental networks. Beneficiaries must see a dentist that participates with the ***Healthy Kids Dental*** contract.

County Name	Number	County Name	Number
Alger	02	Ionia	34
Allegan	03	Iosco	35
Arenac	06	Isabella	37
Barry	08	Keweenaw	42
Branch	12	Lapeer	44
Charlevoix	15	Lenawee	46
Cheboygan	16	Livingston	47
Chippewa	17	Luce	48
Clare	18	Midland	56
Clinton	19	Monroe	58
Dickinson	22	Ontonagon	66
Eaton	23	Roscommon	72
Emmett	24	St. Clair	74
Gladwin	26	St. Joseph	75
Gogebic	27	Sanilac	76
Gratiot	29	Shiawassee	78
Hillsdale	30	Tuscola	79
Houghton	31	Van Buren	80
Huron	32		

9.2 Enrollment Information

Beneficiaries under age 21 with Scope of Coverage F or T whose county code of residence is one of the 37 counties listed above are automatically enrolled in ***Healthy Kids Dental***. Beneficiaries with Scope of Coverage E or 0 (Medicaid deductible) are not covered. Enrollment occurs monthly, and the contractor receives the enrollment file at the beginning of each month. A beneficiary must have active Medicaid status by the end of the month to appear on the following month's enrollment file. Enrollment in ***Healthy Kids Dental*** is always prospective, never retroactive. Beneficiaries have the Medicaid FFS dental benefit until enrolled in ***Healthy Kids Dental***. Foster care children whose service living arrangement places them out of county, or state, or into a facility, do not have the ***Healthy Kids Dental*** contract benefit.

Providers may call the contractor to verify a beneficiary's enrollment, or they may call EVS. (Refer to the Directory Appendix for contact information.) EVS provides enrollment information for beneficiaries, including the type of dental coverage the beneficiary has.

9.3 Loss of Enrollment

Beneficiaries are enrolled in ***Healthy Kids Dental*** until the last day of the month in which they turn age 21 or move out of the selected county. If the beneficiary loses enrollment and is in active treatment that requires multiple appointments, the provider may bill the contractor for the treatment as long as it is completed within 60 days of the loss of eligibility.

Upon turning age 21 or moving out of the selected counties, the dental benefit is no longer administered by the contractor but provided through MDCH.

9.4 Beneficiary Identification

Beneficiaries enrolled in ***Healthy Kids Dental*** receive an ID card from the contractor. This card is issued only once at the initial enrollment. Beneficiaries are identified with their Social Security Number (SSN), and this number is on the contractor's ID card. If the beneficiary does not have a SSN on file, a leading "9" is placed in front of the Medicaid ID number to make a nine-digit number. Providers must use the SSN or identification number on the contractor card when verifying enrollment and for submission of claims.

9.5 Benefit Administration

The contractor administers the Medicaid dental benefit according to their standard policy and procedures, claim submission and reimbursement mechanisms. There is no co-payment for beneficiaries under age 21, and there is no yearly maximum. Dental providers must accept the contractor's reimbursement as payment in full and cannot balance bill the beneficiary for services rendered. As an agent of Medicaid, the contractor must use the same regulations and guidelines that Medicaid follows.

SECTION 10 – FUNDING FOR PUBLIC DENTAL SCHOOLS

10.1 GENERAL

MDCH provides funding to state funded, public dental schools that develop specialized curricula and programs intended to further increase the participation of dentists in the state's Medicaid and Children's Special Health Care Services (CSHCS) programs. Part of these curricula must include teaching modules that deal with dental care for children and other beneficiaries with special needs. Suggested teaching modules include, but are not limited to, providing dental care to HIV-infected individuals, behavioral management, wheelchair transfers, sensitivity training, etc.

MDCH provides the funding to help cover teaching and other administrative costs related to Medicaid and CSHCS covered activity. State funded, public dental schools must establish their allowable costs under this program using the cost centered method. Medicaid and CSHCS utilization will be established based on a ratio of Medicaid/CSHCS procedures to total procedures.

10.2 PAYMENT PROCEDURE

MDCH will make quarterly payments in the first year based on an estimate of program liability. After the first year, quarterly payments will be based on MDCH's prior year program liability. Schools receiving funds must submit annual cost reports to MDCH within five months after the school's fiscal year ends. Cost reports must be completed following federal Office of Management and Budget (OMB) Circular A-21. Dental schools participating in this program must submit a general ledger summary as part of their cost report. Professional costs must be reported separately from all other expenditures. The following costs are not allowed and must be excluded from the school's total costs:

- Unsponsored research;
- Faculty expenses for which the school receives separate graduate medical education (GME) reimbursement from other public or private programs; and
- Special projects.

Reimbursement will be made for the school's total allowed costs times its Medicaid and CSHCS utilization less all third party payments for dental services rendered. Payments will be subject to audit and settlement. After MDCH accepts a school's cost report, reconciliation between the final liability and payments made under this program for the year will be done. If necessary, recovery of overpayments will be made.

10.3 ANNUAL WORK PLAN

Schools receiving funds under this program must prepare an annual work plan including a budget indicating their goals and objectives. Participating schools must submit semi-annual progress reports documenting their efforts and activities towards meeting the goals and objectives. The semi-annual progress reports must include the number of dental students receiving specialized training, the numbers and categories of beneficiaries treated, as well as the school's efforts to increase both. Annually, the school must provide a self-evaluation of its teaching curricula funded under this program, its ability to meet its goals and objectives, and a needs assessment for future change. Both the work plan and payments are subject to the approval of MDCH.

10.4 Cancellation Clause

Failure to submit the cost report, the work plan, the needs assessment, or the semi-annual progress reports on schedule may lead to cancellation of the program and payments. Timeframes for submission of the required reports will be specified in the annual work plan.

EMERGENCY SERVICES ONLY MEDICAID

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers.

Aliens who are not otherwise eligible for full Medicaid because of immigration status may be eligible for Emergency Services Only (ESO) Medicaid.

For the purpose of ESO coverage, federal Medicaid regulations define an emergency medical condition (including emergency labor and delivery) as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to:

- Place the person's health in serious jeopardy, or
- Cause serious impairment to bodily functions, or
- Cause serious dysfunction of any bodily organ or part.

SECTION 2 – ELIGIBILITY

Michigan Department of Human Services (MDHS) determines eligibility for ESO coverage. To qualify for ESO Medicaid, non-citizens must meet all Medicaid eligibility requirements not related to immigration status. The Beneficiary Eligibility Chapter of the Medicaid Provider Manual contains information on how to identify ESO beneficiaries.

Pregnant ESO beneficiaries may also qualify for pregnancy-related services under the MDCH Maternity Outpatient Medical Services (MOMS) program. Refer to the Maternity Outpatient Medical Services Chapter of the Medicaid Provider Manual for additional information on MOMS covered services.

SECTION 3 - COVERAGE

ESO Medicaid coverage is limited to labor and delivery services, and those services necessary to treat emergency conditions. The following services are **not** covered under this benefit:

- Preventative services,
- follow-up services related to emergency treatment (e.g., removal of cast, follow-up laboratory studies, etc.),
- treatment of chronic conditions (e.g., ongoing dialysis, chemotherapy, etc.),
- sterilizations performed in conjunction with delivery,
- organ transplants,
- pre-scheduled surgeries.

The following table provides additional information regarding specific coverage under the ESO program. Prior authorization and/or co-payment requirements may apply to some services listed. Those requirements are described in other chapters of the Medicaid Provider Manual.

Service	Coverage
Ambulance	Limited to emergency transport to a hospital Emergency Department (ED).
Case Management	Not covered
Chiropractor	Not covered
Dental	Not covered
Eyeglasses	Not covered
Family Planning	Not covered
Hearing Aids	Not covered
Home Health	Not covered
Home Help (personal care)	Not covered
Hospice	Not covered

Service	Coverage
Inpatient Hospital	Limited to labor and delivery, and emergency-related services only.
Lab & X-Ray	Limited to services related to labor and delivery, or necessary to diagnose/treat an emergency condition. Follow-up services to emergency treatment are **not** covered.
Medical Supplies/ Durable Medical Equipment (DME)	Medical supplies are limited to those items necessary to treat an emergency condition within an inpatient or outpatient hospital setting. Durable medical equipment is **not** covered.
Mental Health Services	Limited to emergency stabilization of a psychiatric episode within the emergency department of a medical hospital.
Nursing Facility	Not covered
Optometrist	Not covered
Outpatient Hospital/ Emergency Department	Limited to the treatment of emergency conditions. Follow-up care to emergency treatment and chronic care (e.g., dialysis, chemotherapy, etc.) is **not** covered.
Pharmacy	Limited to those drugs directly related to the emergency condition. Refills are **not** covered. Medicaid co-pays apply. (Refer to the Pharmacy Chapter of the Medicaid Provider Manual for additional information.)
Physician **Nurse Practitioner (NP)** **Medical Clinic**	Limited to labor and delivery services, and treatment of an emergency condition. Preventative care, follow-up care to emergency treatment, and chronic care are **not** covered.
Podiatrist	Not covered
Prosthetics/ Orthotics	Not covered
Private Duty Nursing	Not covered

Service	Coverage
Substance Abuse	Limited to medically necessary inpatient detoxification services in a life-threatening situation. Inpatient detoxification of a beneficiary who is simply incapacitated is not covered. (Refer to the Acute Inpatient Medical Detoxification subsection of the Hospital Chapter of the Medicaid Provider Manual for additional information.)
Therapies	Not covered
Transportation (nonambulance)	Not covered

FAMILY PLANNING

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Title X clinics (Provider Type 23).

The Michigan Medicaid Program includes Family Planning services for qualified beneficiaries when the services are determined to be necessary for the health and well being of the beneficiary. The services provided, as well as the type of provider and setting, must be appropriate to the specific medical needs of the beneficiary. Determination of medical necessity is the responsibility of the attending physician (MD or DO), and must be within the scope of current medical practice and Medicaid limitations. Submission of the claim for payment serves as the provider's certification of the medical necessity for these services. This determination of medical necessity is subject to review, in the context of accepted standards of medical practice.

1.1 EXPLANATION OF SERVICES

A family planning clinic or a primary care provider (i.e., MD, DO) or other Medicaid-approved provider (i.e., Certified Nurse Midwife [CNM] and Nurse Practitioner [NP]) can provide family planning services. Family planning clinics are limited to providing only family planning services.

Family planning services are defined as any Medicaid covered contraceptive service, including diagnostic evaluation, drugs, and supplies, for voluntarily preventing or delaying pregnancy.

Services must be furnished under the supervision of a physician or dispensed by a pharmacy for beneficiaries of childbearing age, including minors considered to be sexually active. Family planning services enable beneficiaries to voluntarily choose to prevent initial pregnancy or to limit the number of and spacing of their children.

Covered services include an office visit for a complete exam, pharmaceuticals (including some over the counter [OTC] products), supplies and devices when such services are provided by or under the supervision of a medical doctor, osteopath, or eligible family planning provider. Family planning supplies not furnished by the provider as part of the medical services must be prescribed by a physician and purchased at a pharmacy. Exceptions are condoms and similar supplies which do not require a prescription.

Medicaid does not cover services for treatment of infertility.

1.2 REIMBURSEMENT

If the beneficiary is enrolled in a Medicaid Health Plan (MHP), the MHP is responsible for payment for family planning services provided to their enrollees. Family planning clinics are encouraged to establish a contract with the MHP to define services they will provide and reimbursement methodology. MHP enrollees have freedom of choice to obtain family planning services from any family planning clinic provider. Therefore, a referral from the MHP is not required.

Michigan Department of Community Health (MDCH) reimburses for services provided to beneficiaries who are not enrolled in a MHP.

In order to receive reimbursement, family planning clinics must meet established guidelines and be certified by MDCH. Family planning clinic procedure codes are located in the Family Planning Clinic Database on the MDCH website. (Refer to the Directory Appendix for website information.) Medicaid does not reimburse for physician services, lab tests, prescription drugs, or supplies beyond those specified in the Family Planning Clinic Database when billed by a family planning clinic. Additional services, when appropriate, are available through the primary care provider and other providers, such as pharmacy, labs, etc., in accordance with Medicaid policy and procedures. Family planning clinics wishing to provide services in addition to contraceptive management may specifically enroll in the Medicaid program to provide the broader range of services (i.e., Physicians/NPs or Medical Clinics).

Where applicable, special billing instructions for family planning clinics are noted with the service definitions. General billing instructions are located in the Billing & Reimbursement for Professionals Chapter of this manual.

1.3 Diagnosis Codes

The appropriate diagnosis code(s) from the International Classification of Diseases-Ninth Revision-Clinical Modification (ICD-9-CM) must be indicated on the claim form when billing for family planning services. Family planning services are limited to the V25 diagnosis code range. Providers must enter the appropriate code on the claim form.

SECTION 2 – OFFICE VISITS

2.1 PREVENTIVE MEDICINE SERVICES - EVALUATION AND MANAGEMENT/OFFICE VISITS

Family Planning Clinic providers are limited to providing preventive services for purposes of delaying or preventing pregnancy (i.e., family planning services). Services provided must be in accordance with the standards of care established for contraceptive management for initial and follow-up services as needed. The appropriate lab services required to manage contraceptive services must be made available, either by the clinic or through a referral process.

Providers must bill using the appropriate Preventive Medicine Evaluation and Management (E/M) codes from the Current Procedural Terminology (CPT) manual and/or the Health Care Financing Administration Procedure Coding System (HCPCS) for the services and products listed in the Family Planning Clinic Database. If additional medical problems are identified which need follow-up services, beneficiaries must be referred to their primary care provider.

Counseling services are considered a part of E/M services. As such, no separate reimbursement is available for counseling-only services. The appropriate E/M code that most closely describes the service provided must be billed.

2.2 INFORMATION AND EDUCATION REGARDING CONTRACEPTIVE METHODS

Beneficiaries must be given information and education for all methods of contraception available, including reversible methods (e.g., oral, injectable, implant, IUD, diaphragm, cervical cap, contraceptive patch, vaginal ring, foam, condom, and rhythm) and irreversible methods (e.g., tubal ligation, vasectomy). Education regarding all contraceptive methods must include relative effectiveness, common side effects, and difficulty in usage. Basic information concerning sexually transmitted disease (STD) must also be discussed.

Prescriptions for a contraceptive method must reflect the beneficiary's choice, except where such choice is in conflict with sound medical practice.

2.3 PROBLEM VISITS

Beneficiaries should be encouraged to return whenever they have specific problems related to the contraceptive method or wish to have additional guidance, or service, including additional supplies. For follow-up care unrelated to contraception, referrals must be made to the primary care provider.

All beneficiaries, regardless of the contraceptive method chosen, must be encouraged to return for a physical examination, laboratory services, and health history at least once per year.

SECTION 3 – LABORATORY

Laboratory testing related to contraceptive management or STDs is a covered service. The family planning clinic or a licensed laboratory may provide services. Family planning clinics are limited to the lab services listed in the Family Planning Clinic Database on the MDCH website. (Refer to the Directory Appendix for website information.)

Clinics can bill only for services actually performed by the family planning clinic and in the clinic setting. If an outside lab provides the service, that lab must bill Medicaid directly. For example, Pap smear specimens sent for testing to a lab outside the clinic must be billed by the lab performing the lab test.

Clinics seeking reimbursement for lab services are required to obtain Clinical Laboratory Improvement Act (CLIA) certification. The type of certification determines the complexity of the lab tests the clinic can perform. If a clinic does not have CLIA certification for specific lab service(s) needed by a beneficiary, the beneficiary should be referred to a provider that has CLIA certification to provide the required laboratory service. The clinic's CLIA certification number must be provided to Medicaid Provider Enrollment to be associated with the provider ID number. (Refer to the Directory Appendix for contact information.) MDCH may conduct post-payment reviews to verify the certification level and services performed.

Lab tests conducted by the clinic are subject to the $50 per beneficiary per day limit. For information on exemptions from the daily limit, refer to the Laboratory Chapter in this manual.

Laboratory tests other than those listed in the Family Planning Clinic Database are available to beneficiaries when medically necessary, ordered by a physician, and provided by an independent laboratory or outpatient hospital laboratory. For additional information, refer to the Laboratory Section in the Practitioner Chapter of this manual.

SECTION 4 – STERILIZATION

For Medicaid purposes, a sterilization procedure is defined as any medical procedure, treatment, or operation for the purpose of rendering a beneficiary (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under Medicaid's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). Physicians are responsible for obtaining the signed Informed Consent for Sterilization form (MSA-1959) 30 days prior to surgery. A copy of the form can be found in the Forms Appendix of this manual.

Sterilizations are covered only if:

- The beneficiary is at least 21 years of age at time of informed consent;
- The beneficiary is not legally declared to be mentally incompetent;
- The beneficiary is not institutionalized in a corrective, penal, or mental rehabilitation facility;
- Informed consent is obtained; and
- Informed consent is not obtained while the beneficiary is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.

4.1 INFORMED CONSENT

Sterilization requires the beneficiary's voluntary informed consent. Persons obtaining the informed consent must adhere to the following requirements:

- The beneficiary must be advised that the sterilization will not be performed for at least 30 days but within 180 days after signing the MSA-1959, except in cases of emergency abdominal surgery or premature delivery.
- The person who obtains the informed consent must answer any questions the beneficiary may have concerning the procedure.
- Information must be effectively communicated to the deaf, blind, or otherwise physically challenged.
- An interpreter must be provided if the beneficiary to be sterilized does not understand the language on the informed consent form or used by the person obtaining informed consent.
- Beneficiaries may have a witness of their choice present when informed consent is obtained.
- A copy of the consent form must be given to the beneficiary.
- Informed consent may not be obtained while the beneficiary to be sterilized is:
  - In labor or childbirth;
  - Seeking to obtain or obtaining an abortion; or
  - Under the influence of alcohol or other substances that affect the beneficiary's state of awareness.

The following information must be presented orally to the beneficiary both at the time the beneficiary signs the informed consent form and again by the physician performing the sterilization shortly before the procedure, normally during the pre-operative examination.

- The beneficiary is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the beneficiary might be otherwise entitled.
- A description of available alternative methods of family planning and birth control.
- The sterilization procedure is considered to be irreversible.
- A thorough explanation of the specific sterilization procedure to be performed.
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
- A full description of the benefits or advantages that may be expected as a result of the sterilization.
- The beneficiary, the person who obtained the consent, and the interpreter or translator (if required) must sign the informed consent form at least 30 days but no more than 180 days prior to the sterilization. The physician performing the sterilization must sign and date the informed consent form after the sterilization has been performed.

4.2 Exceptions for Sterilization

All of the above requirements may not be met in some instances, e.g., in cases of premature delivery and emergency abdominal surgery. Exceptions apply when the beneficiary to be sterilized has signed a consent form, and during the required 30-day waiting period a premature delivery or an emergency abdominal surgery is necessary. To avoid an additional surgery at the conclusion of the required 30-day waiting period, federal regulations permit the sterilization to be performed at the same time as the premature delivery or emergency abdominal surgery, if 72 hours have elapsed since the beneficiary signed the consent form. In cases of premature delivery, an additional requirement is that the consent form was signed at least 30 days before the expected delivery date.

4.3 Reimbursement Policy for Sterilization

Pre- and post-operative examinations for the sterilization procedure are included in the reimbursement for the surgical procedure. No additional reimbursement is allowed for the pre-operative examination or the sterilization explanation.

Reimbursement for a vasectomy includes pre- and post-operative visits for counseling, clamp removal, the post-operative semen analysis, etc. No additional charges are allowed for these services and Medicaid does not make separate payment.

Reimbursement for female sterilization and other related medical procedures are available to Medicaid enrolled physicians performing the sterilization. Physicians must bill using their Medicaid provider number in these cases. Reimbursement for female sterilization is not available to a Family Planning Clinic.

4.4 Special Billing Instructions

All items of the MSA-1959 must be completed except in the following circumstances:

- The ethnic information is optional.
- The interpreter statements must be completed only when applicable.

All invoices submitted to MDCH by the clinic for the sterilization must include a copy of the fully completed MSA-1959. (Refer to the Forms Appendix for additional information.) This requirement applies to all practitioners, technical surgical assistants, anesthesiologists, etc., as well as the hospital and clinics. All sterilization claims pend and documentation is reviewed by MDCH. Invoices submitted without the appropriate documentation are rejected. If any field on the form is improperly completed, the claim will be rejected.

When billing for charges related to a sterilization procedure, a copy of the completed MSA-1959 must be included. This form may be submitted by fax or accompany the claim. (Refer to the Directory Appendix for contact information.)

4.5 Consent Form for Sterilization

MDCH allows submission of MSA-1959 forms via fax. Federal regulations require that this form be submitted to Medicaid before reimbursement can be made for any sterilization procedure. Submitting the form via fax eliminates attachments to claims and confirms that the form is acceptable, thus reducing costly claim rejections.

The provider who obtains the consent and completes the MSA-1959 may fax or mail the completed consent form, along with a cover sheet, to the Medicaid Payments Division. (Refer to the Directory Appendix for contact information.) The form is reviewed within five working days. Either an explanation of errors or notice that the form has been accepted and is on file is returned to the submitting provider via the same method it was submitted. When the provider receives notice that the form is accepted and on file, all invoices related to the service may be submitted to MDCH without paper attachments.

4.6 Procedure for Submitting MSA-1959

Providers must complete the following steps when submitting a MSA-1959:

- Complete a cover sheet (typed or printed) which must include:
  - Beneficiary name
  - Beneficiary Medicaid ID number
  - Provider contact person
  - Provider fax number
  - Provider phone number
- Fax the cover sheet and completed consent form to Medicaid Payments Division, Sterilization Consent Form Approval. Do not fax invoices.

- Wait for a response. When notified that the consent form has been accepted and is on file, inform other providers via a copy of the response.
- Providers may then submit claims (either paperless or hard copy) to MDCH. The Remarks section or Comment Record must include the statement "Consent on File."
- When sterilization claims are received with this information in the Remarks section, the claim is forced for payment if the submitted invoice matches the consent form on file.
- If there is no response from MDCH within five working days, review the request submitted to insure that MDCH received the fax (i.e., confirm that the fax is working, make sure the cover sheet included the necessary provider contact information, etc.). Resend the information if necessary.

Providers have the option to attach a copy of the MSA-1959 to the claim without going through the pre-approval process outlined above.

SECTION 5 – PHARMACEUTICALS

Clinics may dispense and receive reimbursement for contraceptives and limited pharmaceutical supplies listed in the Family Planning Clinic Database available on the MDCH website. (Refer to the Directory Appendix for website information.)

Oral contraceptives dispensed may not exceed a six-month supply. All other contraceptive supplies should be dispensed for one month, with the exception of implants and hormonal contraceptives such as Norplant and Depo Provera.

If the only service provided is supplies, no visit code may be billed. A billing unit must equal a billing quantity of one on the claim.

Medicaid covers a broader range of pharmaceuticals than those listed in the Family Planning Clinic Database. These products must be prescribed by a physician and dispensed by a Medicaid-enrolled pharmacy. The Pharmacy Chapter of this manual or the local pharmacy may be referenced/contacted for details.

SECTION 6 – OTHER SERVICES

6.1 REFERRALS

Each clinic is responsible for making appropriate referrals in the following circumstances:

- Medical problems identified by the history or physical examination.
- All positive Gonorrhea and other STD cultures and/or serology.
- Vaginal infections.
- Beneficiaries with abnormal cervical cytology.
- Beneficiaries with positive urine cultures.
- For prenatal services.
- Beneficiaries suffering from anemia.
- Female sterilizations.

6.2 INPATIENT SERVICES

Each clinic must make arrangements for inpatient care for fee-for-service (FFS) beneficiaries requiring inpatient care as a result of complications arising from contraceptive services provided by that clinic. Arrangements for MHP enrollees must be made through the MHP.

6.3 EMERGENCY SERVICES

Each clinic must have a mechanism in place for handling emergency services related to contraceptive services after regular clinic hours.

FEDERALLY QUALIFIED HEALTH CENTERS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Federally Qualified Health Centers (FQHCs), designated FQHC look-alikes, and Tribal Health Centers (THCs) electing to be reimbursed as an FQHC. Subsequent references to FQHCs in this chapter are applicable to all three entities. This chapter provides policy and reimbursement information specific to FQHCs and is to be used in combination with other chapters in this Medicaid Provider Manual.

Section 330 of the Public Health Service Act establishes guidelines for health centers applying for grant funding under the Health Centers Consolidation Act of 1996 (Public Law 104-299). This act combined four federal health center grant programs under one authority (community, migrant, homeless and public housing). Health centers applying for and meeting the criteria for grant funding under Section 330 are eligible to be recognized as FQHCs by CMS for reimbursement purposes. Once FQHC status is designated by CMS and notification of that status is provided to the Michigan Department of Community Health (MDCH), an FQHC is eligible to enroll with Medicaid as an FQHC provider in the State of Michigan.

Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 makes provision for the reimbursement of FQHCs under a prospective payment system (PPS). This PPS applies to the ambulatory/outpatient medical services that FQHCs are required under federal regulation to provide to Medicaid beneficiaries.

Under BIPA, states may elect to reimburse FQHCs under the PPS methodology outlined in the law or they may choose to implement an alternative payment methodology that is agreed to by the FQHC and the state. If an alternative methodology is implemented, it must result in payment at least equal to that which an FQHC would receive under the BIPA PPS.

1.1 MEMORANDUM OF AGREEMENT FOR REIMBURSEMENT

MDCH may enter into an alternative reimbursement methodology with the FQHC known as a Memorandum of Agreement (MOA). Reimbursement for Medicaid primary care services provided by an FQHC to Medicaid beneficiaries is subject to the terms of the signed MOA. The MOA provides reimbursement at least equal to that which the FQHC would have received under the PPS required under federal regulation (BIPA 2000).

The MOA is effective when both MDCH and an FQHC are signatories to the document. The signed agreement supersedes any corresponding policy in the Medicaid Provider Manual. If an FQHC does not sign the MOA, reimbursement and corresponding policy defaults to that which is outlined in this policy manual.

1.2 ENROLLMENT

Each FQHC that is certified by CMS to provide services as a Medicare-enrolled FQHC is eligible to apply to MDCH to be a Medicaid provider. To apply, the FQHC must submit the CMS Medicare certification letter to the MDCH Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.) The FQHC must also notify the MDCH Hospital and Health Plan Reimbursement Division (HHPRD) of certification and enrollment in order to be reimbursed under the PPS.

Each FQHC employed physician (MD, DO), dentist, optometrist, certified nurse practitioner (CNP), and certified nurse midwife (CNM) must be enrolled as a Medicaid provider. Any of these practitioners who is subcontracted with an FQHC must be enrolled as the FQHC's employee in order to be reimbursed under the FQHC PPS. (Refer to the General Information for Providers Chapter of this manual for enrollment information.)

The FQHC has responsibility for notifying the Provider Enrollment Unit and HHPRD of any new physicians, dentists, optometrists, CNPs, CNMs, and/or subcontractors joining the FQHC. To notify MDCH, attach a copy of the original CMS FQHC certification letter to the Medical Assistance Provider Enrollment & Trading Partner Agreement (DCH-1625). These documents are required to approve the practitioner as a provider of FQHC services. (Refer to the Directory Appendix for contact information.)

The FQHC must provide MDCH Provider Enrollment Unit and HHPRD with written notification of any terminating physicians, dentists, optometrists, CNPs, CNMs, and/or subcontractors leaving the FQHC. In the letter, the provider's name, Medicaid identification (ID) number, and termination date must be identified.

FQHC services that are furnished under contract with physicians, clinical social workers, clinical psychologists, physician assistants, certified family and pediatric NPs, visiting nurses, and other approved professionals are billed as FQHC services. However, preventive primary services must be provided by an employee of the FQHC or by a physician under contract with the FQHC. Preventive primary services do not qualify as FQHC services if non-employee providers (except physicians) contracting with the FQHC provide the services.

1.3 Site Specific Certification

FQHCs are required to submit to the MDCH Provider Enrollment Unit documentation of CMS approval as an FQHC provider for each site operated by the FQHC prior to Medicaid enrollment of that site. Satellite FQHC sites not approved by CMS are not eligible for FQHC PPS reimbursement. Copies of approval letters from CMS must be sent to the MDCH HHPRD. (Refer to Directory Appendix for contact information.)

1.4 Allowable Places of Service

Services provided to beneficiaries within the four walls of the FQHC and approved FQHC satellites are allowable for reimbursement under the PPS.

Off-site services provided by employed practitioners of the FQHC to patients temporarily homebound or in any skilled nursing facility because of a medical condition that prevents the patient from going to the FQHC for health care are also allowable for reimbursement under the PPS.

1.5 Nonenrolled Provider Services

Professional services provided by FQHC clinical social workers, clinical psychologists, and physician's assistants are reimbursed under the PPS. However, these providers are not enrolled in Medicaid and, accordingly, do not have their own Medicaid provider identification (ID) numbers. Services provided by these professionals must be billed under the supervising physician's Medicaid ID number. The supervising physician is responsible for ensuring the medical necessity and appropriateness of these services. The clinical psychologist and clinical social worker services must be billed with the appropriate procedure codes that reflect the services provided.

Services provided by clinical psychologists and clinical social workers are included in the 20 outpatient visits for MHP members. FQHCs must participate as part of a MHP provider panel in order to bill for services provided to members, and all services must be prior authorized by the respective MHP.

SECTION 2 – BENEFITS

FQHC services subject to PPS reimbursement are FQHC services defined at Section 1861 (aa)(1)(A)-(C) of the Social Security Act.

2.1 PRIMARY CARE SERVICES

Primary care services are defined as:

- Those required under Section 330 of the Public Health Service Act.
- Medicaid-covered services provided in a place of service that is the FQHC's office or clinic, patient's home, Domiciliary Facility Nursing Home, Nursing Facility (NF), or Skilled Nursing Facility by a provider type physician, medical clinic, podiatrist, dentist, CNP or CNM.
- Medicaid-covered inpatient hospital care (as specified in the MOA) limited to the following procedures:
  - Initial inpatient consultations;
  - Follow-up inpatient consultations;
  - Initial hospital care;
  - Subsequent hospital care; and
  - Newborn care.
- Visits by a clinical psychologist or clinical social worker at the FQHC's office or clinic, patient's home, Domiciliary Facility Nursing Home, Nursing Facility, or Skilled Nursing Facility.
- Other ambulatory services, i.e., Medicaid transportation, Medicaid outreach, and Maternal Infant Health Program (MIHP) services.

2.2 TRANSPORTATION

Non-emergency transportation of the Medicaid beneficiary to and from the FQHC is covered. MDCH requires Medicaid transportation documentation. This documentation would include actual mileage per trip, total mileage for fiscal year, beneficiary Medicaid ID Number and date of service (DOS). The documentation may be requested by HHPRD after the annual reconciliation report has been filed.

SECTION 3 – ENCOUNTERS

3.1 DEFINITION

An allowable FQHC encounter means a face-to-face medical visit between a patient and the provider of health care services who exercises independent judgment in the provision of health care services.

An encounter occurs between a medical provider and a patient when medical services are provided for the prevention, diagnosis, treatment, or rehabilitation of an illness or injury. Included in this category are physician visits and mid-level practitioner visits. Family planning medical visits are a subset of medical visits.

An encounter occurs between a dentist or dental hygienist and a patient when services are for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. A dental hygienist is credited with an encounter only when the professional provides a service independently, not jointly with a dentist. However, two encounters may not be billed for the dental clinic in one day.

An encounter occurs between a speech or physical therapist, audiologist, occupational therapist, clinical psychologist, or clinical social worker and a patient when allied health or mental health services are provided. Allied health services are those provided by specially trained health workers, other than medical and dental personnel. Mental health services are those of a psychological or crisis intervention nature or related to alcohol or drug abuse treatment. For the purpose of these reports, visits with a psychiatrist are included under medical visits.

The following examples help to define an encounter:

- To meet the encounter criteria for independent judgment, the provider must be acting independently and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample is not credited with a separate encounter.
- Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, filling/dispensing prescriptions, or optician services, in and of themselves, do not constitute encounters. However, these procedures may accompany services performed by medical, dental, or other health providers that do constitute encounters.
- Encounters must be documented in the medical record. When a provider renders services to several patients simultaneously, the provider can be credited with a visit for each person if the provision of services is noted in each person's health record. This also applies to family therapy or counseling sessions in which several members of the family receive services relating to mutual family problems and the services are noted in each family member's health record.
- The same billing limitations identified in the General Information for Providers Chapter of this manual apply to claims submitted for FQHC encounters.

The encounter criteria are **not** met in the following circumstances:

- When a provider participates in a community meeting or group session that is not designed to provide health services.

- When the only service provided is part of a larger scale effort, such as a mass immunization program, screening program, or community-wide service program.
- When the following services are provided as stand-alone services: taking vital signs, taking a history, drawing a blood sample, collecting urine specimens, performing laboratory tests, taking x-rays, and/or filling/dispensing prescriptions. Refilling prescriptions, filling out insurance forms, etc., are not visits. Allergy injection(s) are not visits.

3.2 Medicaid Health Plans

Medicaid-covered services provided by an FQHC to Medicaid-eligible beneficiaries enrolled with an MHP are subject to the PPS when the following conditions are met:

- The FQHC and the MHP must be signatories to a contract that addresses the FQHC providing Medicaid covered services to an MHP enrollee.
- The contract must provide for the MHP to reimburse the FQHC at a fair market rate for similarly situated beneficiaries served by a non-PPS provider. The contractor must implement a payment method equal to, or above that of, other affiliated inter-plan and intra-plan subcontracting arrangements when entering into a subcontract with an FQHC.
- The FQHC must request that MDCH pay the PPS rate for MHP enrollees.

MHP beneficiaries are identified with a Level of Care Code 07. Providers must verify eligibility through the eligibility verification system (EVS) before providing services. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

3.3 Healthy Kids Dental

Dental services provided to Medicaid beneficiaries enrolled in the Healthy Kids Dental program are subject to the PPS or MOA rate.

3.4 Substance Abuse Coordinating Agency

Services provided by a Substance Abuse Coordinating Agency (CA) are subject to the PPS or MOA rate when contracted between the FQHC and the CA.

3.5 Allowable Encounters Per Day

An individual provider may be credited with no more than one encounter per patient during a single day, except when the patient, after the first visit, suffers illness or injury requiring additional diagnosis or treatment. For example, a patient sees a physician for flu symptoms early in the day, and then later the same day sees the same physician for a broken leg. These visits may be classified as two encounters.

An FQHC is entitled to two encounters for different types of visits on the same day. For example, a patient first sees a physician at the FQHC and then later sees a dentist. These visits may be classified as two encounters.

3.6 Services and Supplies Incidental to an FQHC Encounter

Services and supplies incident to a FQHC encounter are included in the PPS reimbursement if the service or supply is:

- Of a type commonly furnished in physicians' offices.
- Of a type commonly rendered either without charge or included in the professional bill.
- Furnished as an incidental, although integral part of professional services furnished by a physician, CNP, CNM, or physician's assistant.
- Furnished under the direct personal supervision of a physician, CNP, CNM, or physician's assistant.
- In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

The direct personal supervision requirement is met in the case of a CNP, CNM, or physician's assistant only if such a person is permitted to supervise such services under the written policies governing the FQHC.

SECTION 4 – BILLING

FQHC services must be billed according to instructions published in the Billing & Reimbursement for Professionals Chapter of this manual. FQHCs must refer to this chapter for information needed to submit professional claims for Medicaid services, as well as information about how MDCH processes claims and notifies the FQHC of its action. Policies for specific services are found in the provider-specific chapters of this manual.

It is the responsibility of the FQHC to properly bill all Medicaid FFS claims. Since the annual reconciliation and final reimbursement is based on approved Medicaid claims, incorrect or improper billing may adversely effect reimbursement.

MDCH strongly encourages electronic submission of claims.

The FQHC's MDCH-approved claims must be available for review by authorized personnel or agents of MDCH, the Health Care Fraud Division of the Michigan Department of Attorney General, and U S Department of Health and Human Services in conformity with the provisions of the Social Security Act.

4.1 PLACE OF SERVICE

When billing services provided within the FQHC, the appropriate place of service code is 50. For services not provided in the FQHC, bill the appropriate place of service code listed in the Billing & Reimbursement for Professionals Chapter of this manual.

FQHCs providing Medicaid-covered services in locations other than the FQHC office, home, nursing facility or domiciliary facility are reimbursed at Medicaid fee screens.

4.2 COORDINATION OF BENEFITS

It is the provider's responsibility to question the beneficiary as to the availability of Medicare and other insurance coverage prior to the provision of a service. Providers must bill third party payers and receive payment to the fullest extent possible before billing Medicaid. Private health care coverage and accident insurance, including coverage held by, or on behalf of, a Medicaid beneficiary is considered primary and must be billed according to the rules of the specific commercial plan. (Refer to the Coordination of Benefits Chapter of this manual for additional information.)

The MDCH is not liable for payment of services that would have been covered by the private payer if applicable rules of that private plan had been followed. The beneficiary must seek care from network providers and authorizations or referrals must be obtained as required. If the provider does not participate with the commercial carrier, the provider is expected to refer the beneficiary to a participating provider.

Some private commercial managed care plans involve a capitation rate and fixed co-pay amount. In this instance, it is impossible to determine a specific other insurance payment. MDCH will pay a fixed co-pay amount up to our maximum allowable fee for the service.

4.2.A. Other Insurance and Coverage Payments

All other insurance payments received for services rendered to a Medicaid beneficiary must be reported on the claim submitted to Medicaid. Even if the other insurance payment for a specific service exceeds the amount Medicaid would have paid, the FQHC must still bill the FFS procedure code to receive credit for the encounter. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for specific billing guidelines.)

4.2.B. Medicare and Medicaid Crossover Claims

If a Medicaid beneficiary has Medicare and Medicaid, the FQHC must follow the billing instructions in the Billing & Reimbursement for Professionals Chapter of this manual. Even if the Medicare payment exceeds the Medicaid fee screen, the FQHC must still bill the FFS procedure code to receive credit for the encounter.

4.3 Co-Payments

The Medicaid co-payments for chiropractic, dental, podiatry, and vision services are waived under the FQHC benefit as part of the reconciliation. (Services requiring co-payment are listed in the General Information for Providers Chapter of this manual.)

4.4 Dental Claims

FQHCs providing dental services must refer to the Dental and Billing & Reimbursement for Dental Providers chapters of this manual for information regarding program coverages, prior authorizatioin requirements, claims completion, and billing instructions.

4.5 Billing for Maternity Care

Global codes for maternity care are used to reimburse a package of services (prenatal visits and delivery) at different places of services (FQHC and hospital). In order for the FQHC to be reimbursed for prenatal visits under the PPS methodology, the FQHC should not bill for global maternity care. The claims for delivery and prenatal care should be billed separately. The claim for delivery should show a hospital place of service and will be paid under the FFS methodology. The claim for prenatal care should be billed with a FQHC place of service (50) using the appropriate prenatal codes. These prenatal services will be reimbursed under the PPS methodology.

If the FQHC elects to bill for global maternity care, all services will be reimbursed under the FFS rules.

SECTION 5 – MEDICAID RECONCILIATION REPORT

5.1 RECONCILIATION OF FEE-FOR-SERVICE

Each FQHC is required to submit an annual Medicaid Reconciliation Report. MDCH will include as part of the annual Medicaid Reconciliation Report, fee-for-service (FFS) primary care services claims that are approved through the claims system. In order for this to occur, all FFS primary care services must be submitted and processed through the Medicaid Claims Processing (CP) System. (Refer to the primary care services defined previously in this chapter.) Every individual provider or electronic biller (the billing agent) receives a remittance advice (RA) for services that are billed. The RA informs the provider of the action taken on claims. It is the responsibility of FQHC providers to monitor claim activity and take appropriate steps to resolve pended and rejected claims prior to the final reconciliation. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional billing information.)

For non-primary care services, the FQHC will receive the Medicaid FFS amounts or the amount agreed to with the MHP as payment in full. The FQHC may enter into a risk contract with the MHP for services not included in the primary care definition. Non-primary care services and risk contracts will not be reconciled and are not included in the Medicaid Reconciliation Report.

5.2 RECONCILIATION OF MHPS

The FQHC must file an FQHC Medicaid Reconciliation Report with the MDCH HHPRD and must indicate:

- The number of primary care member months;
- The number of primary care visits for beneficiaries with only Medicaid coverage;
- The number of primary care visits for beneficiaries with dual Medicare and Medicaid coverage;
- The amount of primary care payments from MHPs; and
- All other payments from MHPs.

The FQHC must, upon request, forward a copy of its MHP contract to the MDCH HHPRD.

MDCH will reimburse the difference between the FQHC PPS rate and the MHP payments. The contract and all FQHC services are subject to audit and review.

5.3 RECONCILIATION OF QUARTERLY ADVANCES

Quarterly advances are included as Medicaid revenue on the Medicaid Reconciliation Report and are reconciled with the FQHC PPS. The quarterly payment will be made on the RA at the beginning of each quarter.

Quarterly advances are an estimate of the difference between the payments that a MHP, Substance Abuse Coordinating Agency, and the Healthy Kids Dental contractor make to the FQHC, and the payments the FQHC would have received under the PPS. This quarterly amount may be adjusted periodically by MDCH to account for changes in the payment limits, cost, utilization, and other factors that affect Medicaid reimbursement to FQHCs. The FQHC may request a change in the quarterly payment through the HHPRD.

5.4 Reconciliation of Transportation

Medicaid transportation is paid at actual cost up to the federal mileage reimbursement rate. Medicaid transportation is paid annually with the reconciliation. Documentation of the actual mileage must be provided on the Medicaid Reconciliation Report. Transportation requirements are defined in the Benefits Section of this chapter.

5.5 Prospective Payment Per Visit Rate

An FQHC is reconciled to the prospective payment per visit rate determined under the PPS or the MOA. Under BIPA of 2000, the PPS per visit payment is equal to 100 percent of the average of the FQHC reasonable costs of providing Medicaid services during Fiscal Years 1999 and 2000. The Medicaid per visit amount is an all-inclusive rate that covers all defined primary care services. (Refer to the Medicaid Reconciliation Report subsection of this section for a definition of reasonable costs.)

5.6 New FQHC Prospective Payment Rate

An entity that initially qualifies as an FQHC after fiscal year 2000 will be paid a per visit amount that is equal to 100 percent of the costs of furnishing primary care services during such fiscal year based on the rates established under the PPS for the fiscal year for other FQHCs located in the same or adjacent area with a similar case load. If there is not another FQHC similarly situated, the newly established FQHC shall be paid a per visit amount based on an estimate of its reasonable costs of providing such services and reconciled at the end of its first fiscal year of operation. (Refer to the Medicaid Reconciliation Report subsection of this section for a definition of reasonable costs.)

A newly established FQHC is eligible for quarterly payments. The amount of the quarterly payment will be estimated until the first reconciliation period. In subsequent years, the newly established FQHC shall be paid using the PPS methodology or an alternate MOA methodology.

5.7 PPS Medicare Economic Index Adjustment

The per visit amount is adjusted each year using the Medicare Economic Index beginning January 1, 2002, based on changes in the Medicare Economic Index for the prior calendar year.

5.8 PPS Adjustments in the Per Visit Rate

The per visit rate may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by an FQHC. An adjustment to the per visit rate based upon a change in the scope of services will be prospective. The adjustment may result in either an increase or decrease in the per visit amount paid to the FQHC. (Refer to the Scope of Service subsection of this section for additional information.)

5.9 Alternative Payment Methodology

Some FQHCs have elected to be reimbursed under an alternative method referred to as the Memorandum of Agreement (MOA). FQHCs signing the MOA will be subject to the terms, conditions, and requirements at the time the MOA was signed by both MDCH and the FQHC. The MOA terms, conditions, and requirements include, but are not limited to, calculation of the prospective payment amount (PPA), PPA

services, adjustment to the PPA for changes in the scope of services, denial of change in PPA, quarterly payments, and settlements.

5.10 Scope of Service

5.10.A. Increase/Decrease in Scope of Service

The prospective payment rate may be adjusted for an increase or decrease in scope of service.

- An increase in scope of service results from the addition of a new professional staff member (i.e., contracted or employed) who is licensed to perform medical services that are approved FQHC benefits that no current professional staff is licensed to perform.
- A decrease in scope of service results when no current professional staff member is licensed to perform the medical services currently performed by a departing professional staff member.

An increase or decrease in scope of service does **not** result from any of the following (although some of these changes may occur in conjunction with a change in scope of service):

- An increase, decrease or change in number of staff working at the clinic.
- An increase, decrease or change in office hours.
- An increase, decrease or change in office space or location.
- The addition of a new site that provides the same set of services.
- An increase, decrease or change in equipment or supplies.
- An increase, decrease or change in the number or type of patients served.

5.10.B. Notice of Intent to Change Scope of Service

If an FQHC intends to change its scope of service, the MDCH HHPRD must be notified 90 days before any financial commitments (i.e., money paid or committed to be paid, contracts signed, etc.) have been made. It is the responsibility of the FQHC to notify MDCH for an increase or decrease in scope of service. Notification should include the following documentation:

- A complete description of the service to be changed (addition or deletion).
- A listing of procedure codes to be billed as a result of this new service.
- A budget for the fiscal year showing an estimate of the total increase or decrease in cost resulting from change.
- An estimate of the change in number of visits.
- Estimates of the cost change on the current Medicaid per visit rate.
- The proposed customary charges for this service by the clinic.

- The customary charges for this service by other providers in the area served by this clinic.
- The amount to be paid by a MHP for this service for various programs (Medicare/Medicaid).
- Medicare fee screen for this service for non-PPS providers.
- The current Medicare visit rate.
- Total encounters for last two years by program (Medicaid, Medicare, uninsured, etc.) and type (MHP, fee screen, contracted amount).
- Estimated increase in encounters by program for two fiscal periods following the change in scope of service.
- Copies of notices, certifications, applications, approvals and other documentation from state licensing agency, CMS, Medicare intermediary, or other organizations documenting the change in scope of service.
- Other information showing cost, visits or approvals/denials of the change.
- Other information as requested by HHPRD.

After a review of the information submitted, HHPRD determines if a per visit rate change will be made and notifies the FQHC, specifying the effective date of any change. All scope of service changes are made on a prospective basis.

5.11 Medicaid Reconciliation Report

Each FQHC must complete an FQHC Medicaid Reconciliation Report for its fiscal year. The MDCH HHPRD must receive the report by the due date for the Medicare Cost Report in order for the FQHC to receive PPS reimbursement.

The FQHC's authorized individual who certifies the report and accompanying worksheets for the period noted must sign its FQHC Medicaid Reconciliation Report. If the required report and supplemental documents are not submitted within the required time limit, the FQHC waives its rights to PPS reimbursement for that year.

The FQHC Medicaid Reconciliation Report must be for the same fiscal period and cover the same sites as the Medicare Cost Report.

5.11.A. Reasonable Costs

Reasonable and allowable costs are defined as the per visit amount approved and paid by Medicare or as defined in an MOA.

5.11.B. Maintenance of Medical and Financial Records

The FQHC must maintain, for a period of not less than six years, financial and clinical records for the period covered by the reconciliation report that are accurate and in sufficient detail to substantiate the cost data reported. The records must be maintained

until all issues are resolved. Expenses reported as reasonable costs must be adequately documented in the financial records of the FQHC or the expenses will be disallowed.

The MDCH HHPRD will maintain each required FQHC Medicaid Reconciliation Report submitted by the provider for six years following the date of submission of the report. In the event that there are unresolved issues at the end of this six-year period, the report will be maintained until such issues are resolved.

The financial and clinical records of the FQHC must be available for review by authorized personnel or agents of MDCH, the Health Care Fraud Division of the Michigan Department of Attorney General, and US Department of Health and Human Services in conformity with the provisions of the Social Security Act.

SECTION 6 – AUDITS, RECONCILIATIONS AND APPEALS

6.1 QUARTERLY ADVANCES AND RISK CONTRACTS

The FQHC's quarterly advances will be reconciled annually on the reconciliation report. Risk contracts will not be reconciled.

6.2 RECONCILIATION AND SETTLEMENTS

6.2.A. INITIAL SETTLEMENTS OF FQHCS

An initial settlement is calculated annually. Calculations are determined from the filed FQHC Medicaid Reconciliation Report and Medicaid paid claims information. An initial settlement will be completed generally within three months of the receipt of a complete and acceptable reconciliation report. MDCH retains the right to withhold a portion of an initial payment based on individual circumstances.

6.2.B. FINAL SETTLEMENTS OF FQHCS

Final settlements for FQHCs are generally completed within one year of the FQHC fiscal year end using updated Medicaid data for the period covered by the FQHC Medicaid Reconciliation Report. This will allow sufficient time for all claims to clear the Medicaid payment system. Medicaid data will be updated using approved claims payment data, all other payments for Medicaid services, and Medicaid visits.

The Medicare intermediary field and/or desk audit may cause MDCH to process an additional final settlement. After review of the revised cost report and any statistical and audit findings pertaining to it, MDCH may process a revised Medicaid final settlement for the period covered by the reconciliation report.

6.2.C. UNDERPAYMENTS TO FQHCS

MDCH staff process the full amount of the final settlement through a gross adjustment.

6.2.D. OVERPAYMENTS TO FQHCS

Once a determination of overpayment has been made, the amount determined is a debt owed to the State of Michigan and shall be recovered by MDCH. The recovery will start approximately 30 days after notification to the FQHC. A credit gross adjustment will stop all payments to the FQHC physician(s) until the amount is recovered. This amount will be reflected on the Remittance Advice (RA).

Any issues left unresolved due to the Medicare audit and/or Medicare adjustment process must be appealed through the proper Medicare process before any changes can be made to the Medicaid settlements.

6.3 Response to the Audit Adjustment Report

MDCH staff prepares the Audit Adjustment Report, which contains a descriptive list of all Medicaid data adjustments made to the Medicaid Reconciliation Report by MDCH audit staff. The Audit Adjustment Report must be accepted or rejected by the FQHC within 30 calendar days of its mailing date.

The FQHC may take the following actions:

FQHC Accepts the Report	If the FQHC accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the FQHC must sign the report and mail it to the MDCH HHPRD. (Refer to the Directory Appendix for contact information.) A Notice of Amount of Program Reimbursement will be mailed to the FQHC. No further administrative appeal rights will be available for the adjustments contained in the Audit Adjustment Report.
FQHC Does Not Respond	If the FQHC does not respond within this time period, MDCH shall issue a Notice of Amount of Program Reimbursement, which is the final determination of an adverse action. No further administrative appeal rights are available.
FQHC Rejects the Report	If the FQHC rejects any or all of the findings contained in the Audit Adjustment Report, the FQHC may request a Post-Audit Conference within 30 calendar days from the date of receipt of the Audit Adjustment Report.

The Notice of Amount of Program Reimbursement is the notice of final determination of an adverse action and is considered the offer of settlement for all reimbursement issues for the reporting period under consideration.

6.4 Medicaid Appeals

Medicaid providers have the right to appeal any adverse action taken by MDCH unless that adverse action resulted from an action over which the MDCH had no control (e.g., Medicare termination, license revocation). The appeal process is outlined in the General Information for Providers Chapter of this manual and in the MDCH Medicaid Provider Reviews and Hearings Rules, R400.3401 through R400.3424, filed with the Secretary of State on March 7, 1978. Any questions regarding this appeal process should be directed to the Administrative Tribunal. (Refer to the Directory Appendix for contact information.)

HEARING AID DEALERS

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SECTION 1 - COVERAGE OVERVIEW

This chapter applies to Hearing Aid Dealers (Provider Type 90).

The primary objective of Medicaid is to ensure that essential medical/health services are made available to those who would not otherwise have the financial resources to purchase them. The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services, recommended and supported by a pediatric subspecialist, with care coordination that relates to the CSHCS qualifying diagnosis. Policies are aimed at maximizing the health care services obtained for this population with the limited number of dollars available.

The term Medicaid throughout this chapter refers to both the Medicaid Program and the CSHCS Program.

1.1 PROVIDER LICENSURE REQUIREMENT

Services must be provided by a Medicaid-enrolled hearing aid dealer licensed in the state of Michigan and must conform to the standards of practice described in the current Michigan Occupational Code (Act 299 of 1980, Article 13).

1.2 HCPCS CODES, PARAMETERS AND MODIFIERS [CHANGE MADE 4/1/06]

For specifics regarding Medicaid coverage of the Healthcare Common Procedure Coding System (HCPCS), refer to the Hearing Aid Dealers Database on the MDCH website. (Refer to the Directory Appendix for website information.) The database includes HCPCS codes, short descriptions, current activity status, fee screens, quantity limits, prior authorization (PA) indicators and age limits.

If no established procedure code adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code. All NOC codes require PA.

The "LT" or "RT" modifiers must be reported for all monaural hearing aids, hearing aid repairs/ modifications and earmolds to designate either the left or right side of the body. When the same service is provided for both the left and right ears on the same date of service, the service should be reported on two separate claim lines with the appropriate modifier on each line. **(per bulletin MSA 06-11 effective 4/1/06)**

1.3 COVERED SERVICES

Medicaid covers the following services when provided by a licensed hearing aid dealer:

- Hearing aids and delivery
- Hearing aid repairs and modifications
- Replacement earmolds
- Hearing aid supplies and accessories
- Replacement of hearing aid batteries
- Alternative listening devices for beneficiaries over age 21 years

1.4 Noncovered Items

Noncovered items include, but are not limited to, the following:

- Hearing aids that do not meet U.S. Food and Drug Administration (FDA) and Federal Trade Commission requirements
- Spare equipment (e.g., an old hearing aid in working condition for back-up use in emergencies)
- Personal FM Amplification Systems
- Alerting devices
- Hearing aids requested solely or primarily for the elimination of tinnitus
- Equipment requested solely or primarily for cosmetic reasons or package features relative to cosmetics
- Hearing aids delivered more than 30 days after a beneficiary becomes ineligible for Medicaid

1.5 Mandatory Hearing Aid Manufacturer's Warranty

Medicaid requires that all hearing aids include a manufacturer's warranty that guarantees replacement of a lost, broken or stolen hearing aid one time within the first 12 months after the hearing aid is dispensed. This guarantee must be provided at no cost to the beneficiary or to Medicaid.

1.6 Co-Payments

Beneficiaries are required to pay a $3.00 co-payment for a hearing aid. Exceptions to the co-payment include:

- Medicaid beneficiaries under age 21
- All CSHCS beneficiaries
- All beneficiaries residing in a nursing facility

Providers may not refuse to render service if a beneficiary is unable to pay the co-payment amount at the time the service is provided. However, the uncollected co-payment is considered a bad debt which allows the provider to refuse to provide future services according to Michigan's State Plan. Providers who elect not to provide services based on a history of bad debt, including unpaid co-payments, must give beneficiaries appropriate verbal notice and a reasonable opportunity for payment.

When calculating reimbursement, Medicaid deducts the co-payment from the amount billed when applicable. If the provider deducts the co-payment from his claim, an underpayment results. Addition of the co-payment amount to the acquisition cost is not allowed.

1.7 Dispensing Fee [Change Made 4/1/06]

The hearing aid dealer may only bill the dispensing fee when providing direct patient contact in delivering and instructing beneficiaries on the use and care of the hearing aid. The dispensing fee is billed separate from the hearing aid using the appropriate HCPCS code. Components of the dispensing fee are not to be billed separately. Reimbursement for the hearing aid dispensing fee includes, but is not limited to:

- Hearing aid delivery
- Modification and adjustments required within the manufacturer's warranty period
- Fitting, orientation and checking of the hearing aid
- Instructions on use and care of the hearing aid
- Initial earmolds and impressions
- All necessary components that may include cords, tubing, connectors, receivers and huggies
- One standard package of appropriate batteries per aid (or charger for rechargeable models)
- One year warranty on parts and labor repairs
- A minimum 30-day trial/adjustment period with exchange/return privilege

Providers may not receive dispensing fee reimbursement for hearing aids returned during the 30-day trial period. Any dispensing fees paid to providers for hearing aids subsequently returned during the 30-day trial period must be returned to MDCH via a claim replacement.

MDCH will reimburse for hearing aid fitting/checking services provided during the 30-day trial on returned hearing aids. This service may be billed once per day, a maximum of two times per year, without PA. **(per bulletin MSA 06-11 effective 4/1/06)**

1.8 Medical Clearance

A medical clearance is a signed statement from the physician indicating that:

- A medical evaluation has been performed; and
- There are no contraindications to the use of a hearing aid.

For Medicaid beneficiaries under age 18, an otolaryngologist must complete the medical clearance.

For Medicaid beneficiaries age 18 years or older, the medical clearance may be completed by either an otolaryngologist or the primary care physician.

The medical clearance must include the beneficiary's name, birth date, address, Medicaid identification (ID) number, the services provided, the DOS, the provider's name and Medicaid provider ID number. When the medical clearance is provided by a physician who is not enrolled in Medicaid, it must include the physician's complete office address and phone number.

1.9 Hearing Aid Evaluation and Selection

After receiving the medical clearance, the beneficiary must be referred to one of the following Medicaid-enrolled providers for the hearing aid evaluation and selection:

- Outpatient Hospital
- Comprehensive Outpatient Rehabilitation Facility
- Outpatient Rehabilitation Agency
- University Affiliated Audiology Graduate Education Program

- American Speech-Language-Hearing Association Certified Audiologist/Hearing Center

The hearing aid evaluation and selection must be provided by:

- An audiologist possessing a current Certificate of Clinical Competence (CCC-A) from the American Speech-Language-Hearing Association (ASHA).
- An audiologist candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a CCC-A) supervised by an audiologist having a current CCC-A.
- An audiology student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) an audiologist having a current CCC-A.

Standards of practice must conform to those published in ASHA Preferred Practice Patterns for the Profession of Audiology. Audiologic test equipment and hearing aid test equipment used must conform to applicable American National Standards Institute (ANSI) criteria.

The following equipment must be available to audiologists providing services to infants less than six months of age:

- Infant Diagnostic Testing
  - Tone Burst ABR; and
  - Bone Conduction ABR; and
  - High Frequency Immittance; and
  - Otoacoustic Emissions
- Infant Hearing Aid Evaluation, Selection, and Follow-up
  - Infant Predictive Method (e.g., Desired Sensation Level); and
  - Real-Ear to Coupler Difference

After the appropriate audiologic procedures have been completed and it is determined that the beneficiary requires a hearing aid, a recommendation for the hearing aid is completed and signed by the audiologist. The recommendation, as well as a copy of the physician's medical concurrence, is given to the beneficiary.

1.10 Documentation in Beneficiary File

Hearing aid dealers must maintain all applicable documentation in the beneficiary's file for six years. For audit purposes, the hearing aid dealer's records or patient's medical record must substantiate the medical necessity of the item supplied.

1.11 Measurable Benefits/Hearing Aid Conformity Check

Hearing aid dealers must instruct beneficiaries to return to the evaluating audiologist for the conformity evaluation during the 30-day trial period. Any delivered hearing aid(s) is expected to demonstrate measurable benefit, established either at the time of fitting or follow-up. Benefit may be established by any one of, or a combination of, commonly used procedure(s), including measures of aided hearing and understanding of speech; functional gain measures; probe-microphone measurements, and/or

(minimally) the subjective impressions of the beneficiary, the beneficiary's family member(s) or guardian, or attending staff. One of, or a combination of, the following measures may demonstrate benefit in cases of severe to profound hearing loss:

- Improved functional or insertion gain in the speech frequencies.
- Increased awareness of speech and/or environmental sounds.
- Improved speech recognition performance at average or slightly raised conversational levels with or without visual cues.
- Beneficiary's or family members' subjective report of speech benefit in everyday listening situations.

When a delivered hearing aid does not provide benefit, as defined above, providers are expected to return it to the manufacturer within 30 days for circuitry modifications, remake, exchange, or credit, as recommended by the evaluating audiologist. The hearing aid dealer must notify the beneficiary of this when the hearing aid is dispensed.

All full or partial refunds made by a manufacturer to the hearing aid dealer when a hearing aid is returned within the 30-day trial period and replaced with a less costly aid must be returned to Medicaid via a claim replacement.

1.12 Prior Authorization

Prior authorization (PA) is required for certain services before the services are rendered. To determine which services require PA, refer to the Standards of Coverage, Limitations and Payment Rules Section of this Chapter or the Hearing Aid Dealers Database on the MDCH website.

PA is required for the following situations:

- All hearing aids, except conventional analog hearing aids meeting the bilateral standards of coverage.
- Alternative Listening Devices.
- Services and items that exceed quantity limits, frequency limits, or established fee screen.
- For a NOC code.

1.12.A. Prior Authorization Form and Completion Instructions

Requests for PA must be submitted on the Special Services Prior Approval-Request/Authorization Form (MSA-1653-B). (Refer to the Forms Appendix or the MDCH website for a copy of the form.) Medical documentation (e.g., medical clearance, audiogram and hearing aid recommendation from audiologist, documentation to substantiate the acquisition cost) must accompany the form. The information on the PA request form must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Thorough – Complete information, including manufacturer, model and style of the hearing aid requested, and the appropriate HCPCS procedure codes with applicable

modifiers must be provided on the form. The form and all documentation must include the beneficiary name and Medicaid ID number, provider name, address and Medicaid provider ID number.

PA request forms for all eligible Medicaid beneficiaries must be mailed or faxed to MDCH Prior Authorization Division. To check the status of a PA request, contact the MDCH Prior Authorization Division via telephone. (Refer to the Directory Appendix for contact information.)

A sample of the Special Services Prior Approval-Request/Authorization Form (MSA-1653-B) with additional instructions is available in the Forms Appendix of this manual.

(1.12.B. Emergency Prior Authorization subsection was deleted per bulletin MSA 06-11 effective 4/1/06)

1.12.B. Retroactive Prior Authorization [Renumbered 4/1/06]

Services provided before PA is requested are not covered unless the beneficiary was not eligible on the DOS and a subsequent eligibility determination was made retroactive to the DOS. If MDCH's record does not show that retroactive eligibility was provided, then the request for retroactive PA is denied.

1.12.C. Beneficiary Eligibility [Renumbered 4/1/06]

Approval of a service on the MSA-1653-B confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible. To assure payment, the provider must verify eligibility for Fee-for-Service (FFS) Medicaid or the CSHCS Programs before initiating services. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

1.12.D. Reimbursement Amounts [Renumbered 4/1/06]

Many items have established fee screens that are published in the Hearing Aid Dealers Database. For NOC codes and all codes without established fee screens, the approved reimbursement amount is indicated on the authorized PA request.

1.12.E. Billing Authorized Services [Renumbered 4/1/06]

After authorization is issued, the information (e.g., PA number, procedure code, modifier and quantity) that was approved on the PA must match the information on the claim form. (Refer to the Billing & Reimbursement for Professionals Chapter for complete billing instructions.)

SECTION 2 - STANDARDS OF COVERAGE, LIMITATIONS AND PAYMENT RULES

2.1 HEARING AIDS-GENERAL [CHANGE MADE 4/1/06]

The following definitions are to be used for purposes of administering and clarifying Medicaid coverages and limitations for hearing aid dealers:

Hearing Aid	A hearing aid, also referred to as a hearing instrument, is an electronic device that brings amplified sound to the ear. The hearing aid usually consists of a microphone, an amplifier and a receiver.
Conventional Analog Hearing Aid	An amplification device that uses conventional, continuously varying signal processing. Includes hearing aids that are body worn, behind the ear, in the ear, in the canal and bone conduction. Does not include any hearing aid considered digitally programmable or CROS/BICROS circuitry.
CROS Hearing Aid	Contralateral routing of signal. A hearing aid with a microphone worn on an unaidable ear with a receiver worn on the better ear. The receiver cannot be worn alone.
BICROS Hearing Aid	Bilateral routing of signal. A hearing aid with microphones worn on each ear with a receiver on the better ear.
Programmable Hearing Aid	Digitally controlled analog or digital signal processing hearing aid in which the parameters of the instrument are under computer control.
Digital Hearing Aid	A hearing aid that processes signals digitally (syn:DSP).

Hearing aids are only a benefit when:

- The recommended hearing aid meets U.S. FDA and Federal Trade Commission requirements.
- Medical documentation indicates that the hearing loss is not temporary in nature due to a treatable medical middle ear effusion or that surgery is not planned until at least a year into the future for a conductive type hearing loss.
- No hearing aid has been dispensed to the beneficiary within the last three years.
- The hearing aid includes a mandatory hearing aid manufacturer's warranty

Prior authorization is required when replacing any hearing aid for a beneficiary of any age more frequently than once every three years. For beneficiaries age 21 and over, Medicaid will pay for the replacement of the aid when lost or damaged beyond repair **one** time only within three years of the dispensing date of the lost/damaged aid.

Medicaid will not replace a hearing aid when lost or damaged beyond repair as a result of misuse or abuse by the beneficiary or caregiver. If loss or damage to a hearing aid is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable. A copy of the police or fire report must be submitted with the PA request form.

All liable insurance coverage should be sought before requesting replacement by Medicaid. **(per bulletin MSA 06-11 effective 4/1/06)**

2.2 Conventional Analog Hearing Aids

2.2.A. Standards of Coverage - Bilateral Hearing Loss

The bilateral hearing loss standards of coverage are as follows:

Age Under 21 Years	Conventional analog **monaural or binaural** hearing aid: ▪ Bilateral hearing loss documented by an audiogram showing hearing loss of 25 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000 and 4000 Hz; or ▪ Results of a complete diagnostic audiological evaluation (e.g., auditory brainstem response, evoked otoacoustic emissions, soundfield testing, or any combination of these) indicating a hearing loss of 25 dB HL or greater.
Age 21 Years or Over	Conventional analog **monaural** hearing aid: ▪ Bilateral hearing loss documented by an audiogram showing hearing loss of 30 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000, and 4000 Hz; and ▪ A speech recognition score of at least 20 percent in the ear to be aided.
	Conventional analog **binaural** hearing aid: ▪ Bilateral hearing loss documented by an audiogram showing hearing loss of 30 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000, and 4000 Hz. ▪ A speech recognition score must be greater than 20 percent in both ears; ▪ The four frequency average between ears must not exceed 20dB HL; and ▪ The speech recognition scores must not differ between ears by more than 30 percent.

2.2.B. Standards of Coverage - Unilateral Hearing Loss

The unilateral hearing loss standards of coverage for a conventional analog hearing aid are as follows:

Age Under 21 Years	▪ Hearing loss of 25 dB HL or greater in the ear to be aided with normal hearing in the better ear; ▪ Speech recognition scores must be greater than 60 percent in the ear to be aided; ▪ The beneficiary must be receiving hearing impaired services through the school system; and ▪ A 30-day trial has been completed and indicates that amplification has been accepted and that auditory skills and learning capacity were enhanced or there is a documented history of prior hearing aid use.
Age 21 Years or Over	▪ Hearing loss of 30 dB HL or greater in the ear to be aided with normal hearing in the better ear; ▪ Speech recognition scores must be greater than 60 percent in the ear to be aided; ▪ A Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit or similar inventory indicates a need for amplification; and ▪ Hearing aid is required for independent functioning (e.g., affects on employment, communication status).

2.2.C. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary record includes:

- A medical clearance signed and dated by the physician within six months prior to dispensing the hearing aid.
- An audiogram and recommendation of the make, model and type of hearing aid, signed and dated by the audiologist within six months prior to dispensing the hearing aid.
- Copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts, and shipping and charges.

Additional applicable documentation required when a conventional analog hearing aid is dispensed for unilateral hearing loss includes:

Age Under 21 Years	▪ An audiogram documenting hearing loss of 25 dB HL or greater in the ear to be aided with normal hearing in the better ear. ▪ Documentation of speech recognition scores greater than 60 percent in the ear to be aided. ▪ Documentation from the educational system that the child is receiving hearing impaired services. ▪ Letters of support from the classroom teacher, teacher consultant of the hearing impaired and/or the educational audiologist stating that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial or a documented history of prior hearing aid use.

Age 21 Years or Over	▪ An audiogram documenting hearing loss of 30 dB HL or greater in the ear to be aided with normal hearing in the better ear. ▪ Documentation of speech recognition scores greater than 60 percent in the ear to be aided. ▪ Results of the administration of the Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit or similar inventory indicating need for amplification. ▪ Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

2.2.D. PRIOR AUTHORIZATION REQUIREMENTS

PA is not required for either monaural or binaural conventional analog hearing aids if the bilateral standards of coverage are met.

PA is required for the following:

- Replacement aids within three years.
- Conventional analog hearing aids when the bilateral standards of coverage are not met.
- Conventional analog hearing aids for unilateral hearing loss.

The following documentation must be submitted with all PA requests:

- MSA-1653-B.
- Documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges.
- Medical clearance signed by a physician.
- Audiogram completed within the past six months, signed and dated by the audiologist and including the recommended manufacturer, model and style of hearing aid.

The following additional documentation must be submitted with all PA requests for conventional analog hearing aids provided for unilateral hearing loss:

Age Under 21 Years	▪ An audiogram documenting hearing loss of 25 dB HL or greater in the ear to be aided, with normal hearing in the better ear. ▪ Documentation that the ear to be aided has a speech recognition score greater than 60 percent. ▪ Documentation provided by the educational system that the child is receiving hearing impaired services. ▪ Letters of support from the classroom teacher, teacher consultant of the hearing impaired, and/or the educational audiologist that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial or documentation of a history of prior hearing aid use.

Age 21 Years or Over	▪ An audiogram documenting hearing loss of 30 dB HL or greater in the ear to be aided with normal hearing in the better ear. ▪ Documentation that the ear to be aided has a speech recognition score greater than 60 percent. ▪ Results of administration of the Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit, or similar inventory indicating a need for amplification. ▪ Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

2.2.E. Payment Rules

Payment for a conventional analog hearing aid is the lesser of the provider's acquisition cost or Medicaid's maximum allowable amount. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

2.3 CROS Hearing Aids

2.3.A. Standards of Coverage

CROS hearing aids are a benefit for beneficiaries of all ages when:

- There is demonstrated need for amplification.
- An audiogram indicates no residual hearing in the poorer ear (unaidable) and normal hearing in the better ear as demonstrated by thresholds less than 30 dB HL using the four frequency average of 500, 1000, 2000, and 4000 Hz.

The standards of coverage for CROS hearing aides are as follow:

Age Under 21 Years	▪ The beneficiary must be receiving hearing impaired services through the school system. ▪ A 30-day trial has been completed and indicates that amplification has been accepted and that auditory skills and learning capacity were enhanced or there is a documented history of prior CROS hearing aid use.
Age 21 Years or Over	▪ A Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit, or similar inventory indicates a need for amplification. ▪ Hearing aid is required for independent functioning (e.g., affects on employment, communication status).

2.3.B. Documentation

Applicable documentation to be maintained in the beneficiary record for CROS hearing aids includes:

- A medical clearance signed and dated by the physician within six months prior to dispensing the hearing aid.
- An audiogram and recommendation of the make, model and type of hearing aid, signed and dated by the audiologist within six months prior to dispensing the hearing aid.
- A copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts and shipping charges.
- Documentation of need for amplification addressing beneficiary's communication needs.
- Additional applicable documentation includes:

Age Under 21 Years	▪ Documentation from the educational system that the child is receiving hearing impaired services. ▪ Letters of support from the classroom teacher, teacher consultant of the hearing impaired and/or the educational audiologist stating that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial or documentation of a history of prior CROS hearing aid use.
Age 21 Years or Over	▪ Results of the administration of the Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit, or similar inventory indicating need for amplification. ▪ Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

2.3.C. Prior Authorization Requirements

PA is required for all CROS hearing aids. The following documentation must be submitted with all PA requests:

- MSA-1653-B.
- Documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges.
- Medical clearance signed by a physician.
- Audiogram completed within the past six months, signed and dated by the audiologist and including the recommended manufacturer, model and style. The audiogram must indicate no residual hearing in the poorer ear (unaidable) with normal hearing in the better ear as demonstrated by thresholds less than 30 dB HL using the four frequency average of 500, 1000, 2000, and 4000 Hz.
- Additional requirements include:

Age Under 21 Years	▪ Documentation from the educational system that the child is receiving hearing impaired services. ▪ Letters of support from the classroom teacher, teacher consultant of the hearing impaired and/or the educational audiologist stating that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial.
Age 21 Years or Over	▪ Results of the administration of the Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit, or similar inventory indicating need for amplification. ▪ Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

2.3.D. PAYMENT RULES

Medicaid's payment for a CROS hearing aid is the lesser of the acquisition cost or Medicaid's maximum allowable amount. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

2.4 BICROS HEARING AIDS

2.4.A. STANDARDS OF COVERAGE

BICROS hearing aids are a benefit for beneficiaries of all ages when there is demonstrated need for amplification. The standards of coverage for BICROS hearing aids are as follows:

Age Under 21 Years	An audiogram indicates no residual hearing in the poorer ear (unaidable) and indicates a hearing loss greater than 25 dB HL for the four frequency average of 500, 1000, 2000, and 4000 Hz in the better ear.
Age 21 Years or Over	▪ An audiogram indicates no residual hearing in the poorer ear (unaidable) and indicates a hearing loss greater than 30 dB HL for the four frequency average of 500, 1000, 2000, and 4000 Hz in the better ear. ▪ Hearing aid is required for independent functioning (e.g., affects on employment, communication status).

2.4.B. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary record for BICROS hearing aids includes:

- A medical clearance signed and dated by the physician within six months prior to dispensing the hearing aid.

- An audiogram and recommendation of the make, model and type of hearing aid, signed and dated by the audiologist within six months prior to dispensing the hearing aid.
- A copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts and shipping charges.
- Documentation of need for amplification addressing beneficiary's communication needs.
- For beneficiaries **age 21 years or over:** Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

2.4.C. Prior Authorization Requirements

PA is required for all BICROS hearing aids. The following documentation must be submitted with all PA requests:

- MSA-1653-B.
- Documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges.
- Medical clearance signed by a physician.
- Audiogram completed within the past six months, signed and dated by the audiologist, and including the recommended manufacturer, model and style.
- Additional requirements include:

Age Under 21 Years	An audiogram indicates no residual hearing in the poorer ear (unaidable) and indicates a hearing loss greater than 25 dB HL for the four frequency average of 500, 1000, 2000, and 4000 Hz in the better ear.
Age 21 Years or Over	▪ The audiogram must indicate no residual hearing in the poorer ear (unaidable) and a hearing loss greater than 30 dB HL for the four frequency average of 500, 1000, 2000, and 4000 Hz in the better ear. ▪ Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

2.4.D. Payment Rules

Medicaid's payment for a BICROS hearing aid is the lesser of the acquisition cost or Medicaid's maximum allowable amount. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

2.5 Digital/Programmable Hearing Aids

2.5.A. Standards of Coverage

Digital/Programmable hearing aids are a benefit for beneficiaries **under 21 years of age** only when the digital/programmable aid shows superior performance over a conventional analog hearing aid.

The bilateral hearing loss standards of coverage for digital/programmable monaural or binaural hearing aides are as follows:

- Bilateral hearing loss documented by an audiogram showing hearing loss of 25 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000 and 4000 Hz;

  or

- Results of a complete diagnostic audiological evaluation (e.g., auditory brainstem response, evoked otoacoustic emissions, soundfield testing, or any combination of these) indicating a hearing loss of 25 dB HL or greater.

The unilateral hearing loss standards of coverage for digital/programmable monaural hearing aides are as follows:

- Hearing loss of 25 dB HL or greater in the ear to be aided with normal hearing in the better ear.
- Speech recognition scores must be greater than 60 percent in the ear to be aided.
- The beneficiary must be receiving hearing impaired services through the school system.
- A 30-day trial has been completed and indicates that digital/programmable amplification has been accepted and that auditory skills and learning capacity were enhanced.

2.5.B. Documentation

Applicable documentation to be maintained in the beneficiary's record includes:

- A medical clearance signed and dated by the physician within six months prior to dispensing the hearing aid.
- An audiogram and recommendation of the make, model and type of hearing aid, signed and dated by the audiologist within six months prior to dispensing the hearing aid.
- Copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts, and shipping charges.

When the acquisition cost of the digital/programmable hearing aid exceeds Medicaid's maximum allowable amount for a comparable conventional analog hearing aid, applicable documentation also includes:

- Documentation of superiority of aided thresholds and speech recognition ability in a comparison study of digital/programmable vs. conventional analog aids, including functional gain measures and probe microphone measurements.
- Letters of support from the school system, teacher consultant of the hearing impaired or educational audiologist outlining objective and subjective benefits during a 30-day trial period. Documentation from the parents may be used for supplemental support.
- For infants and young children who are unable to be tested in a comparison study, a letter of justification for advanced technology is required.

When a digital/programmable hearing aid is dispensed for unilateral hearing loss, applicable documentation also includes:

- Documentation from the educational system that the child is receiving hearing impaired services.
- Letters of support from the classroom teacher, teacher consultant of the hearing impaired and/or the educational audiologist that digital/programmable amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial.

2.5.C. Prior Authorization Requirements

PA is required for all digital/programmable hearing aids. The following documentation must be submitted with all PA requests:

- MSA-1653-B.
- Documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges.
- Medical clearance.
- Audiogram completed within the past six months, signed and dated by the audiologist, and including the recommended manufacturer, model and style.
- Additional documentation requirements include:

When the acquisition cost exceeds Medicaid's maximum allowable amount for a comparable conventional analog hearing aid	▪ Documentation of superiority of aided thresholds and speech recognition ability in a comparison study of digital/programmable vs. conventional analog aids, including functional gain measures and probe microphone measurements. ▪ Letters of support from the school system, teacher consultant of the hearing impaired or educational audiologist outlining objective and subjective benefits during a 30-day trial period. Documentation from the parents may be used for supplemental support. ▪ For infants and young children who are unable to be tested in a comparison study, a letter of justification for advanced technology is required.
For aids provided for unilateral hearing loss regardless of acquisition cost	▪ Documentation that the ear to be aided has a speech recognition score greater than 60 percent. ▪ Documentation provided by the educational system that the child is receiving hearing impaired services. ▪ Letters of support from the classroom teacher, teacher consultant of the hearing impaired, and/or the educational audiologist that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial.

2.5.D. Payment Rules

Payment for a digital/programmable hearing aid may not exceed Medicaid's maximum allowable amount for a comparable conventional analog hearing aid unless the

documentation submitted with the PA request supports the need for the more advanced technology found with a digital/programmable hearing aid. When documentation of the need for a digital/programmable hearing aid is provided, the payment is the acquisition cost for the digital/programmable hearing aid. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

2.6 Hearing Aid Supplies and Accessories Replacement

2.6.A. Standards of Coverage

The following hearing aid supplies and accessories are considered a benefit, if necessary, at a maximum of:

Item	Maximum
Hearing Aid Dry Aid Kit	Two per year per hearing aid
Hearing Aid Earhook	Four per year per hearing aid
Hearing Aid Superseals	Two per year per hearing aid
Hearing Aid Holster/Huggies	Four per year per hearing aid
Stetheset (Under 21 years old)	One with initial hearing aid only
Hearing Aid Battery Tester	One with initial hearing aid only
Hearing Aid Earmold Blower	One with initial hearing aid only

2.6.B. Documentation

Applicable documentation to be maintained by the provider includes:

- A list of hearing aid supplies/accessories provided to the beneficiary within the past 365 days; and
- A copy of the manufacturer's invoice showing the invoice price of the supplies/accessories, applicable discounts, and shipping charges.

2.6.C. Prior Authorization Requirements

PA is **not** required for hearing aid supplies and accessories if the sum of all payments for accessories/supplies billed within the past 365 days is $40 or less.

PA **is** required for hearing aid supplies and accessories if:

- Any single item is billed with requested payment amounts of over $40.
- The sum of all payments for accessories/supplies billed within the past 365 days is over $40.
- An item exceeds the standards of coverage.

Hearing aid supplies/accessories that exceed either the maximum payment limit of $40 or the standards of coverage require PA. A list of supplies/accessories provided within the past 365 days must be submitted with the MSA-1653-B PA request.

2.6.D. Payment Rules

Payment for hearing aid supplies and accessories includes the acquisition cost plus 9.6 percent. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

2.7 Replacement of Disposable Hearing Aid Batteries

2.7.A. Standards of Coverage

Medicaid covers replacement of disposable hearing aid batteries, as appropriate, up to a quantity of 25 batteries per hearing aid per six months. All batteries must be dispensed in the original packaging and must be dispensed at least one year before the expiration date shown on the package. The establishment of a "battery club", where batteries are automatically mailed to a beneficiary, regardless of need, is not allowed.

Hearing Aid Dealers may not bill for replacement of disposable batteries for cochlear implant devices.

2.7.B. Prior Authorization Requirements

PA is required for quantities exceeding the standards of coverage. Documentation must accompany the MSA-1653-B PA request to substantiate the need for additional batteries.

2.7.C. Payment Rules

Medicaid's payment for disposable hearing aid batteries is the lesser of Medicaid's maximum allowable amount or the acquisition cost plus 9.6 percent. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

2.8 EARMOLDS FOR COCHLEAR IMPLANTS [NEW SUBSECTION 4/1/06]

(added per bulletin MSA 06-11 effective 4/1/06)

2.8.A. STANDARDS OF COVERAGE

Earmolds to secure an ear-level cochlear implant processor for proper function of the device are a covered benefit.

2.8.B. PRIOR AUTHORIZATION REQUIREMENTS

PA is required for all earmolds to secure an ear-level cochlear implant processor. A letter of justification for the earmold, completed by the managing audiologist, must be submitted with all PA requests.

2.8.C. PAYMENT RULES

Medicaid's payment for earmolds for cochlear implants is the lesser of Medicaid's maximum allowable amount or the provider's usual or customary charges.

2.9 REPLACEMENT EARMOLDS [RENUMBERED 4/1/06]

2.9.A. STANDARDS OF COVERAGE

13 years and over	Beneficiaries who use hearing aids that require custom earmolds are eligible for replacement earmolds every 12 months without prior approval.
3 to 12 years	Beneficiaries are eligible for replacement every six months without prior approval.
Under age 3 years	Beneficiaries eligible for replacement every three months without prior approval.

2.9.B. PRIOR AUTHORIZATION REQUIREMENTS

PA is required for replacements exceeding the standards of coverage. Documentation must accompany the MSA-1653-B PA request to substantiate the need for additional earmold replacements.

2.9.C. PAYMENT RULES

Medicaid's payment for replacement earmolds is the lesser of Medicaid's maximum allowable amount or the provider's usual or customary charges.

2.10 Hearing Aid Repairs and Modifications [Renumbered 4/1/06]

2.10.A. Standards of Coverage

Providers may bill for repairs and modifications only to the most recently dispensed out-of-warranty hearing aid. Repairs are not covered for back-up aids or devices. Services under warranty may not be billed to Medicaid.

2.10.B. Documentation

Applicable documentation to be maintained in the beneficiary's record includes an itemization of materials used to repair the hearing aid and related labor costs.

2.10.C. Prior Authorization Requirements [Change Made 4/1/06]

PA is **not** required for hearing aid repairs and/or modifications if:

- The payments for the repair/modification are less than $80.
- No more than two separate repairs/modifications are billed in 365 days.

PA **is** required for hearing aid repairs and/or modifications if:

- The requested payment amount is over $80.
- Separate repairs/modifications are billed over two times in 365 days.
- Medicaid did not purchase the hearing aid. **(per bulletin MSA 06-11 effective 4/1/06)**

Repairs that are expected to exceed either the maximum payment limit of $80 or two episodes in 365 days require PA. Documentation must be submitted with the MSA-1653-B PA request providing a written estimate of what the repair and/or modifications will be. The estimate should include the materials, labor and shipping costs.

The repair/modification of a hearing aid not purchased by Medicaid may be covered only when:

- The beneficiary's hearing level, as supported by an audiogram, meets Medicaid coverage criteria; and
- The aid itself meets Medicaid coverage criteria.

A prior authorization request for this type of repair/modification must include both the date of purchase and the current audiogram. **(per bulletin MSA 06-11 effective 4/1/06)**

2.10.D. Payment Rules [Change Made 4/1/06]

Medicaid's payment for hearing aid repairs/modifications includes no more than the actual cost plus $19.20 per aid. **(per bulletin MSA 06-11 effective 4/1/06)** Actual cost consists of acquisition cost of materials used for the repair plus related labor costs and actual shipping costs.

2.11 Alternative Listening Devices [Renumbered 4/1/06]

An Alternative Listening Device (ALD) is defined as a special purpose electro-acoustic device designed to enhance receptive communication (e.g., Pocket Talker).

2.11.A. Standards of Coverage

ALDs are a benefit for beneficiaries **age 21 or over** under the following conditions:

- No hearing aid has been dispensed to the beneficiary within three years.
- No ALD has been dispensed to the beneficiary within three years.
- The beneficiary is residing in a nursing facility.
- Patient management of a personal hearing aid is considered unrealistic and/or frequency-specific audiometric data cannot be obtained in each ear.
- The ALD is provided for situations involving one-on-one conversation.
- The ALD is not designed primarily for television or telephone amplification, theater or classroom use.

2.11.B. Documentation

Applicable documentation to be maintained in the beneficiary's record includes:

- A letter from the audiologist delineating why a personal hearing aid is inappropriate and the recommended type of ALD.
- An audiogram, signed and dated by the audiologist within six months prior to dispensing the device or documentation showing that frequency-specific audiometric data could not be obtained in each ear.
- Copy of the manufacturer's invoice showing the ALD model, serial number, invoice price, applicable discounts and shipping charges.

2.11.C. Prior Authorization Requirements

PA is required for all alternative listening devices. The following documentation must be submitted when requesting PA:

- MSA-1653-B.
- Documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges.
- A letter from the audiologist delineating why a personal hearing aid is inappropriate and the recommended type of ALD.
- An audiogram signed and dated by the audiologist within six months prior to dispensing the device or documentation showing that frequency-specific audiometric data could not be obtained in each ear within six months prior to dispensing the device.

2.11.D. Payment Rules

Medicaid's payment for an ALD includes the provider's acquisition cost plus $19.20. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs. Medicaid does not reimburse providers for a separate dispensing fee for ALDs.

HEARING SERVICES

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SECTION 1 - COVERAGE OVERVIEW

This chapter applies to Audiology Providers (PT 40 and 80), and Cochlear Implant Manufacturers (PT 80).

The primary objective of Medicaid is to ensure that essential medical/health services are made available to those who would not otherwise have the financial resources to purchase them. The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services, recommended and supported by a pediatric sub-specialist, with care coordination that relates to the CSHCS qualifying diagnosis. Policies are aimed at maximizing the health care services obtained for this population with the limited number of dollars available.

The term Medicaid throughout this chapter refers to both the Medicaid and CSHCS programs.

1.1 ENROLLMENT REQUIREMENTS

1.1.A. AUDIOLOGY PROVIDERS

1.1.A.1. AMERICAN SPEECH-LANGUAGE HEARING ASSOCIATION CERTIFIED AUDIOLOGISTS / HEARING CENTERS

Audiologists holding a current American Speech-Language Hearing Association (ASHA) certificate of clinical competence (CCC-A) practicing in freestanding hearing centers may enroll with Medicaid for reimbursement of audiology services. The freestanding hearing center must not be part of, or owned by, a hospital, Comprehensive Outpatient Rehabilitation Facility, Rehabilitation Agency or university graduate education program. Services must be provided at the service/practice address identified on the provider enrollment application or may be provided to nursing home residents at a Medicaid-enrolled nursing facility. When enrolling in Medicaid, audiologists must provide proof of their current ASHA CCC-A. Out of state providers must be licensed in the state where services are rendered if that state requires audiologists to be licensed. Proof of licensure must be presented upon enrollment.

1.1.A.2. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES AND OUTPATIENT REHABILITATION AGENCIES

Comprehensive Outpatient Rehabilitation Facilities (CORF) and Outpatient Rehabilitation Agencies (Rehab Agencies) may enroll with Medicaid for reimbursement of audiology services provided by qualified professionals. All CORF's and Rehab Agencies must provide proof of Medicare certification when enrolling in Medicaid.

1.1.A.3. UNIVERSITY AFFILIATED AUDIOLOGY GRADUATE EDUCATION PROGRAMS

University graduate education programs accredited by ASHA's Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA), may enroll with Medicaid for reimbursement of audiology services provided by qualified professionals. The university program must be freestanding and not part of, or owned by, a hospital, CORF, or Rehab Agency. All university programs must provide proof of their current ASHA-CAA when enrolling in Medicaid.

1.1.B. Cochlear Implant Manufacturers

Cochlear Implant Manufacturers must be licensed in the State in which they conduct business if that State requires licensure.

1.2 HCPCS Codes and Parameters

For specifics regarding Medicaid coverage of the Healthcare Common Procedure Coding System (HCPCS), refer to the Hearing Services Database on the MDCH website. (Refer to the Directory Appendix for contact information.) The database includes the HCPCS code, short description, current activity status, fee screens, quantity limits, prior authorization (PA) indicator, and age limits.

If no established procedure code adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code. All NOC codes require PA.

1.3 Documentation in Beneficiary File

Hearing services providers must maintain all applicable documentation in the beneficiary's file for six years. For audit purposes, the patient's medical record must substantiate the medical necessity of the item or service supplied.

1.4 Prior Authorization

PA is required for certain services before the services are rendered. To determine which services require PA, refer to the Standards of Coverage and Limitations Section of this chapter or the Hearing Services Database on the MDCH website. (Refer to the Directory Appendix for contact information.)

Requests for PA for all services must be submitted on the Special Services Prior Approval-Request/Authorization Form (MSA-1653-B). (Refer to the Forms Appendix or the MDCH website for a copy of the form.) Required medical documentation must accompany the form. The information on the PA request form must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Thorough – Complete information, including the appropriate HCPCS procedure codes must be provided on the form. The form and all documentation must include the beneficiary name and Medicaid identification (ID) number, provider name, address and the provider's Medicaid ID number.

PA request forms for all eligible Medicaid beneficiaries must be sent or faxed to the MDCH Prior Authorization Division. To check the status of a PA request, contact the MDCH Prior Authorization Division via telephone. (Refer to the Directory Appendix for contact information.)

1.4.A. Retroactive Prior Authorization

Services provided before PA is requested are not covered unless the beneficiary was not eligible on the date of service (DOS) and a subsequent eligibility determination was made retroactive to the DOS. If MDCH's record does not show that retroactive eligibility was provided, then the request for retroactive PA is denied.

1.4.B. Beneficiary Eligibility

Approval of a service on the Special Services Prior Approval-Request/Authorization (MSA-1653-B) confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible. To assure payment, the provider must verify eligibility for fee-for-service (FFS) Medicaid or the CSHCS before initiating services.

1.4.C. Reimbursement Amounts

Many items have established fee screens that are published in the Hearing Services Database. For NOC codes and all codes without established fee screens, the approved reimbursement amount is indicated on the authorized PA request.

1.4.D. Billing Authorized Services

After authorization is issued, the information (e.g., PA number, procedure code, modifier, and quantity) that was approved on the authorization must match the information on the claim form. (Refer to the Billing & Reimbursement Chapters of this manual for complete billing instructions.)

The copy of the PA request returned to the provider must be retained in the beneficiary's medical record.

1.5 CSHCS Requirements

As a condition to participate in the CSHCS program, the beneficiary's assigned pediatric sub-specialist must coordinate treatment and services relating to the beneficiary's CSHCS-qualifying diagnosis. CSHCS beneficiaries must be referred by their pediatric sub-specialist directly to the specified Medicaid-enrolled provider of audiology services. Documentation of the referral must remain in the beneficiary's medical record.

Audiologists providing or supervising services provided to CSHCS beneficiaries must have obtained at least one year of prior professional experience treating the healthcare needs of pediatric patients with physical disabilities. Professional resumes documenting pediatric experience, as well as a copy of the facility's program description and mission/vision statement, must be submitted to the MDCH Prior Authorization Division. (Refer to the Directory Appendix for contact information.) CSHCS will make the determination, based on this documentation, of whether the provider is approved to provide audiology services to CSHCS beneficiaries.

Once approved to provide audiology services to CSHCS beneficiaries, the provider may accept referrals from the pediatric sub-specialist. Before billing for audiology services, the enrolled provider must be listed on the beneficiary's CSHCS Client Eligibility Notice. Providers may contact the Prior Authorization Division to request addition to a Client Eligibility Notice. (Refer to the Directory Appendix for contact information.) The provider should always check the beneficiary's CSHCS Client Eligibility Notice prior to rendering services.

These requirements do not apply to services provided to Medicaid-only or dual Medicaid/CSHCS beneficiaries.

SECTION 2 – STANDARDS OF COVERAGE AND LIMITATIONS

2.1 AUDIOLOGY SERVICES

Audiology services may be provided by any of the following Medicaid-enrolled providers when performed by properly credentialed professionals:

- CORF
- Rehab Agency
- CAA-Accredited University Graduate Education Program
- ASHA Certified Audiologist/Hearing Center

Audiology services (other than newborn hearing screening tests) may be performed by:

- An audiologist possessing a current ASHA CCC-A.
- An audiologist candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a CCC-A) supervised by an audiologist having a current CCC-A.
- An audiology student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) an audiologist having a current CCC-A.

Standards of practice must conform to those published in ASHA Preferred Practice Patterns for the Profession of Audiology. Audiologic test equipment and hearing aid test equipment used must conform to applicable American National Standards Institute (ANSI) criteria.

2.1.A. DIAGNOSTIC AND AMPLIFICATION SERVICES

The following diagnostic and amplification services may be provided to all eligible beneficiaries:

- Air and/or bone conduction audiogram
- Basic hearing evaluation (includes pure-tone audiometry, speech audiometry and report)
- Diagnostic audiologic evaluations
- Ear mold fabrication
- Electroacoustic analysis of hearing aid
- Aided performance assessment with the beneficiary's hearing aid
- Hearing aid evaluation and selection
- Hearing aid orientation/training or hearing therapy

2.1.B. Hearing Aid Evaluation and Selection [Change Made 4/1/06]

Audiologists may perform hearing aid evaluations and selections only after a medical concurrence from the physician is obtained:

- If the beneficiary is under 18 years of age, he must obtain a signed statement from the otolaryngologist that a medical evaluation indicates that a hearing aid is medically necessary and there are no contraindications to the use of a hearing aid.
- If the beneficiary is 18 years of age or older, he must obtain a signed statement from either an otolaryngologist or the primary care physician indicating that a hearing aid is medically necessary and there are no contraindications to the use of a hearing aid.

After the appropriate audiologic procedures have been completed and it is determined that the beneficiary requires a hearing aid, a recommendation for the hearing aid must be completed and signed by the audiologist. The recommendation, as well as a copy of the physician's medical concurrence, is given to the beneficiary along with a list of Medicaid-enrolled hearing aid dealers in the area. Beneficiaries must be given freedom of choice of any Medicaid-enrolled hearing aid dealer when obtaining their hearing aid, even when the audiologist is also state-licensed and enrolled with Medicaid to dispense hearing aids. **(added per bulletin MSA 06-11 effective 4/1/06)**

2.1.C. Measurable Benefits/Hearing Aid Conformity Check

Any delivered hearing aid is expected to demonstrate measurable benefit, established either at the time of fitting or follow-up. Benefit may be established by any one of, or a combination of, commonly used procedures, including:

- Measures of aided hearing and understanding of speech;
- Functional gain measures;
- Probe-microphone measurements; and/or
- (Minimally) the subjective impressions of the beneficiary, the beneficiary's family members or guardian, or attending staff.

Benefit may be demonstrated in cases of severe to profound hearing loss by one of, or a combination of, the following measures:

- Improved functional or insertion gain in the speech frequencies.
- Increased awareness of speech and/or environmental sounds.
- Improved word recognition performance at average or slightly raised conversational levels with or without visual cues.
- Beneficiary's or family member's subjective report of speech benefit in everyday listening situations.

When a delivered hearing aid does not provide benefit, as defined above, the hearing aid dealer is expected to return it to the manufacturer within 30 days for circuitry

modifications, remake, exchange or credit, as recommended by the hearing and speech center.

2.1.D. Newborn Hearing Services

All Medicaid-covered newborns must be screened using the auditory brainstem response (ABR) method and/or the evoked otoacoustic emissions (EOAE) method.

If the birthing hospital is not equipped for ABR or EOAE, the child's physician, certified nurse midwife (CNM), or nurse practitioner (NP) must refer the newborn to a Medicaid-enrolled hearing and speech center, where screening must be completed prior to one month of age.

Audiology newborn hearing screening tests must be performed by staff trained in the screening of infant hearing via the ABR or EOAE method. Medicaid requires appropriate interaction with parents/guardians and the medical team, and the proper filing of paperwork with the State's monitoring program.

The following equipment must be available to audiologists providing services to infants less than six months of age:

- Infant Diagnostic Testing
  - Tone Burst ABR; and
  - Bone Conduction ABR; and
  - High Frequency Immittance; and
  - Otoacoustic Emissions
- Infant Hearing Aid Evaluation, Selection, and Follow-Up
  - Infant Predictive Method (e.g., Desired Sensation Level); and
  - Real-Ear to Coupler Difference

2.1.E. Cochlear Implant Programming

The initial post-operative sessions for analysis and fitting of a previously placed external device, connection to the cochlear implant, and programming of the stimulator may be billed once per beneficiary.

Subsequent sessions for measurements and adjustment of the external transmitter and re-programming of the internal stimulator may be billed two times in one year. If additional sessions are needed, a PA is required.

2.1.F. Hearing Aids Dispensed by Audiologists

Audiologists who dispense hearing aids must be licensed as a hearing aid dealer and bill using their provider type 90 provider ID.

2.2 Speech Services

Refer to the Outpatient Therapy Chapter for information related to speech services.

2.3 Cochlear Implant Manufacturers

2.3.A. Cochlear Implant Repair and/or Replacement of Parts

Coverage of cochlear replacement parts is considered if:

- The device is in continuous use and still meets the needs of the beneficiary.
- A certified audiologist has established a plan of care and substantiates the need for the repairs.
- Repairs are necessary to allow the device to be functional.
- The device being repaired is FDA-approved and meets all Medicaid standards of coverage.
- For replacement of a speech processor (out of the three year warranty), the speech processor is irreparable or lost.
- For replacement of a speech processor with an upgraded model:
  - Documentation substantiates that the newer generation technology provides additional capacity for functional improvement in oral communication and learning; and
  - The current processor has been worn for at least four years.

All charges for cochlear implant parts and repairs are to reflect no more than the usual and customary (U&C) charge to the general public.

2.3.B. Cochlear Implant Parts Replacement Maximums

The following replacement parts may be considered for reimbursement, if necessary, at a maximum of:

Item	Maximum
Headset (3-piece component)	1 per 3 years
Headset (as component parts) ▪ Microphone ▪ Cochlear Coil ▪ Cochlear Magnet	 ▪ 1 per year ▪ 1 per year ▪ 1 per year
Transmitter Cable or Cord	4 per 6 months
Headset Cable or Cord	4 per 6 months
Pouch	1 per year
Microphone Cover	1 per year
Cochlear Harness Extension Adapter	1 per 3 years
Cochlear Belt Clip	1 per 3 years
Cochlear Auxiliary Cable	1 per 3 years
Cochlear Signal Checker	1 per 3 years
Rechargeable Batteries (per set of two)	1 per year
Disposable Batteries for Ear Level Processors	150 per 6 months
Battery Charger Kit	1 per 3 years

2.3.C. Prior Authorization Requirements for Replacement of Cochlear Implant Parts

PA is **not** required for cochlear implant parts replacement if:

- The sum of all charges for parts and repairs equals $200 or less on one date of service.
- The sum of all charges for parts and repairs within the past 365 days is $400 or less.

PA **is** required for cochlear implant parts replacement if:

- The sum of all charges for parts and repairs exceeds $200 on one date of service.
- The sum of all charges for parts and repairs within the past 365 days exceeds $400.
- An item exceeds the item maximums as stated above.

The following documentation must be submitted with the PA request:

- Documentation from the certified audiologist and/or other medical professional on the team to substantiate the need for the parts and/or repair.
- Itemization of materials used to repair the device and rationale for any related labor costs.

2.3.D. Replacement of the Speech Processor

Replacement of the speech processor with a new same generation or new upgraded speech processor always requires PA.

Documentation from the certified audiologist and/or other medical professional on the team to substantiate the need for the processor replacement must be submitted with the PA request.

Payment for the speech processor includes an initial supply of rechargeable batteries.

HOME HEALTH

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Home Health providers (Provider Type 15).

Home health is a covered Medicaid benefit for beneficiaries whose conditions do not require continuous medical/nursing and related care, but do require health services on an intermittent basis in the home setting for the treatment of an injury, illness, or disability. Medicaid covered services may be provided in the home only if circumstances, conditions, or situations exist which prevent the beneficiary from being served in a physician's office or other outpatient setting. Except as detailed in this chapter, the beneficiary's primary need must be for nursing care and/or physical therapy, rather than personal care or physician's care.

A Home Health Agency (HHA) is an organization that provides home care services, such as skilled nursing care, physical therapy (PT), occupational therapy (OT), speech therapy (ST) and care by home health aides. The HHA must be Medicare certified to enroll as a Medicaid provider and must comply with the Medicare/Medicaid Conditions of Participation (42 CFR § 484) and the policies outlined in this manual.

If a HHA is certified as a parent with subunit(s) or branches, both the subunit(s) and branches must obtain and bill Medicaid using their own provider identification (ID) numbers as does the parent. (Refer to the General Information for Providers Chapter of this manual for additional information regarding enrollment.)

Services solely to prevent an illness, injury or disability are only covered for women/newborns following delivery. For postpartum/newborn follow-up nurse visits, a nursing diagnosis can be used to establish medical necessity. Otherwise, a medical diagnosis is required to establish medical necessity. Medicaid beneficiaries are expected to be an active participant in the planning for their home health care. For beneficiaries enrolled in a Medicaid Health Plan (MHP), the HHA must contact that health plan for authorization to provide services to their members.

Medicaid home health services must be ordered, in writing, by the beneficiary's attending physician (MD, DO) as part of a written plan of care (POC) and reviewed by this physician every 60 days. The physician's order and POC must be only for functions that are within the scope of his current medical practice and Medicaid guidelines.

This chapter includes information about services covered for Medicaid and Children's Special Health Care Services (CSHCS) beneficiaries unless otherwise noted.

Private Duty Nursing (PDN) is not covered under the Home Health benefit.

SECTION 2 – HOME SETTING

Home health services are intended for beneficiaries who are unable to access services (nursing, OT, PT, speech and language pathology therapy [ST]) in an outpatient setting. However, it is not required that beneficiaries be totally restricted to their home. For example, a beneficiary may leave their home to attend school, adult day care, or family gatherings. A determination and documentation is required by the HHA that the home is the most appropriate setting in which to provide the service(s). Home health services are **not** provided solely on the basis of convenience.

All covered home health services must be rendered in a beneficiary's home, except for those services listed below. Home may be the beneficiary's owned/rented home, an apartment, Assisted Living Facility, Adult Foster Care (AFC) facility, or home of another family member (secondary residence of the beneficiary, i.e., joint custody situation for a minor child).

- Home Health aide services are not a covered benefit for beneficiaries who reside in a Home for the Aged (HFA) or Adult Foster Care (AFC) facility as this would be duplication of personal care services already provided by staff of these facilities.
- MDCH does not cover any Home Health services rendered to a beneficiary in a hospital, nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR) or Intermediate Care Facility for the Mentally Ill (ICF/MI), school or adult day care.

To determine if services in the home, rather than in an outpatient setting, are most appropriate, consider the following:

- Is in-home care necessary for the adaptation, training or teaching of nursing or treatment procedures, plans, equipment, appliances or prosthetics in the home setting?
- Is in-home care necessary to prevent undue exposure to infection and/or stress for the beneficiary as identified and documented by a health care professional?
- Is leaving the home medically contraindicated, as identified and documented by a health care professional?
- Is in-home care necessary to prevent a documented problem with access to services, continuity of care or provider, or coordination of services, as documented by a health care professional?
- Is in-home care the most cost-effective method to provide care?

Services must be appropriate and necessary for the treatment of an identified illness, injury or disability. The services provided must be consistent with the nature and severity of the beneficiary's illness, injury or disability, his particular medical needs and accepted standards of medical practice. Beneficiaries with established frail conditions may need assessments by skilled nurses to prevent further decline of the frail condition.

SECTION 3 – PLAN OF CARE

The plan of care (POC) must include the following:

- Date of most recent hospitalization.
- Medical diagnosis and impact of functional limitation.
- Specific circumstances, conditions, or situations that required services to be provided in the home and not in a physician's office or outpatient clinic.
- Date of the HHA's first visit for this admission.
- The date for which the HHA began providing home care. (This date remains the same on subsequent POCs until the beneficiary is discharged from home health care services.)
- Detailed description of each service to be provided, including frequency and duration of services.
- Detailed description of current goals as related to the services provided and the goal for discharge planning.
- A full description of the reason(s) that initial and or continued home care is needed (e.g., pertinent laboratory values, medications, wounds, abnormal vital signs).
- Environment status (e.g., electricity, telephone, indoor plumbing).
- Identification of other resources used by the beneficiary (e.g., Area Agency on Aging, Protective Services, Home Help Services).

If the physician orders Home Health aide service and the beneficiary is also receiving personal care through another entity (Home Help Program, MI Choice Waiver), there must be a coordination between the two entities and documentation in the POC to verify there is no duplication of services. (Refer to the Personal Care Section of this chapter for additional information.)

- Date of physician's last contact.
- Role of family or support person.

If home health aide services are ordered, an assessment of the family's ability and willingness to perform the services must be made and included in the POC. If the family is unable to perform the services, the reason must be stated on the POC.

- HHA's name and address and provider ID number, beneficiary's name, date of birth, and Medicaid ID number.
- The attending physician's signature and date he signed the POC. The POC must be signed and dated by the beneficiary's attending physician before the HHA submits a claim to MDCH for payment.

If the attending physician signs the POC after the service(s) is rendered, there must be a pre-existing written or verbal order for the service(s) to be covered by Medicaid. If the service(s) is rendered prior to the date the physician dated the POC and there is no pre-existing written or verbal order, Medicaid does not cover the service(s) provided. The verbal order obtained from the ordering physician must contain the signature of the HHA staff person who obtained the verbal order and the date the verbal order was received. All verbal orders must be countersigned and dated by the ordering physician before the claim is submitted to MDCH for payment.

Ordering physicians must determine that medical/health services are medically necessary and/or appropriate. Any increase in the frequency of services, addition of new services, or modifications of treatment during a certification period must be authorized by the attending physician and documented in the beneficiary's medical record by way of a verbal order or written order prior to the provision of the increased, additional, or modified treatment.

The POC signed by the attending physician, along with any written or verbal orders as needed, and progress notes must be retained in the beneficiary's medical record.

SECTION 4 – OUTCOME AND ASSESSMENT INFORMATION SET

The Centers for Medicare and Medicaid Services (CMS) requires Medicare certified HHAs to use a standard assessment data set, referred to as the Outcome and Assessment Information Set (OASIS). The requirement to collect and submit OASIS clinical data applies to all beneficiaries receiving Medicare and/or Medicaid home health services. This means beneficiaries under Medicaid traditional fee-for service (FFS), MHP, Children's Waiver, Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice Waiver), Habilitative/Support Services Waiver, and CSHCS who receive home health services are to have OASIS information collected by the HHA. Assessments for all beneficiaries are to be conducted in compliance with Medicare certification requirements.

The OASIS requirements do not apply if the HHA is providing only housekeeping/chore services, prepartum and postpartum services, or if the beneficiary is under 18 years of age.

HHAs are also required to electronically transmit the OASIS data to the designated state agency responsible for collecting OASIS data in accordance with CMS specifications. MDCH contracts with a vendor to provide OASIS transmission assistance. HHAs needing assistance with transmitting data to the state repository should contact the MDCH contractor. (Refer to the Directory Appendix for contact information.)

The CMS rules for OASIS are published in the January 25, 1999, June 18, 1999, and December 16, 2002 Federal Registers and are available online at the OASIS Website. (Refer to the Directory Appendix for contact information.)

SECTION 5 – POST-PAYMENT REVIEW

Ordering physicians must determine that medical/health services are medically necessary and/or appropriate. All home health services ordered are subject to review for conformity with accepted medical practice and Medicaid coverage and limitations. Post-payment reviews of paid claims may be conducted to assure that the services provided, as well as the type of provider and setting, were appropriate, necessary, and compliant with Medicaid policy. Post-payment review also includes verification that appropriate procedure codes were used to bill the services provided.

Post-payment review includes verification that all third-party resources were utilized to their fullest extent prior to billing MDCH. If post-payment review reveals that MDCH was billed prior to utilizing these resources and the HHA knew the beneficiary had other insurance coverage for the service rendered, it may be considered fraud.

The General Information for Providers Chapter of this manual contains additional information regarding post-payment review and fraud.

SECTION 6 – NURSING SERVICES

Nursing services are covered on an intermittent (separated intervals of time) basis when provided by, or under the direct supervision of, a registered nurse (RN).

A nursing visit may include, but is not limited to, one or more of the following nursing services:

- Administering prescribed medications that cannot be self-administered.
- Changing an in-dwelling catheter.
- Applying dressings that require prescribed medications and aseptic techniques.
- Teaching the beneficiary, available family member, willing friend or neighbor, or caregiver (paid or unpaid) to carry out all or some of the services, as detailed below.
- Observation and evaluation, as detailed below.

Intermittent (separated intervals of time) nurse visits are intended for beneficiaries that generally require nursing services on a short-term basis (typically 60 days or less) for the treatment of an acute illness, injury, or disability and who cannot receive these services in an outpatient setting. Intermittent nursing visits may last from 15 minutes to one or two hours and are reimbursed at a flat rate (i.e., Medicaid fee screen for a visit) regardless of the length of the visit.

Intensive care (for cases that require five or more visits per week or beyond 60 days) may be reviewed by MDCH during post-payment audit to determine if home care is medically appropriate and a cost effective alternative to institutional care.

6.1 COVERED NURSING SERVICES

The following nursing services are covered home health care services. Limitations, conditions and special considerations are noted when applicable. (Refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual for billing information.)

6.1.A. BLADDER TRAINING

When use of a catheter is temporary, visits made by the nurse to change the catheter must also include instruction to the beneficiary in bladder training methods. The actual bladder training (e.g., forcing fluids, or other measures) does not require the skills of a nurse. After the catheter is removed, a limited number of visits (maximum two visits per month) are allowed to observe and evaluate the effectiveness with which the bladder training has been accomplished (e.g., the degree to which the bladder is emptying).

6.1.B. BLOOD LEAD POISONING NURSING ASSESSMENTS / INVESTIGATION VISITS

A physician's order is required for a HHA to make home visits regarding blood lead poisoning. Visits must be billed as a nurse visit with applicable International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis coding. Medicaid reimburses up to two visits per child, regardless of the number of children in the home diagnosed with blood lead poisoning.

HHAs who suspect beneficiaries may have evidence of blood lead poisoning or blood lead levels above accepted state levels in the home should refer the beneficiary to the local health department (LHD).

6.1.C. Enemas

Giving enemas usually does not require the skills of a nurse, and Medicaid does not cover such visits unless the physician has ordered that a nurse give the enema because of clinical indications.

6.1.D. Eye Drops and Topical Ointments

Two nurse visits are allowed to teach the administration of eye drops and topical ointments. Nurse visits solely to perform these services are not covered.

6.1.E. Intravenous Infusions

If the beneficiary is in need of intravenous infusion and an Infusion Clinic or ancillary Medicaid Provider (who has no nurse) does not cover the service, or family member/care giver will not accept this task, the HHA may perform this service and bill accordingly.

6.1.F. Neonatal Jaundice

Nurse visits related to neonatal jaundice require supporting documentation that the nurse visits are required for a specific medical condition. Supporting documentation should include pertinent laboratory values if the infant is being breast-fed, etc.

6.1.G. Observation/Evaluation

If the attending physician determines that the beneficiary's condition is unstable and that significant changes may occur, Medicaid covers nurse visits for observation/evaluation. Once the beneficiary's condition has stabilized and there has been no significant change (e.g., no change in medication or vital signs, no recent exacerbation in the beneficiary's condition) for a period of three weeks and no other necessary nursing services are being furnished, nursing visits solely for observation/evaluation are no longer covered.

Visits for observation/evaluation to ensure stability of a beneficiary who has an established disability or frail condition are covered by Medicaid if circumstances, conditions, or situations exist that prevent the beneficiary from obtaining services from a physician's office or outpatient clinic as described in the Home Setting Section of this chapter. Such visits are limited to two visits per month.

Nurse visits for observation/evaluation to insure stability of a beneficiary's condition cannot be billed within a 30-day period of an initial/subsequent postpartum/newborn follow-up nurse visit, suspected abuse nurse visit or aide visit.

If the beneficiary is enrolled in the MI Choice Waiver, a nurse visit for observation and evaluation to insure stability is not a home health covered service but a responsibility of the waiver staff. (Refer to the Directory Appendix for the website containing the regional map, and addresses of the MI Choice Waiver agents.)

6.1.H. Oral Medications

Administration of oral medications does not usually require the skills of a nurse in the home setting. Visits are covered only if the complexity of the beneficiary's condition and/or the number of drugs prescribed require the skill or judgment of a nurse to detect and evaluate side effects (adverse reactions) and/or provide necessary teaching and instruction.

Placing medication in envelopes/cups, giving reminders, etc., to assist the beneficiary in remembering to take them does not constitute a nursing service.

6.1.I. Postpartum / Newborn Follow-up Nurse Visit

Home visits for assessment, evaluation and teaching are covered for women and newborns following delivery when a physician has determined the mother or newborn may be at risk. The goals of these services include:

- Fostering a positive outcome for the mother and newborn by detecting medical complications manifested during the postpartum/newborn period;
- Instructing the mother in newborn care; and
- Identifying situations that may require intervention with medical and community resources.

The HHA must assess and document, in writing, that the beneficiary is receiving services by a Maternal Infant Health Program (MIHP) provider. If the HHA is also an enrolled MIHP provider, services for this mother and newborn cannot be billed as home health care but must be billed as MIHP services. If the beneficiary is receiving MIHP services from another provider and the HHA is also providing services, the POC must clearly identify why home health services are needed in addition to MIHP and that the two providers do not duplicate services.

Medicaid allows one initial postpartum visit, one initial newborn visit, and one subsequent visit to mother and newborn for a total of three visits per pregnancy.

- The initial postpartum visit must be billed using the mother's Medicaid ID number.
- The initial newborn visit must be billed using the newborn's Medicaid ID number.
- The subsequent visit may be billed under either the mother's ID number or newborn's ID number, based on the most time spent with each beneficiary.

Claims indicating that the services provided were not preventive or not driven by a specific medical condition pend for manual review. These claims require supporting documentation that the nurse visits were driven by a specified medical condition and must be recorded in the Remarks section of the claim. An example of supporting documentation for the diagnosis of abnormal weight loss would be the newborn's birth weight, newborn's weight upon hospital discharge, gestational age of newborn, and number of days the newborn was hospitalized following delivery.

6.1.J. Prenatal Nurse Visit

Medicaid covers home visits for a specific pregnancy related medical condition provided by a HHA.

Home visits provided for preventive health services which address psychosocial issues, provide education, provide transportation, etc. and that do not provide treatment for an illness or injury are a covered service of the MIHP, not Home Health.

6.1.K. Routine Prophylactic and Palliative Skin Care

The recognized stages of decubitus ulcers are classified as:

- Stage I - Inflammation or redness of the skin;
- Stage II - Superficial skin break with erythema of surrounding area;
- Stage III - Skin break with deep tissue involvement; and
- Stage IV - Skin break with deep tissue involvement with necrotic tissue present.

The existence of Stage III or IV decubiti or other widespread skin disorders may necessitate the skills of a nurse. The physician's orders for treating the skin determine the need for this service.

The presence of Stage I or II decubiti, rash, or other relatively minor skin irritations do not indicate a need for nursing care unless ordered by a physician. Bathing the skin, applying creams, etc., are not covered nursing services.

6.1.L. Suspected Abuse

If there is reasonable cause to suspect that a beneficiary may be in danger of abuse, neglect, exploitation, cruelty, or other hazards, the HHA must report the suspected abuse to the Adult or Child Protective Services Unit of the local Department of Human Services (DHS) office. (Refer to the General Information for Providers Chapter of this manual for additional information.)

Once suspected abuse is reported, the local DHS office can request supplemental home health visits to complement the protective services from DHS. Medicaid covers up to two home health visits for this purpose. The HHA must document in the beneficiary's medical record the county and the name of the individual DHS staff member who approved the request.

Approved visits must be ordered by the attending physician and documented in the beneficiary's medical record.

A nursing visit for suspected abuse cannot be billed within 30 days of an aide visit, an observation/evaluation, or an established disability or frail condition visit.

6.1.M. Teaching and Training Activities

HHA services are not covered if the beneficiary has a willing, available, and competent designated caregiver (e.g., family member, friend, neighbor, Home Help provider) that can demonstrate the ability for the beneficiary and/or designated caregiver to provide appropriate care. Medicaid does cover HHA teaching and training activities to enable the beneficiary to become independent of skilled care. The teaching of a procedure or service is covered if it is reasonable and necessary for the treatment of a specific illness, injury or disability.

If a beneficiary or available family member is mentally/physically able to be taught and utilize a particular procedure, and the nurse has completed the teaching but the beneficiary or available family member is subsequently noncompliant, a maximum of three additional teaching visits are allowed for reinforcement teaching. (Medicaid defines noncompliance as the failure or refusal to follow instructions related to improving or stabilizing a condition.)

Teaching visits are not covered if a beneficiary, family member, friend, or neighbor is not mentally or physically able to be taught and utilize a procedure or service as documented in the POC. In these cases, as well as when a caregiver could be taught but is not available or willing to be taught, aide visits (not nurse visits) may be covered to perform these services, as long as other Medicaid coverage criteria are met.

Teaching and training activities covered by Medicaid include, but are not limited to:

- Giving an injection.
- Prefilling insulin syringes.
- Inserting/irrigating a catheter.
- Administering eye drops/topical ointments.
- Caring for a colostomy or ileostomy.
- Administering oxygen.
- Preparing and following of a therapeutic diet.
- Applying dressings to wounds that require prescription medications and aseptic techniques.
- Bladder training.
- Bowel training (e.g., bowel incontinency, constipation due to beneficiary's immobility).

- Performing activities of daily living (dressing, eating, personal hygiene, etc.) for the beneficiary through use of special techniques and adaptive devices where the beneficiary has suffered a loss of function.
- Aligning and positioning a bed-bound beneficiary.
- Performing transfer activities (e.g., from bed to chair or wheelchair, wheelchair to bathtub).
- Ambulating by means of crutches, walker, cane, etc.

Medicaid reimbursement for teaching visits is based on whether the teaching provided in the home is a reinforcement of previous teaching or is initial instruction. If teaching constitutes reinforcement of training previously received, fewer visits should normally be required than for initial training.

Visits made solely to remind or emphasize to the beneficiary, family member, friend, or neighbor the need to follow the instructions are not covered services. However, visits to supervise and evaluate the practical application of training require the skills of a nurse and are considered reasonable and necessary where the complexity of the service being taught indicates such visits are warranted (e.g., insulin injections or preparation of formula feedings for gastrectomy beneficiaries).

Whether the teaching is reinforcement or initial, the nurse must establish the goal(s) or intended outcome(s) for the beneficiary and a reasonable period of time to attain them and document these in the POC. The beneficiary must be encouraged to become independent of skilled services in his home whenever feasible.

Visits for teaching and training activities solely to ensure stability or solely to prevent an illness, injury, or disability are only covered for beneficiaries who have an established or frail condition or for women/newborns following delivery, as detailed in previous sections.

Except as detailed above, visits solely for teaching designed to prevent an illness, injury, or disability are not covered. Visits for teaching must be necessary for the treatment of a specific illness. For example, instruction in the importance of good nutritional habits, exercise regimens, and good hygiene are not covered services in the absence of a specific supporting diagnosis of illness, injury, or disability.

6.2 Noncovered Nursing Services

The following services are not covered as home health nursing services. As noted, they may be covered under another service.

6.2.A. Bathing

Bathing does not require the skills of a nurse and is not covered by the Medicaid home health benefit.

6.2.B. Prefilling Insulin Syringes

If the sole purpose of a nurse visit is to prefill insulin syringes, this service is not covered as a nursing visit.

This service is covered as an aide visit with a maximum of two visits per month. The Remarks section of the claim must state that the visit was for prefilling insulin syringes.

6.2.C. Psychiatric Nursing Visit

Nursing visits for the primary purpose of providing a psychiatric nursing service is not a Home Health benefit covered by Medicaid, but may be covered under another Medicaid program. Examples of noncovered nurse visits include psychiatric evaluation, psychotherapy, administration of psychotropic drugs, assessment of beneficiary's adjustment to a psychotropic drug, venipuncture to obtain specimen for psychiatric medication review, and nurse visit to prefill medication cups/boxes, giving reminders, etc., to assist the beneficiary in remembering to take psychiatric medication.

6.2.D. Routine Foot Care

Medicaid does not cover nursing visits solely to provide routine foot care (e.g., removal of corns, calluses, trimming of nails). Nursing visits for the debridement of mycotic nails are not covered by the Medicaid home health benefit.

SECTION 7 – THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH)

7.1 OCCUPATIONAL THERAPY

For all beneficiaries, Occupational Therapy (OT) must be medically necessary, reasonable, and required to:

- Help the beneficiary return to the functional level prior to illness or disability;
- Help the beneficiary return to a functional level that is appropriate to a stable medical status; or
- Prevent a reduction in the beneficiary's medical or functional status that would occur had the therapy not been provided.

If Medicare determines that the service is not medically necessary, Medicaid also considers the service not medically necessary.

Medicaid covers OT services when provided by:

- An occupational therapist (OTR) currently registered in Michigan.
- A certified occupational therapy assistant (COTA) under the supervision of an OTR (i.e., the occupational therapy assistant's services must follow the evaluation and treatment plan developed by the OTR and the OTR must supervise and monitor the assistant's performance, with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the appropriately supervising OTR.
- A student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) an OTR. All documentation must be reviewed and signed by the appropriately supervising OTR.

OT may be provided without prior authorization (PA) by a HHA in the home setting for beneficiaries of all ages for up to 60 consecutive calendar days, with a maximum of 24 visits within those 60 days. If continued therapy is required beyond the initial 60 days, the OT must request PA by completing a Occupational/Physical Therapy – Speech Pathology Prior Approval-Request/Authorization form (MSA-115) and mailing or faxing it to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

Requests for PA to continue active OT must also include:

- A treatment summary of previous periods of OT, including measurable progress on each short-term and long-term goal. This should include the treating OTR's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. (Daily treatment notes are not required.)
- A progress summary related to the identified treatment goals reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- Documentation must cover a period no more than 30 days before the time period for which PA of continued therapy is being requested.
- A statement of the beneficiary's response to treatment, including factors that have affected progress.

- A statement detailing coordination of services with other therapies, if appropriate.
- A copy of the prescription signed by the physician and dated within 30 days prior to the initiation of the request for continued OT services.
- A discharge plan.

7.2 Physical Therapy

For all beneficiaries, physical therapy (PT) must be medically necessary, reasonable, and necessary to help the beneficiary return to the functional level prior to illness or disability or to a functional level that is appropriate to a stable medical status within a reasonable amount of time. Therapy provided to make changes in components of function that do not impact the beneficiary's ability to perform age-appropriate tasks is not covered. If Medicare determines that the service is not medically necessary, Medicaid also considers the service not medically necessary.

For beneficiaries over age 21, PT is covered if it can be reasonably expected that therapy will result in an increase in the beneficiary's ability to perform day-to-day activities.

For CSHCS beneficiaries, PT must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the care of the beneficiary. Functional progress must be demonstrated and documented.

Medicaid covers PT, when medically necessary, for beneficiaries under age 21 who are not enrolled in CSHCS.

PT services must be provided by a Michigan-Licensed Physical Therapist (LPT) or an appropriately supervised Certified Physical Therapy Assistant (CPTA) (i.e., the LPT supervises and monitors the CPTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the supervising LPT. The Code of Ethics, Standards of Practice, and Practice Guidelines provided by the American Physical Therapy Association (APTA) should serve as the basis of appropriate standards of practice.

PT services may be covered for one or more of the following criteria:

- Therapy can be expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills.
- The service is diagnostic.
- Therapy is for a condition that is temporary in nature and creates decreased mobility.
- Skilled services are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers. (The performance of maintenance/preventive therapies is not a covered service.)

PT may include:

- Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility).
- Stretching for improved flexibility.
- Instruction of family or other caregivers.
- Treatment modalities to facilitate gains in function, strength, or mobility.
- Training in the use of orthotic/prosthetic devices.

7.2.A. ACTIVE THERAPY

PT may be provided up to a maximum of 24 times within the first 60 consecutive calendar days in the home setting without PA. There must be a written order for PT signed by the physician and kept in the beneficiary's medical record. If therapy is not initiated within 30 days of the prescription date, a new prescription is required.

To request approval to continue therapy beyond the initial 60 days, the LPT must complete an Occupational/Physical Therapy – Speech Pathology Prior Approval-Request/Authorization form (MSA-115) and mail or fax it to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.) The LPT may request up to 60 consecutive calendar days of additional therapy in the home setting.

7.2.B. MAINTENANCE/MONITORING SERVICES

In some cases, a beneficiary may not need active treatment, but the skills of a LPT are required for training or monitoring of maintenance programs that are being carried out by the family or caregiver. Training or monitoring may be provided up to four times per 60 consecutive day period in the home setting without PA.

PA requests are required for additional maintenance/monitoring services and may be for up to 60 consecutive calendar days in the home setting. The LPT must complete an MSA-115 and include:

- A service summary, including a description of the skilled services being provided. This should include the LPT's analysis of the progress rate, and justification for any change in the treatment plan. Documentation must cover the period immediately before the time for which PA is being requested.
- A comprehensive description or copy of the maintenance/activity plan.
- A statement of the beneficiary's response to treatment, including factors affecting progress.
- A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- A discharge plan.

Mail or fax requests for continued maintenance/monitoring services to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

7.3 Speech-Language Therapy

Medicaid does not cover Speech-Language Therapy (ST) in the home but is a covered service for children enrolled in CSHCS and can be provided in the home under exceptional circumstances. Medicaid beneficiaries not enrolled in CSHCS may obtain ST services from an outpatient hospital or hearing and speech center.

There must be a written order for ST by the physician documented in the beneficiary's medical record. Coverage is limited to services for:

- Articulation
- Language
- Rhythm
- Swallowing
- Training in the use of speech generating devices

The school system provides educational speech; therefore, educational speech is not a covered Medicaid or CSHCS benefit. Examples of educational speech are enhancing vocabulary, improving sentence structure, improving reading, increasing attention span and identifying colors and numbers.

MDCH reimburses services for ST when provided by:

- A speech-language pathologist (SLP) with a current Certificate of Clinical Competence (CCC) or Letter of Equivalency from the American Speech and Hearing Association (42 CFR § 440.110).
- An appropriately supervised SLP candidate (i.e., in their clinical fellowship year [CFY] or having completed all requirements but has not obtained a CCC or Letter of Equivalency). All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.
- A student completing his clinical affiliation under direct supervision of (i.e., in the presence of) an SLP having a current CCC or Letter of Equivalency. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

The SLP must complete an Occupational/Physical Therapy – Speech Pathology Prior Approval-Request/Authorization form (MSA-115) for all services requested through the HHA for a CSHCS beneficiary. Mail or fax the form to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.) Therapy may be requested for up to 60 consecutive calendar days in the home setting.

If continued ST services are required, the SLP may request up to an additional 60 consecutive calendar days for the CSHCS beneficiary receiving speech therapy in the home. A MSA-115 form must be completed and submitted with the following information:

- A treatment summary of previous period of ST, including measurable progress on each short-term and long-term goal. This should include the treating SLP's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. (Daily treatment notes are not required.)

- A progress summary related to the identified treatment goals reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- Documentation must cover the period no more than 30 days before the time period for which prior approval of continued therapy is being requested.
- A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- A statement detailing coordination of services with other therapies, if appropriate.
- A copy of the prescription hand signed by the physician and dated within 30 days prior to the initiation of continued ST services.
- The anticipated frequency and duration of continued treatment.
- A discharge plan.

7.4 Resuming Therapies

If OT, PT, or ST services must be resumed within a 12-month period for the same diagnosis, prior approval is required. The provider must submit an MSA-115 form, along with a copy of the discharge summary of the previous therapy, or an explanation of the changes in functional or medical status since therapy ended. These requests may be submitted by mail or fax to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

SECTION 8 – HOME HEALTH AIDES

Home health aide services are covered only when ordered by the attending physician and performed in conjunction with direct, ongoing skilled nursing care and/or PT.

For example, if a beneficiary with a diagnosis of quadriplegia requires a monthly urinary catheter change, and this is not in conjunction with other skilled nursing needs, home health aide services would not be covered. Another example would be that of an elderly and frail beneficiary with a diagnosis of osteoarthrosis requiring a monthly observation/evaluation visit. If their need is assistance with personal care needs (such as eating/feeding, bathing, toileting, dressing, transferring, laundry, housework, shopping/errands) at specified intervals (daily, weekly, etc.) not in conjunction with direct, ongoing nursing or PT services, Medicaid would not cover the aide services.

If the beneficiary's attending physician orders home health aide services to be performed in conjunction with the nursing and/or PT services, the HHA must assess the ability of the family or another entity (e.g., Home Help Program or MI Choice Waiver) to perform the services. If the family or other entity is unable to perform the service, the reason must be fully documented in the POC. (Refer to the Personal Care Section in this chapter for additional information.)

8.1 SUPERVISORY VISIT

HHA registered nurses (RN) must assign a Home Health aide to a particular beneficiary, prepare written instructions for the beneficiary's care, and supervise home health aide visits. RNs must make a supervisory visit to the beneficiary's home at least once every two weeks and document the supervisory visit in the beneficiary's medical record.

SECTION 9 – PERSONAL CARE

If the physician orders home health aide services and the beneficiary is also receiving personal care services through another entity (e.g., Home Help Program, MI Choice Waiver), there must be coordination between the two providers and documentation in the POC to verify that there is no duplication of personal care services.

9.1 HOME HELP PROGRAM

The Home Help Program provides unskilled personal care services (e.g. laundry, housekeeping, snow removal, and other personal care tasks) to assist eligible beneficiaries who are blind, disabled, or otherwise functionally limited. The beneficiary's adult services worker at the local DHS office arranges for these services with the personal care provider. The POC must clearly identify why the HHA services are required along with Home Help. Medicaid covers occasional follow-up HHA visits made to observe, evaluate and document the beneficiary's progress, if ordered by the attending physician.

9.2 HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY AND DISABLED

Medicaid's Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice Waiver) covers those services to aged and disabled individuals (aged 18 and over) who, without the provision of waiver services, would require nursing facility care. Examples of services are chore, respite, and emergency response systems.

MI Choice beneficiaries are identified as Level of Care code 22 in the Medicaid Eligibility Verification System (EVS). When the physician orders home health services, and the beneficiary is enrolled in the waiver program, the HHA should contact the waiver agent in order to assure coordination and verify there is no duplication of care provided.

SECTION 10 – DURABLE MEDICAL EQUIPMENT (DME) / SUPPLIES

Durable Medical Equipment (DME), certain medical supplies, orthotic and prosthetic appliances, shoe supplies, and oxygen (gas and equipment) are covered services for HHA beneficiaries. These items must be supplied and billed by a Medicaid enrolled medical supplier, orthotist, prosthetist, shoe supplier, or oxygen supplier, except as noted below. The beneficiary's attending physician (MD, DO, DPM) must order these items in writing. These providers may have to obtain PA for certain services, and the services provided must be in accordance with Medicaid policies.

MDCH encourages the HHA to submit the beneficiary's POC to the medical supplier to help support the need for the item.

Routine medical supply items are included in the reimbursement for the HHA's nurse or aide visit. No separate reimbursement for such supplies is allowed. These supplies include, but are not limited to:

- Band-aids
- Enema kits (e.g., Fleet)
- Gloves (sterile, nonsterile), up to four pair
- Simple dressing (including 10 4x4's and one roll of tape)
- Skin cleansers - swabs or wipes (e.g., iodine, alcohol, Betadine)
- Sterile solutions (up to 30 ml.)
- Syringes and needles
- Thermometers
- Cotton swabs, balls
- Specimen cups
- Suture removal kits
- Gowns

If the treatment regimen requires quantities beyond those listed above for gloves, simple dressings, or sterile solutions, the HHA or the medical supplier may bill separately for the additional quantities. The need for additional supplies must be documented in the medical record.

The HHA coding and fee screen information on the MDCH website contain a list of medical supply items that may be billed separately from the nurse or aide visit. (Refer to the Directory Appendix for website information.) These are items that may be left in the beneficiary's home between visits where repeated applications are required and the applications will be performed by the beneficiary, family member, nurse, etc. Supplies billed to Medicaid must be dispensed to a specific beneficiary and must be ordered by the attending physician as part of a written POC.

SECTION 11 – NONCOVERED SERVICES

The services listed below are **not** covered under the home health program.

11.1 AMBULATORY UTERINE ACTIVITY MONITOR

Home health services related to the use of an ambulatory uterine activity monitor (AUAM) are not separately reimbursable. Reimbursement is made on a per diem rate to a medical supplier approved by MDCH to provide this service. All equipment, perinatal nursing services, technical services, and supplies necessary for the provision of AUAM are included in the rate.

11.2 DRUGS AND BIOLOGICALS

The cost of drugs and biologicals are not HHA benefits but may be covered by Medicaid. For information on PA for certain prescribed drugs, contact the MDCH Pharmacy Benefit Manager (PBM). (Refer to the Directory Appendix for contact information.)

11.3 EVALUATION VISITS

Nursing or PT evaluation visits to assess the acceptance of the beneficiary by the HHA are not covered, i.e., adequacy of the environment for providing nursing care or PT in the home, ability and willingness of family members to meet the beneficiary's medical needs in the home setting, if the beneficiary meets Medicaid home health policy criteria. When the agency makes such an initial evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not covered as a visit because the beneficiary has not been accepted for care by the HHA.

If, however, during the course of this initial evaluation visit the beneficiary is accepted by the HHA for care, and is also furnished the first service as ordered under the physician's POC, the visit becomes the first billable visit.

11.4 HOSPICE

MDCH does not separately reimburse HHAs for services related to the beneficiary's terminal illness when the beneficiary is enrolled in a hospice program. All HHA services related to the beneficiary's terminal illness are either arranged for (contractual agreement), or provided by, the hospice program.

11.5 MEDICAL SOCIAL SERVICES

Medical social services are not a Medicaid covered HHA service.

11.6 MISSED VISITS

Missed visits are not covered. If a beneficiary is not home when HHA staff arrives to provide a service, MDCH does not reimburse the agency for the missed visit. The HHA may not charge the beneficiary for a missed visit unless it is the HHA's normal practice to charge everyone for missed visits. (The HHA must notify the beneficiary, in advance, that the beneficiary is required to pay for missed visits).

11.7 OXYGEN

The administration of oxygen is included in the cost of the nurse or aide visit and is not separately reimbursable.

Oxygen gas and equipment are Medicaid benefits when supplied and billed by an enrolled pharmacy, oxygen supplier, or medical supplier in accordance with Medicaid policy.

HOSPICE

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SECTION 1 - INTRODUCTION

This chapter applies to Hospice providers (Provider Type 15).

Hospice is a health care program designed to meet the needs of terminally ill individuals when the individual decides that the physical and emotional toll of curative treatment is no longer in their best interest. These individuals choose palliative care, which is not a cure, but ensures comfort, dignity and quality of life. Hospice is intended to address the full range of needs of the individual with a terminal illness, while also considering family needs. Care must be consistent with the individual's values, regardless of the location where care is provided.

The primary objective of the Medicaid Hospice Program is to ensure that essential medical/health services are available to those who would not otherwise have the financial resources to purchase them. Medicaid policies are designed to achieve this objective with fiscal responsibility. Hospice providers must verify Medicaid eligibility of beneficiaries prior to provision of services. Medicaid eligibility information may be obtained by calling the Michigan Department of Community Health (MDCH) Eligibility Verification System (EVS). (Refer to the Beneficiary Eligibility Chapter of this manual for more information regarding obtaining beneficiary information from the EVS and the Directory Appendix for contact information.)

SECTION 2 – PROVIDER REQUIREMENTS

Hospice providers are bound to all rules, regulations, and policies specified in this chapter for program participation/enrollment of Medicaid beneficiaries. Hospice providers must also comply with the Medicare Conditions of Participation (42 CFR § 418) which generally apply to nonMedicare beneficiaries as well as to Medicare beneficiaries.

Additional information regarding federal Hospice requirements and guidelines is contained in the Centers for Medicare & Medicaid Services [CMS] State Operations Manual 2083.

The exceptions are 42 CFR § 418.60 and 42 CFR § 418.98(c) conditions that apply only to Medicare beneficiaries.

MDCH requires Hospice agencies to be licensed by the state-licensing agency, certified by Medicare, and enrolled in Medicaid. (Refer to the General Information for Providers Chapter of this manual for more information.)

Hospice providers cannot engage in any of the following marketing-related practices:

- Provide cash, gift incentives, or rebates to prospective covered persons;
- Claim superior medical care or provider skills; or
- Make untruthful statements regarding the merits of the hospice.

The use of marketing practices that mislead, confuse, or defraud either the beneficiary or MDCH is considered grounds for terminating the hospice from participation in Medicaid. Such actions may also result in investigation leading to possible prosecution under applicable State and Federal statutes.

SECTION 3 – BENEFICIARY ENROLLMENT

3.1 BENEFICIARY ENROLLMENT DETERMINATION

A terminally ill Medicaid beneficiary who lives in a hospice service area and whose life expectancy is six months or less (if the illness runs its normal course), as determined by a licensed physician and the Hospice Medical Director, has the option to enroll in a hospice program. A representative, such as a spouse, parent, legal guardian, or other authorized adult, may act on behalf of the beneficiary.

Medicaid does not cover Hospice services if the following conditions exist:

- The individual is not eligible for the Medicaid benefit.
- The beneficiary does not meet the hospice's enrollment criteria.
- The beneficiary is currently enrolled in a Medicaid Health Plan (MHP). (In this case, hospice services must be arranged and reimbursed by the MHP.)

All Hospice enrollment activities must be conducted according to MDCH policies and in such a manner as to maximize the beneficiary's ability to make a choice between enrollment in hospice or maintaining current active treatment with Medicaid coverage. Such activities must assure that the beneficiary fully understands how to use hospice services and that all care must be received from or through the hospice (except those services not related to the terminal illness or services provided by his attending physician).

It is imperative that the Hospice provider read the Conditions of Enrollment on the Hospice Membership Notice form (DCH-1074) to the beneficiary and answer any questions raised by the beneficiary. (Refer to the Forms Appendix for an example of the DCH-1074 and instructions for its completion.)

3.2 BENEFICIARY ENROLLMENT PROCESS

Hospice providers are responsible for enrolling beneficiaries for hospice services. A DCH-1074 must be completed, including the signature of the beneficiary or his legally appointed representative. Fax the completed form to the MDCH Enrollment Services Section. (Providers are not required to submit the form by US mail.) A copy of the form must be given to the beneficiary, and the original filed in the beneficiary's record.

Do not submit forms in batches.

A copy of the following information must be retained in the beneficiary's record:

- Hospice Membership Notice form (DCH-1074).
- Effective date of enrollment. (If the date entered on the DCH-1074 is changed, the hospice must contact the beneficiary to notify him of the new effective date.)
- Hospice enrollment identification card (if the hospice chooses to issue one to their beneficiaries).

3.3 Beneficiary Notification

Hospice providers must provide Medicaid beneficiaries with the following materials and written information within ten days of the effective date of enrollment in hospice:

- Conditions of enrollment, including:
  - Scope, content, and duration of coverage;
  - Enrollee grievance procedure; and
  - Beneficiary responsibility for reporting coverage by any other insurance.
- Procedures for obtaining health care, including:
  - Address, telephone number, and service hours of the health care providers;
  - Emergency medical care (other than for the treatment of the terminal illness); and
  - Health care provision outside of the hospice.

3.4 Place of Service

3.4.A. Beneficiary's Home

A beneficiary eligible for hospice may receive hospice services in their home. If the beneficiary is eligible for hospice services but does not have family or friends to provide the necessary home care, the beneficiary may live in a residential setting that may include an Adult Foster Care (AFC) facility, boarding home, Home for the Aged (HFA), or assisted living facility. The setting must be appropriate for the type of care required by the beneficiary. Medicaid does not pay room and board in these settings.

Beneficiaries may receive hospice services in these settings. The hospice is responsible for developing and implementing a coordinated plan of care to avoid duplication of services. These care settings are available for Medicare, Medicaid, and dually eligible beneficiaries.

3.4.B. Nursing Facility

When a dually enrolled Medicare/Medicaid beneficiary enters a nursing facility (NF), the beneficiary can elect the Medicare hospice benefit if that NF has hospice services available. In this case, the beneficiary revokes the 100 days of Medicare reimbursement for skilled NF care.

Revocation of the 100-day NF skilled care is a beneficiary's decision and should not be influenced by the NF's funding source for the bed.

The DCH-1074 is used as the benefit election form for Medicaid eligible beneficiaries. This does not mean that the beneficiary has revoked the Medicare benefit for services not related to their terminal illness. The beneficiary remains eligible for Medicare, but has elected to use only the hospice portion of the Medicare benefit.

If the NF contracts to make hospice services available, the hospice must provide DCH-1074 forms to Medicaid, Medicare and dually eligible beneficiaries. The facility must provide room and board for the beneficiary, and the hospice must provide its normal services.

The Pre-Admission Screening/Annual Resident Review (PASARR) form (DCH-3877) must be completed for a hospice patient entering a NF, unless the hospice beneficiary is entering for a five-day respite period. The DCH-3877 is not required for the respite period. The DCH-3877 is to identify individuals who may be mentally ill or mentally retarded. If the patient is on antipsychotic, antianxiety, or antidepressant medications for purposes of pain control/symptom relief for end of life, it should be noted on the DCH-3877. This allows the Community Mental Health Services Program (CMHSP) worker to better evaluate the need for further (Level II) screening. If the patient is on any of the above mentioned psychotropic medical groups for a related mental illness, the CMHSP will determine the need for a Level II screening.

When a hospice beneficiary resides in a NF or in a hospice-owned NF with beds designated for hospice, Medicaid reimburses the hospice for room and board. The hospice then reimburses the NF. The Medicaid reimbursement to the hospice for NF room and board is equal to 95% of the total Medicaid NF rate. For Class I NFs, reimbursement also includes 95% of the Quality Assurance Supplement (QAS) amount due the NF through the Quality Assurance Assessment Program (QAAP). QAAP funds are not included in the reimbursement for County Medical Care Facilities, Hospital Swing Beds, or specialized Medicaid ventilator dependent care units as they are not eligible for that program. Reimbursement for private hospital Long Term Care Units equals 95% of the Medicaid per diem plus the QAS. Public hospital LTCUs are not eligible for the QAS.

If a hospice/NF resident has a Memorandum of Understanding (MOU) for an illness not related to the terminal illness, the hospice may bill Medicaid for room and board for that resident. The room and board rate is part of the MOU reimbursement.

Per Medicare guidelines, the term "room and board" in a NF includes the performance of personal care services that a family caregiver would provide if the individual were at home. This includes assistance in the activities of daily living such as bathing, grooming, toileting, dressing, meal service, socializing, companionship, hobbies, administration of medication, maintaining the cleanliness of the beneficiary's bed and room, and supervising/assisting in the use of durable medical equipment (DME) and prescribed therapies (e.g., range of motion, speech and language exercises). The NF may not include hospice staff to meet its staffing requirements.

Hospice covered beneficiaries residing in the NF must not experience any lack of NF services or personal care due to their status as a hospice beneficiary. NFs must offer the same drugs, services, medical supplies and DME to all residents who have elected the hospice benefit in the same manner that services are provided to other residents in the facility who have not elected hospice care. If a service is normally furnished as part of the facility's per diem, the service must also be provided to hospice beneficiaries. If

services are provided for needs associated with a nonterminal illness and are normally furnished and billed by another provider, that practice would continue.

3.4.C. Hospital Inpatient Care

Medicaid hospice reimbursement includes payment for any hospitalizations related to the terminal illness. The hospice must contract with, and reimburse, a hospital for medically necessary inpatient services related to the beneficiary's terminal illness. Medicaid does not reimburse the hospital separately unless the hospitalization is not related to the terminal illness.

3.5 Duration of Coverage

Based on hospice eligibility criteria, the duration of hospice services is generally six months or less. There is no minimum period of hospice enrollment. A change in the beneficiary's prognosis could eliminate the need for hospice care. A beneficiary may cancel his enrollment in the hospice at any time and without cause. Beneficiaries who become ineligible for Medicaid while enrolled in a hospice also become ineligible for Medicaid reimbursement for hospice services.

SECTION 4 - BENEFICIARY DISENROLLMENT

Disenrollments from hospice may be initiated for any of the reasons noted below. A DCH-1074 indicating the reason for the disenrollment must be signed and dated by the beneficiary as proof of notification of disenrollment (unless the beneficiary has expired). The hospice must submit a copy of the disenrollment notice to the MDCH Enrollment Services Section. (Refer to the Directory Appendix for contact information.)

Terminations generated by the hospice are subject to the appeal procedures, as required by licensure requirements.

4.1 BENEFICIARY DIES

When a hospice-enrolled beneficiary dies, the hospice must complete the DCH-1074 indicating the date the beneficiary expired and submit it to MDCH.

4.2 BENEFICIARY ELECTS TO DISENROLL

If the beneficiary elects to disenroll from the hospice, the hospice must give a copy of the disenrollment notice to the beneficiary when he signs it, and retain another copy in the beneficiary's record.

4.3 BENEFICIARY NO LONGER MEETS ENROLLMENT CRITERIA

An enrolled beneficiary may have a change in condition and would no longer qualify for hospice services. If the beneficiary is disenrolled for this reason, the hospice must send a copy of the DCH-1074 (indicating the disenrollment) to the beneficiary along with a letter explaining the reason and effective date for the disenrollment.

4.4 BENEFICIARY BECOMES INELIGIBLE FOR MEDICAID

The hospice is responsible for verifying the beneficiary's continued Medicaid eligibility once he is enrolled. Medicaid does not reimburse hospice services rendered to a Medicaid ineligible beneficiary.

4.5 BENEFICIARY MOVES OUTSIDE THE HOSPICE SERVICE AREA

At the time of enrollment, beneficiaries must be told to notify the hospice and their local Department of Human Services (DHS) worker if their place of residence changes. If the new residence is located in the hospice's normal service area, or if the hospice agrees to continue to provide services to the beneficiary, the move creates no changes except an address change. However, if the move is too far for the hospice to continue services for the beneficiary, the hospice must arrange a transfer of care for the beneficiary to another Medicaid enrolled hospice. The two hospices must work together to assure that no lapse occurs in services to the beneficiary.

The effective date of disenrollment for a beneficiary who has moved is the day that the beneficiary moves. It is preferable that the DCH-1074 indicating the disenrollment from the first hospice, and the DCH-1074 indicating enrollment for the second hospice be sent to MDCH together. If the notices are sent separately, each hospice must place an explanation in the Remarks box on the DCH-1074 indicating the reason for the transition to the new hospice.

4.6 Hospice Elects to Terminate the Beneficiary's Enrollment

The hospice may disenroll a beneficiary if the beneficiary violates any of the conditions of membership in the hospice. MDCH must give approval for such a disenrollment. The decision to disenroll a beneficiary and the effective date of disenrollment are determined on an individual basis by the hospice Medical Director.

The hospice may request disenrollment of a beneficiary for any of the following reasons:

- Fraud;
- Abuse (including repeated instances of willfully and knowingly obtaining health care services for the terminal illness from nonhospice providers); or
- Misconduct (including violence that interferes with or interrupts the provider's proper delivery of health care to the patient or other patients).

SECTION 5 - HOSPICE SERVICES

5.1 CORE SERVICES

The hospice must provide all or substantially all of the core services applicable for the terminal illness in the beneficiary's home. (Home may include the beneficiary's private dwelling, apartment, boarding home, assisted living facility, AFC facility, HFA, NF or hospice-owned NF.)

These core services are:

- Physician care
- Nursing care
- Social work
- Counseling
  - Bereavement
  - Spiritual
  - Dietary

5.2 OTHER HOSPICE COVERED SERVICES

Other services that may be necessary due to the terminal illness and must be available but are not considered core services are:

- Home Health Aide services
- Medical Supplies
- Homemaker services
- Occupational Therapy
- Short-Term Inpatient care
- Physical Therapy
- Speech Therapy
- Drugs*/Biologicals

***Although the drug AZT (Retrovir) is related to the terminal illness of AIDS, MDCH reimburses the pharmacy separately for a hospice beneficiary receiving AZT.**

These other services may be provided by contractual agreement or provided by the hospice directly and are not reimbursed separately.

5.3 Transportation

5.3.A. Home Setting

Nonemergency transportation related to the terminal illness is the responsibility of the hospice agency.

Routine, nonemergency transportation to obtain Medicaid covered services not related to the terminal illness is available through the local DHS for beneficiaries who do not reside in a nursing facility (NF). The beneficiary/responsible party should contact the DHS worker to determine the appropriate mode of nonemergency transportation and make the necessary arrangements. The transportation provider, not the hospice, bills the local DHS office for the transportation provided.

Nonemergency transportation by ambulance not related to the terminal illness requires a physician's signed order to allow the ambulance provider to bill Medicaid directly.

Emergency transportation related to the terminal illness is the responsibility of the hospice agency.

Emergency ambulance transportation not related to the terminal illness may be billed directly to Medicaid by the ambulance provider.

5.3.B. Nursing Facility Setting

Nonemergency transportation related to the terminal illness is the responsibility of the hospice agency.

Routine, nonemergency transportation not related to the terminal illness must be provided by the NF as part of their per diem.

Nonemergency ambulance transportation not related to the terminal illness requires a signed physician's order and may be billed directly to Medicaid by the ambulance provider. If the NF does not have a physician's order, neither the NF nor the ambulance provider can bill Medicaid, the resident, the resident's family, or use the offset to the patient pay amount. Arrangement for payment is between the NF and the ambulance provider.

Emergency transportation related to the terminal illness is the responsibility of the hospice agency.

Emergency ambulance transportation not related to the terminal illness may be billed directly to Medicaid by the ambulance provider.

5.4 Hospice Service Log

The hospice must complete a monthly service log that indicates, on a daily basis, the services provided to the beneficiary and whether an employee or a volunteer provided them.

The log must be retained as part of the beneficiary's medical record. However, if the hospice maintains this information electronically in a secure, yet readily understood format, it is not necessary to maintain a paper copy of the log.

5.5 Categories of Care

There are four categories of hospice care:

Routine Home Care	Routine Home Care is defined as hospice home care that is not continuous.
Continuous Home Care	Continuous Home Care is defined as short-term in-home care that is reflective of at least half of the hours predominantly being nursing care, provided by either a registered nurse or licensed practical nurse in a crisis situation. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home hospice care. Payment is made for the hours of continuous care provided, up to 24 hours in one day.
Inpatient Respite Care	Inpatient Respite Care is defined as short-term inpatient care to relieve the primary caregiver(s) providing at-home hospice care for the beneficiary. Hospice care may be provided in a hospice-owned NF, hospital, or NF meeting hospice standards for staffing and patient areas. The length of stay may not exceed five consecutive days.
General Inpatient Care	General Inpatient Care may be provided in a hospice inpatient unit, hospital, or NF meeting hospice standards for staffing and patient areas. This care is usually for pain control, or acute or chronic symptom management that cannot be successfully treated in another setting.

Guidelines for core and other services as detailed above apply to all categories of care.

5.6 Plan of Care

After enrollment in the hospice, a plan of care (POC) must be developed before the beneficiary can receive services. The hospice Medical Director (or physician designee), the beneficiary and/or family or involved support system, and the Interdisciplinary Group (IDG) as defined by federal regulations, must participate in the development of the plan. The beneficiary's attending physician should be encouraged to attend as well. The hospice is responsible for implementing the POC for hospice services.

5.6.A. Adult Foster Care Facility / Home for the Aged

The Adult Foster Care Facility/Home for the Aged (AFC/HFA) is responsible for care related to the nonterminal needs of the beneficiary who resides in their facility. There is to be no duplication of services by either staff.

5.6.B. Assisted Living Facility

The hospice is responsible for implementation of the POC for hospice services provided in this setting.

5.6.C. Nursing Facilities

The NF and hospice are responsible for performing their respective functions, which have been agreed upon and included in the jointly developed POC. The joint POC must include directives for managing pain and other uncomfortable symptoms, and be revised and updated as necessary to reflect the beneficiary's current status. The hospice retains overall professional management and responsibility for directing the implementation of the POC.

The joint POC should reflect the participation of the hospice, NF, and the beneficiary to the extent possible. The hospice and NF must communicate with each other when any changes to the POC are indicated, and each provider must be aware of the other's responsibilities in implementing the POC. There must be evidence of this coordination of care in the clinical records of both providers. All aspects of the joint POC must reflect the hospice philosophy. NF services must be consistent with the POC developed in coordination with the hospice.

5.6.D. Adult Home and Community Based Waiver Beneficiaries (MI Choice)

If the hospice finds that the beneficiary is enrolled in the waiver program, the hospice should contact the beneficiary's waiver coordinator/agent. A joint POC must be retained in the beneficiary's record by both the hospice and the waiver coordinator. The waiver coordinator must understand the hospice philosophy so that the two agencies work for a common goal and eliminate duplicate services. Ongoing communication and coordination must occur regularly between the two providers during the time they are serving the same beneficiary. Written documentation of this ongoing communication and coordination must be kept in the beneficiary's record at each agency.

The hospice is not required to submit a DCH-1074 to MDCH for each waiver participant it serves.

Beneficiaries may receive services from both types of providers concurrently as long as the services are not duplicative. Level of Care (LOC) 22 identifies the beneficiary as receiving services through the Home and Community Based Waiver for the Elderly and Disabled (MI Choice Waiver) and remains on the MDCH eligibility file for the beneficiary.

The hospice should not complete enrollment for a beneficiary whose eligibility verification indicates a LOC 22 until the hospice contacts the waiver coordinator to discuss and coordinate the services required.

The fact that the beneficiary has a LOC 22 on the MDCH EVS must also be noted prominently on the claim form in order to allow correct claims processing.

Hospice services must be used to the fullest extent before additional waiver services of the same type are initiated. Post-payment review may be employed to monitor services. If inappropriate (i.e., duplicative) services were authorized, MDCH seeks recovery of Medicaid funds paid for those services from the waiver coordinator.

MDCH maintains a list of MI Choice waiver coordinators and contact information on the MDCH website. (Refer to the Directory Appendix for website information.) Habilitation Supports waiver coordinators may be contacted through the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) provider.

5.7 Special Programs

5.7.A. Children's Home and Community Based Waiver Beneficiaries (Children's Waiver, Habilitation Supports Waiver)

If waiver services are not related to the terminal illness, the hospice should send the MDCH waiver program coordinator an explanation of the situation when enrolling the beneficiary. The hospice agency should contact the waiver case manager or supports coordinator at the PIHP/CMHSP to coordinate care and to develop a combined POC.

5.7.B. Children's Special Health Care Services

To be eligible and authorized for the Children's Special Health Care Services (CSHCS) hospice benefit, the beneficiary must be determined by MDCH to have:

- CSHCS coverage; and
- Reached the terminal phase of illness where the physician treatment plan deems palliative measures necessary and appropriate, versus the ongoing aggressive treatment typically engaged for curative measures; and
- Documentation from the treating specialty physician, indicating the need to pursue the palliative measures; and
- Limited life expectancy of approximately six months or less; and
- Need for services that are clinically and developmentally appropriate to the beneficiary's needs and abilities; and
- Need for services that are consistent with the philosophy/intent of hospice.

Requests for hospice must be made in writing to CSHCS. (Refer to the Directory Appendix for contact information.)

5.8 Home Help / Personal Care

Home Help/personal care may be available to the hospice beneficiary living at home (e.g., not residing in a hospice residence, NF, AFC, etc.). It is important that hospice services be utilized first, prior to Home Help services. Home Help services may be in addition to hospice care and must not duplicate hospice services. Home Help/personal care services are assistance with eating, toileting, bathing, grooming, dressing, transferring, self-administered medication, meal preparation, shopping/errands, laundry and light housekeeping. Some examples of when these services are appropriate are:

- The caregiver is too frail or otherwise unable to provide all of the needed personal care.
- There is no unpaid caregiver available and the beneficiary wishes to remain at home.
- The beneficiary is new to hospice but has been receiving personal care services through Home Help.

If hospice services duplicate or replace personal care services, payment is not approved for Home Help/personal care.

The hospice must contact the beneficiary's DHS adult services worker or ask for the assignment of an adult services worker if the beneficiary does not already have one. The adult services worker determines which personal care services may be provided in addition to hospice care. This determination may require the hospice to submit a POC for the worker's review.

SECTION 6 - BILLING & REIMBURSEMENT

6.1 MEDICARE/MEDICAID BENEFICIARIES

If a beneficiary is dually enrolled in Medicare and Medicaid, he must receive hospice coverage under the Medicare benefit. (Medicaid is the payer of last resort.) If the beneficiary resides in a NF, Medicare may pay hospice services, with NF room and board paid for by Medicaid. When a beneficiary is receiving services through the Medicare hospice benefit, Medicaid does not pay for curative or duplicative services. The hospice provider must complete the DCH-1074 whenever Medicaid is billed (i.e., coinsurance, deductibles, and room and board in the NF or hospice-owned NF).

If the hospice benefit is revoked under Medicare, the beneficiary cannot use the Medicaid hospice benefit as a replacement. Hospices should carefully explain this situation to the dually eligible beneficiary, especially during the fourth Medicare benefit period.* However, if the dually eligible beneficiary is no longer appropriate for hospice care and is disenrolled as a hospice beneficiary, that beneficiary is able to re-enroll with the hospice for the Medicaid benefit period if he becomes eligible for hospice again.

6.2 MEDICAID HEALTH PLAN ENROLLEES

Hospice services are included in the Medicaid Health Plan (MHP) covered services package for Medicaid enrollees. If the terminally ill enrollee requests and meets the criteria for hospice services, the MHP must cover the requested hospice services. If the terminally ill enrollee does not request hospice services, the MHP may provide its own array of services for the terminally ill. If MHP enrollment is indicated when verifying a Medicaid beneficiary's eligibility through the MDCH EVS (a LOC code 07 is noted on the EVS), the hospice must contact the MHP immediately to receive prior authorization (PA) from the MHP before furnishing services. The MHP may require its enrollees to receive hospice services through a contracted hospice with which they have made arrangements. MHPs are responsible for arrangement of, and payment for, the enrollee's hospice care. The enrollee's LOC code does not change; the appropriate managed care code remains throughout the hospice care.

If a fee-for-service (FFS) Medicaid beneficiary is automatically enrolled in a MHP while receiving hospice care, the beneficiary or his representative should contact the MDCH Hospice Enrollment Coordinator if he wishes to continue receiving services from his current hospice provider. (Refer to the Directory Appendix for contact information.) The hospice enrollment coordinator initiates the process of disenrollment from the MHP. It is not the intent of MDCH to disrupt a hospice beneficiary's care through automatic enrollment in a MHP. If the beneficiary subsequently disenrolls, or is discharged, from hospice care, the beneficiary may be offered the opportunity to join a MHP.

If the MHP enrollee requires hospice services in a NF or hospice-owned NF, the MHP pays a negotiated rate for room and board in addition to the payment for the hospice services. The hospice must contact the MHP prior to enrolling the beneficiary to request authorization by the MHP.

* The fourth Medicare benefit period is the subsequent extension period during the beneficiary's lifetime that occurs after the first two 90-day periods, and subsequent 60-day period, have been utilized.

6.3 Reimbursement

MDCH employs the following standards when reimbursing for hospice care:

6.3.A. Rate Methodology

MDCH uses the Medicaid rates established by CMS and applies the appropriate local wage adjustors for the categories of care provided. Medicaid publishes and implements rate updates when new rates are released and MDCH receives CMS approval for publication. (Refer to the MDCH Hospice Reimbursement Rates on the MDCH website.)

6.3.B. Co-Payments

When a Medicaid beneficiary is receiving hospice services under Medicare, the hospice may bill Medicaid for the coinsurance, as well as room and board if the beneficiary resides in a NF or hospice-owned NF. Coinsurance and/or room and board cannot be billed to a Medicaid beneficiary, his family, or his representative.

6.3.C. Date of Discharge

Hospice services are reimbursable for day of discharge if services were rendered, regardless of the setting in which the services were provided. This includes the transfer of the beneficiary from one hospice provider to another, as long as services were provided by both agencies. (This will be randomly verified by post payment audit and as indicated.) If the beneficiary has hospice as of 12:01 am, the hospice is responsible for the payment of services provided to the beneficiary until midnight. The hospice will continue, for payment purposes, as the primary provider for the full day of discharge.

Room and board for a hospice/nursing facility (NF) resident is reimbursable on the day of discharge **only** if the discharge is due to resident death. Room and board reimbursement for the day of discharge from the NF for any other reason is not covered as the resident is not there at the midnight census to be counted as a resident.

6.3.D. Physician Services

Reimbursement for administrative duties performed by the Medical Director is included in normal hospice rates. Direct patient care provided by the Medical Director, hospice-employed physician or consulting physician may be billed by the hospice and is separately reimbursable based on the lesser of Medicaid's maximum allowable amount for the service or the charge. Claims must reflect the Health Care Financing Administration Common Procedure Coding System (HCPCS) procedure codes for the physician's direct patient care.

6.3.E. Patient-Pay Amount

If the Medicaid beneficiary residing in a NF has a patient-pay amount (PPA), the hospice must collect that amount each month and apply it toward the beneficiary's Medicaid covered services, and non-covered services as allowed by Medicaid. While the hospice is responsible for collecting the PPA, this duty may be delegated to the NF (via contract

with the hospice) as long as the amount is applied to the room and board bill. The PPA must be exhausted each month (even if services do not span the entire month) before any Medicaid payment can be made. Whenever the hospice collects a PPA, a receipt must be given to the beneficiary (or family).

The provider must bill Medicaid for services rendered even if the PPA exceeds the Medicaid reimbursement rate resulting in a zero dollar payment. The Hospice Claim Completion Section of the Billing & Reimbursement for Institutional Providers Chapter contains examples of the application of the PPA.

6.3.F. Payment for Noncovered Services

For necessary medical or remedial care recognized under the State law but not covered by Medicaid, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows NF beneficiaries to access their patient-pay amount to pay for these services as allowed by Medicaid. If Medicare covers the beneficiary's need for medical services, then Medicaid continues to cover the Medicare deductible and coinsurance in the event it does not exceed the Medicaid fee screen.

6.3.G. Medicaid Deductible

Prior to provision of hospice services to the beneficiary in a home setting, the hospice should utilize the MDCH EVS to determine if the beneficiary has a Medicaid deductible or not. If the Medicaid deductible is identified as "yes" on the EVS, the hospice should ask the beneficiary or their responsible person for a copy of the DHS letter sent the first of each month which indicates the dollar amount the beneficiary must spend before becoming Medicaid-eligible for services. Medicaid may not be billed until the Medicaid deductible obligation is met.

6.3.H. Room and Board to Nursing Facilities

When Medicaid reimburses the hospice for room and board in a NF, the beneficiary must be placed in a bed certified by Medicaid (i.e., a Medicare/Medicaid certified bed or one certified Medicaid-only). If the beneficiary is not placed in a bed certified for Medicaid, MDCH does not pay for any services. MDCH pays the hospice 95 percent of the individual or specific facility's Medicaid rate for room and board plus 100 percent of the nursing facility's Quality Assurance Supplement (QAS) rate. Hospice reimbursement to the NF for room and board must be outlined in the contract established between the hospice and the NF.

- **Holding a Bed (Hospital Leave and Therapeutic Leave).** For NF beneficiaries on hospice, Medicaid reimburses the hospice for holding a NF bed as indicated below.

  Hospice reimbursement to the NF for bed holds must be outlined in the contract between the NF and the hospice.

  Family members/responsible parties for the hospice/NF beneficiary must be informed of the bed hold and readmission policy of the NF. If the beneficiary refuses to have a

family member/responsible party notified, this must be documented in the beneficiary's medical record.

- **Hospital Leave Days.** For Hospital Leave Days, Medicaid will pay to hold a beneficiary's bed only when the facility's total available bed occupancy is at 98 percent or more on the day the beneficiary leaves the facility. Facilities at 97.5 percent occupancy may round up to 98 percent. Medicaid reimburses during a beneficiary's temporary absence (up to 10 days) from the NF for admission to the hospital for emergency medical treatment, as documented by the attending physician in the beneficiary's medical record. The facility must hold the bed, and the hospice may bill Medicaid, if the attending physician documents a reasonable expectation at the point of admission to the hospital that the beneficiary will return to the NF by the end of the 10th day.

  The beneficiary must return to the NF within 10 days for the hospice to bill for hospital leave days. If the beneficiary is in the hospital for more than 10 days, the NF is released from its obligation to hold the bed and the hospice cannot bill Medicaid for any leave days. Reimbursement to the hospice is at 100 percent of the class wide NF hospital leave day rate. This rate, determined annually by MDCH, is available on the MDCH website. (Refer to the Directory Appendix for website contact information.)

  If the beneficiary is expected to be in the hospital for 10 days or fewer, and dies while in the hospital, the hospice may bill Medicaid for the hospital leave days up to the day before the beneficiary died.

  If the resident returns to the NF under Medicare coverage and still elects hospice care, the hospice may bill Medicaid for the hospital leave days if the emergency hospitalization was for no more than 10 consecutive days.

  Patient-pay amounts and billing methods are not affected by this hospital leave day policy. The hospice/NF should continue to collect any patient-pay amount, typically on the first day of the month, and indicate the amount collected on the Medicaid claim. The Medicaid claims processing system automatically deducts the patient-pay amount and reimburses the provider for the balance. If the hospice bills Medicaid for hospital leave days that occur at the beginning of the month, then the hospice should collect the patient-pay amount as usual. The hospice should charge the amount against the patient-pay that Medicaid pays for that day. For example, if a beneficiary has a patient-pay of $200 and is in the hospital for an emergency condition for the first five days of the month (the stay totals no more than 10 consecutive days), the hospice should collect the patient-pay amount from the beneficiary and then submit a Medicaid claim. Medicaid reimburses the hospice for the hospital leave day per diem rate, minus the patient-pay amount. The hospice reimbursement, based on 2003 rates, would be $132.80 [($66.56 x 5) - $200].

  There is no annual limit to the number of hospital leave days, per beneficiary, that may be billed to Medicaid as long as there are no more than 10 consecutive leave days per hospital stay.

- **Therapeutic Leave Days.** If the beneficiary has a temporary absence from the NF for therapeutic reasons approved by the attending physician, the hospice may be reimbursed by Medicaid to hold the bed open for up to a total of 18 days during a 365-day period. Therapeutic leave is for nonmedical reasons such as overnight stays with friends/relatives, Make-a-Wish Foundation trips, etc. The beneficiary's POC must provide for such absences. There is no limit to the number of therapeutic leave days that may be reimbursed at one time as long as the total does not exceed 18 days in a 365-day period. If a beneficiary does not return from a therapeutic leave, the beneficiary must be discharged on the date he left the facility. The date of admission and the date of discharge may not be billed as therapeutic leave days.

  Reimbursement is at 95 percent of the individual or specific NF's daily per diem rate, just as the customary room and board rate is reimbursed.

- **Hospice Revocation or Decertification.** If a Medicaid hospice beneficiary, who resides in a NF, revokes his hospice services or is deemed no longer certifiable for the Medicaid hospice benefit, the hospice may bill for services on the day of revocation/ decertification as well as the hospice/NF room and board, as long as the beneficiary is in the facility at the midnight census.
- **Memorandum of Understanding (MOU).** Refer to the Place of Service subsection for information regarding payment of room and board for hospice beneficiaries with an MOU.

6.3.I. Hospice-Owned Nursing Facility

When the Medicaid or Medicare/Medicaid beneficiary resides in an inpatient hospice facility (hospice-owned NF with hospice-designated beds), the reimbursement for room and board by Medicaid follows the policy for reimbursement for NFs as noted above. Medicaid, as provider of last resort, covers the beneficiary's room and board.

6.3.J. Adult Foster Care Facilities / Home for the Aged Facilities

Medicaid does not reimburse for room and board in these settings. Reimbursement is made directly to the facility provider in the normal manner (i.e., Supplemental Security Income, Personal Care/Supplemental Payment). This payment is made in full. The AFC or HFA cannot seek additional restitution from the beneficiary or the hospice provider.

6.3.K. Boarding Homes

Medicaid does not reimburse for room and board in these settings.

6.3.L. Assisting Living Facility

Medicaid does not reimburse for room and board in these settings.

6.4 Reimbursement Limits

Medicaid must apply the aggregate inpatient (80/20) payment capitation, and follow the guidelines established for the Medicare beneficiary. The 80/20 capitation requirement means no more than 20 percent of all days of care provided by a hospice can be paid as inpatient hospice days. Inpatient days that exceed the 20 percent capitation must be paid as routine care. Beneficiaries with AIDS are exempt from the 80/20 capitation.

Medicaid does not apply an aggregate dollar capitation. (The Medicare program establishes the maximum total dollar amount per year that Medicare pays for hospice services. Medicaid does not apply this policy to beneficiaries receiving hospice care.)

Medicaid applies the same number of inpatient respite days as Medicare (i.e., no more than five consecutive days are allowed). If more than five consecutive days are billed, the number is reduced to five days, and the excess days must be billed as routine care by the hospice.

Reimbursement for routine, nonemergent transportation is included in the per diem (room and board amount) negotiated between the hospice and the NF.

HOSPITAL

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SECTION 1 – GENERAL INFORMATION

This chapter applies to services provided to Fee for Service (FFS) beneficiaries in an inpatient and/or outpatient hospital (Provider Types 30, 40) setting unless otherwise indicated. Medically necessary services provided to Medicaid beneficiaries by an enrolled hospital are generally covered by Medicaid, administered through the Michigan Department of Community Health (MDCH). The attending physician (MD or DO) is responsible for determining medical necessity and appropriateness of service within the scope of current medical practice and Medicaid guidelines. Services described in this chapter must also be available to Medicaid Health Plan (MHP) enrollees; however, the MHPs may implement different authorization and service criteria. For billing purposes, a revenue code is identified as a specific accommodation, ancillary service or billing calculation for all institutional claims.

The appropriate revenue code from the National Uniform Billing Committee (NUBC) and/or State Uniform Billing Committee (SUBC) manuals must be used on each claim line for all institutional claims. If a procedure code is required, a Health Care Financing Administration Common Procedure Coding System (HCPCS) code(s) must be used.

Prior authorization (PA) information in this chapter pertains to FFS Medicaid and FFS Children's Special Health Care Services (CSHCS) only. If the beneficiary is enrolled in a MHP, the hospital must obtain any required PA from the beneficiary's MHP when providing services.

1.1. INPATIENT HOSPITAL

An inpatient hospital is defined as a facility, other than psychiatric, which primarily provides medically necessary diagnostic, therapeutic (both surgical and nonsurgical) or rehabilitation services to inpatients. Services provided to inpatients include bed and board; nursing and other related services; use of facility; drugs and biologicals; supplies, appliances and equipment; diagnostic, therapeutic and ancillary services; and medical or surgical services. Services of professionals (e.g., physician, oral surgeon, dental, podiatric, optometric) are not included and must be billed separately. Inpatient hospital services are:

- Ordinarily furnished in a facility for the care and treatment of inpatients.
- Furnished under the direction of a physician (MD or DO) or a dentist.
- Furnished in a facility that is:
  - Maintained primarily for the care and treatment of inpatients with disorders other than mental diseases;
  - Licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
  - Medicare-certified to provide inpatient services.

An inpatient is an individual who has been admitted to a hospital for bed occupancy with the expectation that he will remain at least overnight, even when it later develops that he can be discharged or is transferred to another hospital and does not use the bed overnight. Days of care provided to a beneficiary are in units of full days, beginning at midnight and ending 24 hours later. Medicaid covers the day of admission but not the day of discharge. If the day of admission and the day of discharge are the same, the day is considered an admission day and counts as one inpatient day.

Medicaid generally covers semi-private, three-bed, or four-bed accommodation. When private accommodations are furnished to the beneficiary because the semi-private accommodations are not available, MDCH only pays for the semi-private accommodation and the beneficiary cannot be billed for the difference. The hospital's inpatient accommodation rate includes all charges associated with routine services (e.g., linens, nursing services, etc.) rendered during the inpatient stay. All dietary services, including special diets, are included in the accommodation rate and are not allowable under any other cost center.

1.1.A. Private Rooms

Medicaid covers private rooms only when determined medically necessary. Beneficiaries who request a private room when it is not medically necessary must be informed in advance that they are responsible for the entire room charge. If the beneficiary insists on a private room, the hospital should obtain the beneficiary's acknowledgement of his responsibility in writing. Hospitals may not split bill Medicaid FFS for a semi-private room and the beneficiary, or his family, the difference for a private room.

1.1.B. Intensive Care

Intensive care provided in an intensive care unit(s) is covered for the treatment of critically ill beneficiaries. Neonatal intensive care unit accommodations may be billed only if medically necessary, the infant is treated in this setting, and the neonatal unit has been approved by the MDCH to provide this level of service.

1.2 Outpatient Hospital

An outpatient hospital (OPH) is defined as a portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require inpatient hospitalization. Outpatient hospital services are:

- Furnished under the direction of a physician (MD or DO) or a dentist.
- Furnished in a facility that is certified as a provider, or as having provider-based status, by Medicare.

1.2.A. Multiple Visits – Same Revenue Center

MDCH reviews all multiple visit claims, and does not pay for more than one visit on the same date of service, in the same revenue center, unless the visits are separate, distinct and constitute independent visits. The services must be billed appropriately and supported in the hospital medical record documentation and in the claim Remarks section.

1.2.B. Multiple Visits - Different Revenue Center

MDCH reviews all unrelated services performed on the same day (i.e., Emergency Room and Operating Room, Emergency Room and Treatment Room, etc.) when submitted as one claim.

1.2.C. Medical/Surgical Supplies

Supplies used during the course of treatment in the outpatient hospital are covered and billable. An itemized list of supplies used, including the number of specific items and related charges, must be recorded in the patient's record.

Use/rental of equipment and durable items routinely used for surgery cannot be billed separately as they are included in the reimbursement for the operating room. These include, but are not limited to, microscopes, monitors, drills, lasers, etc. Surgical supplies used for surgery are covered and can be billed separately with a supporting HCPCS code. All appropriate surgical supply revenue codes should be reported on the same outpatient claim and are paid as a percent of charge for billable supplies used during the surgical procedure.

1.2.D. Personal Items

Personal comfort and convenience items (e.g., toiletries, slippers, hospitality kits, etc.) cannot be billed to MDCH.

1.2.E. Take-Home Supplies

Medicaid covers a limited supply of take-home medical supplies until the beneficiary is able to obtain these items from an enrolled medical supplier and/or pharmacy.

1.3 Clinic Services

Hospital Clinic services are covered if rendered in a clinic setting that is part of the licensed and Medicaid-enrolled hospital, and that satisfies Medicare requirements for provider-based status. Clinic services rendered in the outpatient hospital include nonemergency outpatient services that are provided to ambulatory beneficiaries.

MDCH covers Urgent Care Clinics (as part of the Medicaid-enrolled hospital and that satisfies Medicare requirements for provider-based status) when the services provided are specific to urgent medical care (i.e., suturing, most fracture care) and are medically necessary for a nonlife threatening condition or injury, or illness that should be treated within 24 hours. Urgent care clinic visits provided on the same date of service with any other clinic visit or emergency department service/visit (i.e., Emergency Medical Treatment and Active Labor Act [EMTALA] Screen) are not covered unless the second visit is medically necessary to treat an acute exacerbation or a new condition. Claims for more than one visit per day are manually reviewed.

1.4. Emergency Department Services

1.4.A. Screening Exam and Stabilization

The MDCH and its contracted health plans must follow the applicable requirements and definitions of the federal EMTALA 42USC§1395dd.

Medicaid covers the medical screening examination, any ancillary service(s) if performed in a hospital emergency department (ED) for the sole purpose of determining if an emergency medical condition exists, and any necessary stabilizing treatment.

For both Medicaid FFS and MHP beneficiaries, the screening examination and any physician-ordered procedures (e.g., x-rays, lab, etc.) necessary to determine the patient's condition are covered without PA. For Medicaid FFS beneficiaries, the screening examination and related diagnostic procedures are billed to MDCH. For Medicaid beneficiaries enrolled in a MHP, these services are billed to the beneficiary's MHP.

Facility charges for the ED screening exam are included in the hospital inpatient admission when services occur at the same facility. If the patient is transported to another facility for a prior authorized inpatient admission, the first hospital's facility fees for the ED are reimbursed separately. In both instances, the professional fees for medical screening and stabilization in the emergency room are reimbursed separately from the facility fees.

1.4.B. Treatment of Emergency Medical Condition

PA is not required for the treatment of emergency medical conditions.

An emergency medical condition is defined by the Balanced Budget Act of 1997 and its regulations.

An emergency may exist whether the patient is discharged from the ED or admitted to the inpatient hospital. This includes admissions where death occurs before a bed is occupied.

If an emergency medical condition exists, the medical findings must be fully documented in the patient's medical record.

1.4.C. Treatment for Nonemergency Medical Conditions

If the medical findings from the screening determine that the patient's condition does not meet the definition of an emergency medical condition, but requires additional, follow-up treatment, the following rules apply:

- MHP enrollees must be referred to their primary care provider for treatment, or the ED can contact the MHP to request authorization to provide the treatment. The hospital must document all telephone calls made to the enrollee's MHP for the purpose of requesting post-stabilization authorization. If the MHP fails to respond within one hour to the request for additional services beyond those required for stabilization, the request for authorization is deemed approved.
- FFS Medicaid beneficiaries with private health insurance must follow the rules of the private health insurance. Private insurances frequently require that the primary care provider for the private insurance perform follow-up treatment. If the private insurance refuses payment for treatment because their rules were not followed, MDCH does not pay for services. Medically necessary services not covered by the primary insurer that

are covered by Medicaid are reimbursed if the Medicaid coverage requirements are followed.

- FFS Medicaid beneficiaries without private health insurance should be encouraged to obtain treatment from their primary care provider. However, treatment may be rendered in the ED and does not require PA.

1.4.D. Psychiatric Screening and Stabilization Services

Screening and stabilization of a psychiatric emergency does not require PA. A psychiatric emergency is defined as a situation in which an individual must be treated to protect him from inflicting injury to self or others as the result of a serious mental illness, emotional disturbance, or developmental disability or could reasonably be expected to intentionally or unintentionally injure himself or others in the near future. The emergency may result from an inability to provide food, clothing, or shelter for him or others, inability to attend activities of daily living, or when judgment is so impaired the individual is unable to understand the need for treatment.

If the treating hospital determines that the beneficiary requires post-stabilization psychiatric services, the hospital must contact the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) for PA. The need for PA includes, but is not limited to, inpatient psychiatric care, partial hospitalization, and/or specialty mental health services. If a beneficiary requires inpatient psychiatric hospitalization and is admitted directly from the ED to the same facility, the local PIHP/CMHSP must prior authorize the admission.

If the beneficiary is transported to another facility for a prior authorized inpatient admission, the first hospital's facility fees for the ED are reimbursed separately.

In both instances, the professional fees for medical screening and stabilization in the ED are reimbursed separately.

1.5 Third Party Liability

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage. (Refer to the Coordination of Benefits Chapter of this manual for more information.)

1.5.A. Medicare-Related Services

MDCH reimburses for Medicare-covered services up to the beneficiary's financial obligation to pay, or the Medicaid fee screen, whichever is less. This limitation also applies if the beneficiary is eligible for, but not enrolled in, Medicare. Medicare benefits must be used prior to billing MDCH or any Medicaid-capitated plan (MHP, PIHP/CMHSP, Substance Abuse Coordinating Agency [CA]) for any portion of the claim.

MDCH reimburses Medicare coinsurance and deductible amounts subject to Medicaid's reimbursement limitations on all Medicare-approved claims, even if Medicaid does not normally cover the service. Lifetime Reserve Days must be used, if available.

1.5.B. Other Insurance

Medicaid and CSHCS beneficiaries may have insurance coverage, either traditional health insurance or a Health Maintenance Organization (HMO) through private and/or employer-based commercial policies. The other insurance is always primary, and the rules of that insurer must be followed. This includes, but is not limited to, PA requirements, provider qualifications, and receiving services through the insurer's provider network. MDCH does not pay for services denied by the primary insurer because the primary insurer's rules were not followed.

Medicaid covers the appropriate co-pay and deductibles, up to the beneficiary's financial obligation to pay, or the Medicaid fee screen, whichever is less. If the primary insurer has negotiated a rate for a service that is lower than the Medicaid fee screen, MDCH cannot be billed more than the negotiated rate. MDCH reimburses Medicaid-covered services that are not included in the primary insurer's plan up to the Medicaid fee screen if all Medicaid coverage rules have been followed. If a beneficiary is enrolled in a MHP, or is receiving services through PIHP/CMHSP/CA, the MHP/PIHP/CMHSP/CA is responsible for payment.

1.6 Miscellaneous

1.6.A. Abuse

Providers with reasonable cause to suspect that a child or vulnerable adult may have been abused or neglected are required by law to immediately report it to the appropriate Protective Services Unit of the local Department of Human Services (DHS). Inpatient hospital stays for suspected abuse or neglect are covered if the attending physician determines the beneficiary requires further assessment and treatment. Inpatient stays for the sole purpose of custodial or protective care are not a covered benefit.

1.6.B. Administrative Services

Interns, resident physicians, dentists, or medical staff that are functioning in an administrative, teaching, or learning capacity for the hospital cannot bill MDCH for their professional services as these costs are included in the hospital's Graduate Medical Education (GME) payments. This includes physician-owners or other staff paid by the hospital. Staff meetings for any purpose are not reimbursable. Reimbursement for administrative services is included in the Diagnosis Related Group (DRG) payment, as well as the MDCH Outpatient Hospital Fee Screen on the MDCH website.

1.6.C. Communicable Disease

Cases of communicable disease, such as tuberculosis, hepatitis, meningitis, and enteric disease, must be reported to the local health department (LHD). For additional information, contact the LHD.

1.6.D. Education Costs for Professional Education

Payments for educational costs are made directly to hospitals for health professional education in both the inpatient and outpatient hospital setting according to the requirements and formulas in the Hospital Reimbursement Appendix to this chapter.

1.6.E. Hospital-Based Provider

A hospital-based provider (HBP) is defined as a hospital-employed MD, DO, Certified Registered Nurse Anesthetist (CRNA), dentist, podiatrist, optometrist, or nurse-midwife. HBPs must be enrolled separately as Medicaid providers and bill MDCH directly using their own Medicaid ID number for any covered professional service(s) that they provide. (Refer to the appropriate provider-specific chapter and the Billing & Reimbursement for Professionals Chapter of this manual for additional information.)

1.6.F. Hospital Personnel Providing Ambulance Transport Assistance

Only enrolled ambulance providers may provide ambulance services. MDCH does not reimburse hospitals for staff personnel who assist with an ambulance transport. The cost of all hospital personnel is considered part of the normal hospital operation (included in the cost center) and may not be billed to MDCH or to the beneficiary.

1.6.G. Pharmacy

Pharmaceutical products (drugs and biologicals) provided to inpatients are covered as a component of the inpatient DRG and are not reimbursed separately.

Pharmaceutical products administered in conjunction with outpatient laboratory, radiology, or other medical procedures/treatment are covered and may be billed individually by the outpatient hospital

Take-home drugs require a written prescription and are covered only when provided by a Medicaid-enrolled pharmacy. Contact the Medicaid Payments Division, Provider Enrollment Unit to become an enrolled pharmacy provider. (Refer to the Directory Appendix for contact information.)

(Refer to the Pharmacy Chapter of this manual for additional information.)

1.6.H. Outpatient and Emergency Services Provided on Date of an Inpatient Hospital Admission

Outpatient surgical and ED services provided at the same hospital resulting in an inpatient admission must be included as a part of the inpatient stay and are reimbursed as part of the DRG payment. Charges for emergency services or ambulatory surgery that result in admission must be reflected on the inpatient claim for that episode of care. The date of admission should be reported as the date the physician wrote the order to admit the beneficiary.

1.6.I. Services That Must be Billed by Other Providers

The following services may not be provided and billed as an outpatient hospital service. These services may be provided and billed by the appropriate enrolled provider:

Ambulance	Nurse-midwife*
Certified registered nurse anesthetist (CRNA)	Optical
Chiropractor	Oxygen (take-home)
Dentist	Orthotics
Durable medical equipment	Pharmacy (take-home)
Hearing aids	Physician
Home health	Podiatrist
Medical supplies (take-home)	Prosthetics
Nurse Practitioner*	Shoes

* If not an employee of the hospital.

1.6.J. Technician Calls

Overtime or holiday pay to technicians who are required to be at the hospital outside of their normal work hours are not separately billable to beneficiaries or to Medicaid. These charges are included in the hospital's standard charge structure.

SECTION 2 - PRIOR AUTHORIZATION

MDCH requires prior authorization (PA) for certain procedures to validate the medical need for the service. The following chart, intended for reference only, indicates services provided in the hospital setting that require PA, who must obtain it, how to obtain the PA, and the documentation required when the claim is submitted. Hospital services requiring PA include:

Service	PA Obtained By	Obtained Via	Documentation for Claim
* Cosmetic Surgery	Attending Physician	Letter to Office of Medical Affairs (OMA)	Copy of Letter from OMA
* Elective Admissions, All Re-admissions, Transfers for treatment of general medical conditions	Attending Physician	Admissions and Certification Review Contractor (ACRC)	PACER Certification number
Freestanding Rehabilitation	Hospital	ACRC	Billing Authorization Number
Inpatient Psychiatric Admissions/Continued Stay	Hospital or Attending Physician	Phone call to local PIHP/CMHSP	Reimbursed by the PIHP/CMHSP, not MDCH
* Outpatient Occupational Therapy (OT) (after the initial 90 days of treatment or 36 visits)	Hospital	Occupational/Physical Therapy-Speech Pathology Prior Approval Request/Authorization (MSA-115)	PA number and, in Remarks, the From and Through dates of the PA number
* Physical Therapy (PT) (after the initial 90 days of treatment or 36 visits)	Hospital	Occupational/Physical Therapy-Speech Pathology Prior Approval Request/Authorization (MSA-115)	PA number and, in Remarks, the From and Through dates of the PA number
* Outpatient Speech-Language Pathology (after the initial 90 days of treatment or 36 visits)	Hospital	Occupational/Physical Therapy-Speech Pathology Prior Approval Request/Authorization (MSA-115)	PA number and, in Remarks, the From and Through dates of the PA number
Outpatient Psychiatric Partial Hospitalization	Hospital	Phone call to PIHP/CMHSP	Reimbursed by the PIHP/CMHSP, not MDCH
* Services for Weight Reduction (e.g., Surgery)	Attending Physician	Letter to OMA	Copy of Letter from OMA

Service	PA Obtained By	Obtained Via	Documentation for Claim
* Organ Transplants	Attending Physician	Contact the OMA	Copy of the Letter of Authorization from OMA
* Pediatric Multi-Channel Recording (if more than two per year considered medically necessary)	Attending Physician	Contact the OMA	Copy of the Letter of Authorization from OMA

*If the beneficiary is enrolled in a MHP, providers must contact the individual MHP to verify PA requirements.

PA does not guarantee payment or beneficiary eligibility. The provider must check the beneficiary's Medicaid eligibility prior to rendering services. (Refer to the General Information for Providers and Beneficiary Eligibility Chapters of this manual for further information.)

PA is not required if the beneficiary is receiving Medicare benefits for a Medicare-approved service.

SECTION 3 – COVERED SERVICES

Hospital services requiring additional information are listed below in alphabetical order. Some services have coverage limitations and/or PA requirements.

3.1 ABORTIONS

Abortions performed by physicians and related hospital charges are a covered service only when medically necessary to save the life of the mother and/or the pregnancy is the result of rape or incest. Copies of the Certification for Induced Abortion (MSA-4240), completed by the physician, and the Recipient Verification of Coverage (MSA-1550) must accompany all claims, except those for ectopic pregnancies or spontaneous, incomplete or threatened abortions. The physician certifies on the MSA-4240 that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the pregnancy terminated was the result of rape or incest.

The physician who completes the MSA-4240 must also ensure completion of the MSA-1550 and is also responsible for providing copies of both the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) who bill for services related to the abortion. Providers must obtain copies of the completed MSA-4240 and MSA-1550 from the physician and attach them to their claim when billing. (Refer to the Forms Appendix for sample forms.)

The medical record must include a complete beneficiary history, including the medical conditions that made the abortion necessary to save the life of the mother. When the pregnancy is the result of rape or incest, the medical record must include the circumstances of the case and documentation that the pregnancy was the result of rape or incest.

3.2 ANESTHESIA

Medicaid coverage includes anesthesia services when provided by qualified practitioners in conjunction with surgical services or other procedures when medically necessary.

Physician or CRNA professional charges may not be billed on the outpatient hospital claim format. These professional charges must be billed on a CMS 1500 claim form. (Refer to the Billing & Reimbursement for Professionals and Practitioner Chapters of this manual for additional information.)

3.3 APHERESIS

Apheresis (therapeutic apheresis) is a covered service in an outpatient hospital for certain conditions. Therapeutic apheresis is defined as a continuous autologous procedure and is covered as follows:

- Plasma exchange for acquired myasthenia gravis.
- Leukapheresis in the treatment of leukemia.
- Plasmapheresis in the treatment of primary macro-globulinemia (Waldenstrom).
- Treatment of hyperglobulinemias, including (but not limited to) multiple myelomas, cryoglobulinemia, and hyperviscosity syndromes.
- Plasmapheresis or plasma exchange and last resort treatment of thrombotic thrombocytopenic purpura (TTP).

- Plasmapheresis or plasma exchange in the last resort treatment of life-threatening rheumatoid vasculitis when all other conventional therapies have failed.
- Plasma exchange in the treatment of life-threatening forms of Goodpasture's Syndrome when the beneficiary has not responded to more conventional forms of therapy.
- Plasma exchange in the treatment of life-threatening forms of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage, when the beneficiary has not responded to more conventional forms of therapy.
- Plasma perfusion of charcoal filters for treatment of pruritis of cholestatic liver disease.
- In the treatment of chronic relapsing polyneuropathy for beneficiaries with severe or life-threatening symptoms who have failed to respond to conventional therapy.
- When used in the treatment of life-threatening scleroderma and polymyositis, when the beneficiary is unresponsive to conventional therapy.
- For the treatment of Guillain-Barre Syndrome.
- A treatment of last resort for life-threatening Systematic Lupus Erythematosous (SLE), when conventional therapy has failed to prevent clinical deterioration.

Apheresis is not a covered service when a beneficiary donates blood preoperatively and, at a later date, the blood is transfused back to the beneficiary.

3.4 Apnea Monitors

Medicaid guidelines for home apnea monitors are based on the Report of the Michigan Ad Hoc Task Force on Apnea: A Consensus, which was prompted by the 1986 National Institute of Health Consensus Development Conference Statement on Infantile and Home Monitoring. Guidelines are subject to change as the consensus changes.

Monitors must be provided by a Durable Medical Equipment (DME)/Medical Supply provider and may be covered on a rental basis without PA for up to three months from the date of discharge from the hospital for symptomatic infants discharged on a monitor. The hospital medical record must document that the infant was discharged on a monitor. The medical supplier also must note in its records that the child was discharged on a monitor, and a hospital discharge planner arranged for the apnea monitor rental. (Refer to the Medical Supplier Chapter of this manual for additional information.)

3.5 Beneficiary Education

Beneficiary education in the inpatient setting is included in the DRG payment. Beneficiary education services are covered in an outpatient setting as follows:

3.5.A. Childbirth Education

MDCH covers a childbirth education program for pregnant women. The prenatal care provider must make written referrals for the pregnant woman and the program must be provided by qualified educators in a Medicaid-enrolled outpatient hospital, or by a certified Maternal Infant Health Program (MIHP) provider. This service is not covered if rendered by a prenatal care provider in the office setting. MDCH reimbursement is for the childbirth education (also referred to as birthing education) as a complete program.

Childbirth education includes, but is not limited to, the following topics:

Pregnancy	▪ Health care during pregnancy ▪ Physical and emotional changes during pregnancy ▪ Nutrition
Labor and Delivery	▪ Signs and symptoms of labor, including information regarding pre-term labor ▪ Breathing and relaxation exercises ▪ Analgesia and anesthesia ▪ Avoiding complications ▪ Coping skills ▪ Types of deliveries ▪ Episiotomy ▪ Support techniques ▪ Hospital tour
Infant Care	▪ Preparation for breast feeding ▪ Infant feeding ▪ Immunizations ▪ Infant car seat use ▪ Parenting
Postpartum	▪ Postpartum physical and emotional changes, including depression ▪ Feelings of partner ▪ Potential stress within the family ▪ Sexual needs ▪ Exercise ▪ The importance of family planning

3.5.B. Diabetes Self-Management Education Training Program

MDCH reimburses for Diabetes Self-Management Education (DSME) training programs provided in an outpatient hospital if ordered by a physician and Community Public Health (CPH) certifies the program. Certification must be on file with Medicaid Payments Division, Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

- An initial DSME training program is covered once within a 12-month period and may not exceed ten hours of instruction. The initial training program may include up to a maximum of one hour of individual training and up to nine hours of group training.
- A maximum of two hours per year of follow-up training (individual or group) may be provided after completion of the initial 12-month training period.

MDCH covers more than two individual sessions on an individual basis (not to exceed a total of 10 hours initial) for a beneficiary who meets either of the following conditions:

- No group training session is available within two months of the date the training is ordered.
- The beneficiary's physician documents in the medical record that the beneficiary has special needs resulting from conditions, such as severe vision, hearing, or language limitations, that hinders effective participation in a group training session.

MDCH does not cover DSME if provided by a physician in the office setting, or by a nonenrolled or nonCPH certified provider.

3.6 Blood Products

Hospitals and/or beneficiaries are expected to attempt to replace blood used by the beneficiary. Medicaid covers whole blood if replacement is not available from other sources. If blood is purchased (i.e., from the Red Cross), the hospital may bill for the blood not replaced, the administration, and the procedure room.

3.7 Chemotherapy Treatment

MDCH covers antineoplastic drugs when supported by reporting the appropriate HCPCS/Current Procedural Terminology (CPT) code. MDCH does not cover antineoplastic agents that are investigational or experimental.

3.8 Dental Services

Dental services are routinely rendered in the dental office unless the situation requires that the dental service be performed in the outpatient hospital setting. However, services are not covered in the outpatient hospital setting for the convenience of the dentist or beneficiary.

Nonemergency routine dental treatment provided in an outpatient hospital setting is covered only under the following conditions:

- A concurrent hazardous medical condition exists;
- The nature of the procedure requires hospitalization; or
- Other factors (e.g., behavioral problems due to mental impairment) necessitate hospitalization.

Hospitals should refer to the Dental Chapter of this manual for information regarding program limitations prior to rendering services.

The dentist/physician must document in the beneficiary's medical record the condition that required the dental service be done in the hospital setting.

3.9 Dialysis (Hemodialysis and Peritoneal Dialysis)

MDCH reimbursement is an all-inclusive rate for maintenance dialysis services for beneficiaries receiving hemodialysis or peritoneal dialysis. Individual services may not be billed separately. The rate is the same whether the beneficiary dialyzes in the facility or at home, and includes all necessary home and facility dialysis maintenance services, supplies, equipment and supportive services such as:

- Oxygen;
- Filters;
- Declotting of shunts;
- Staff time to administer blood or oxygen; and
- Routine parenteral items: Heparin, Protamine, Mannitol, saline, glucose, dextrose, topical anesthetics, and arrythmics.

MDCH reimburses the physician directly for professional services related to maintenance dialysis.

Nonroutine additional services must be billed using the appropriate supporting HCPCS code. The facility is responsible for making arrangements with a DME provider for supplies not available from the dialysis facility. MDCH does not reimburse the medical supplier separately. The facility is responsible for payment to the supplier or independent lab for services provided.

3.9.A. Dialysis Laboratory Services

Payment for laboratory services related to maintenance dialysis is included in the composite rate regardless of whether the tests are performed in the facility or an independent laboratory. The following tests are considered to be a routine part of maintenance dialysis and may not be billed separately unless it is medically necessary to perform them in excess of the frequencies indicated.

Laboratory tests for Hemodialysis, Peritoneal Dialysis, and Continuous Cycling Peritoneal Dialysis (CCPD) that are included in the composite rate:

Per Treatment	Weekly	Monthly
▪ All hematocrit or hemoglobin tests and clotting time tests	▪ Prothrombin time for patients on anticoagulant therapy ▪ Serum Creatinine ▪ BUN	▪ CBC, including platelet count and additional indices ▪ Serum Calcium ▪ Serum Chloride ▪ Serum Potassium ▪ Serum Bicarbonate ▪ Serum Phosphorus

Per Treatment	Weekly	Monthly
		▪ Total Protein ▪ Serum Albumin ▪ Alkaline Phosphatase ▪ SGOT ▪ LDH

Laboratory tests for Continuous Ambulatory Peritoneal Dialysis (CAPD) that are included in the composite rate on a monthly basis include:

BUN	Creatinine	Sodium	CO2
Calcium Magnesium	Phosphate	Potassium	Total Protein
Albumin	Alkaline Phosphatase	LDH	AST
HCT	Hgb	Dialysate Protein	SGOT

Laboratory tests not listed above may be separately billed by the dialysis facility or Clinical Laboratory Improvement Act (CLIA)-certified lab performing the test.

3.9.B. Dialysis Self-Care Training

MDCH reimburses for dialysis self-care training provided by outpatient dialysis clinics.

- A session is considered as one training day and a complete course is considered 10 – 15 sessions.
- Sessions must be documented in the beneficiary's medical record and are subject to post-payment review.

3.10 Diagnostic Testing

MDCH reimburses for diagnostic testing to diagnose a disease or medical condition. Outcomes must be documented in the medical record. Diagnostic testing in an inpatient hospital is included in the inpatient DRG payment. Outpatient hospitals must bill MDCH using the appropriate HCPCS code.

MDCH does not reimburse for:

- Routine screening, such as spirometry, holter monitor, Doppler flow-study or pelvic echography.
- Testing to establish baseline values.
- Testing for the general health and well being of a beneficiary.
- Any test not generally recognized as relevant to the condition being investigated.

3.10.A. Fetal Monitor - Fetal Nonstress Test

A Fetal Nonstress Test is covered as a diagnostic test when performed as part of routine monitoring of an ongoing pregnancy. MDCH does not cover a room charge in addition to the test when it is being performed as part of routine monitoring of an ongoing pregnancy.

3.10.B. Pediatric Multi-Channel Recording

A pediatric multi-channel recording is a continuous and simultaneous recording of at least four channels and may include electrocardiogram (ECG), thoracic impedance, airflow measurements, oxygen saturation, esophageal pH, or strain gauge measurements. Additional channels may be appropriate and do not have to include an electroencephalogram (EEG).

MDCH reimburses for two multi-channel recordings per year per beneficiary under age 21 when provided by qualified personnel and interpreted by the physician. The physician must obtain PA if more than two tests per year are considered medically necessary and must provide a copy of the PA for the hospital's medical record.

Multi-channel recordings are not covered in the beneficiary's home.

3.11 Hearing Services

Hospitals may bill for speech and hearing evaluations, testing, and therapy for beneficiaries of all ages.

Audiology services other than newborn hearing screening tests must be provided by:

- A licensed audiologist possessing a current Certificate of Clinical Competence (CCC) from the American Speech-Language Hearing Association (ASHA).
- An audiologist candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a CCC) supervised by a licensed audiologist having a current CCC.
- An audiology student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) a licensed audiologist having a current CCC.

Standards of practice must conform to those published in ASHA Preferred Practice Patterns for the Profession of Audiology. Audiologic test equipment and hearing aid test equipment used must conform to applicable American National Standards Institute (ANSI) criteria.

The following equipment must be available to audiologists providing services to infants less than six months of age:

- Infant Diagnostic Testing
  - Tone Burst ABR; and
  - Bone Conduction ABR; and
  - High Frequency Immittance; and
  - Otoacoustic Emissions

- Infant Hearing Aid Evaluation, Selection, and Follow-Up
  - Infant Predictive Method (e.g., Desired Sensation Level); and
  - Real-Ear to Coupler Difference

MDCH requires that all Medicaid-covered newborns be screened using the auditory brainstem response (ABR) method and/or evoked otoacoustic emissions (EOAE) method as recommended by the American Academy of Pediatrics (AAP).

- Hospitals with 15 or more Medicaid deliveries per year must provide newborn hearing screening using the policies and procedures recommended by the AAP.
- Hospitals with less than 15 Medicaid deliveries per year may provide the service or advise the physician, nurse midwife, or nurse practitioner to refer the newborn for the hearing screening prior to age one month.

For hospitals that provide EOAE and/or ABR newborn hearing screening, reimbursement is included in the calculation for the DRG. MDCH recommends hospitals that provide delivery services have qualified staff to:

- Develop screening protocol.
- Appropriately train staff to perform screenings and, in matters of confidentiality, recognition of psychological stress for the parents or guardians, infection control practices, and established policies and procedures for handling newborns in the hospital.
- Develop a system for monitoring the performance of screenings.
- Inform parents or guardians about the procedure(s), potential risks of hearing loss, and the benefits of early detection and intervention.
- Allow parents or guardians an opportunity to decline screening. (Providers must document in the medical record if screening was declined.)
- Delineate responsibility for documenting screening results.
- Develop methods for communicating results in a sensitive and timely manner to the parents or guardians and the physician. If repeat screening is recommended following discharge, establish procedures for appropriate follow-up.
- Report critical data to the State's monitoring program.

3.12 Hyperbaric Oxygen Therapy

Medicaid covers hyperbaric oxygen therapy when provided in a hyperbaric chamber for selected indication (e.g., decompression illness, gas gangrene, etc.). It is not to be used as a replacement for standard medical management.

3.13 Hysterectomy

Federal regulations prohibit Medicaid reimbursement for hysterectomies solely for the purpose of sterilization. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications, which alone do not indicate a hysterectomy.

A hysterectomy is covered only if the beneficiary has been informed orally, prior to surgery, that a hysterectomy will render her permanently incapable of reproducing. The beneficiary or her representative must sign a written acknowledgment of receipt of that information using the Acknowledgment of Receipt of Hysterectomy Information form (MSA-2218). All items on the MSA-2218 must be completed. The beneficiary (or representative) and the physician (MD or DO) must sign the form. (Refer to the Forms Appendix for a sample form.)

The Acknowledgment of Receipt of Hysterectomy Information form is not required if the beneficiary was already sterile before the hysterectomy.

Refer to the Practitioner Chapter of this manual for instructions regarding the completion and submission of the MSA-2218.

3.14 Injections / Intravenous Infusions

MDCH reimburses for intramuscular, subcutaneous or intravenous injections and intravenous (IV) infusions when medically necessary. In the inpatient hospital, reimbursement is included in the DRG payment.

In an outpatient hospital:

- Intramuscular, subcutaneous or intravenous injections require detailed coding using the appropriate Medicaid-covered CPT/HCPCS code(s). If the medication does not have a specific code, providers must supply the National Drug Code (NDC) drug detail (brand name, manufacturer, NDC drug code and drug cost) in the Remarks area of their claim. Reimbursement for the injection includes the cost of the drugs, supplies, administration and observation for any adverse reaction.
  - MDCH covers room and equipment charges for IV fluid administration. Tubing, syringes, needles, and other miscellaneous items, such as sterile gloves and gauze used during IV fluid administration, must be billed as a supply (i.e., IV Therapy/Supplies).
  - Certain IV solutions are identified (i.e., dextrose, saline solutions) as a diluent or vehicle for drug therapy and must be billed as an IV therapy service.
  - IV solutions used only as hydration solutions and not in conjunction with drug therapy must be billed as such.

3.15 Labor & Delivery / Nursery

MDCH reimburses for labor and/or delivery room(s) or when an active labor does not progress to delivery. During active labor, MDCH covers a fetal contraction or fetal nonstress test in addition to the labor and delivery room charge. When there is no active labor, MDCH does not cover labor and/or delivery room charges for fetal monitoring or treatment of other medical conditions.

In an inpatient hospital, reimbursement is included in the DRG payment. Inpatient newborn nursery charges are covered and must be billed under the newborn's ID number. (Refer to the Billing & Reimbursement for Institutional Providers Chapter for additional information.) In an outpatient hospital, reimbursement is by the appropriate revenue code from the National and/or State Uniform Billing manuals and the appropriate supporting HCPCS code.

3.16 LABORATORY

MDCH reimburses hospitals for medically necessary laboratory tests:

- Performed in a laboratory certified by the Clinical Laboratory Improvement Act (CLIA);
- Needed to diagnose a specific condition, illness, or injury; and
- Ordered by physicians (MD or DO), podiatrists, dentists, nurse practitioners, or nurse-midwives.

MDCH requires medical record documentation of medical necessity. An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity. For approval of payment, the laboratory procedure(s) must be specific and appropriate to the beneficiary's documented condition and diagnosis.

Reimbursement to the inpatient hospital is through the DRG payment.

Reimbursement for outpatient services is billed using the appropriate HCPCS code and includes the collection of the specimen(s), the analysis, and the lab test results. MDCH performs pre- and/or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. Outpatient hospitals are subject to corrective action, including the recovery of funds, for laboratory services not specifically ordered by a practitioner.

MDCH does not cover:

- Screening or routine laboratory testing, except as specified for EPSDT Program, or by Medicaid policy;
- "Profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition; or
- Multiple laboratory tests performed as a part of the beneficiary evaluation if the history and physical examination do not suggest the need for the tests.

Services performed by an outpatient hospital laboratory or its employees may not be billed to, or by, the ordering practitioner.

3.16.A. PREGNANCY-RELATED LABORATORY SERVICES

The obstetric profile must be ordered by the attending practitioner and billed as an all-inclusive panel of tests for required prenatal laboratory services. It must include the following:

- Hemogram, automated, and manual differential WBC count CBC or Hemogram and platelet count, automated, and automated complete differential WBC count (CBC)

- Hepatitis B surface antigen (HBaAg)
- Antibody, rubella
- Syphilis test, qualitative (e.g., VDRL, RPR, ART)
- Antibody screen, RBC, each serum technique
- Blood typing, ABO
- Blood typing, Rh(D)

If all components of the obstetric panel are not performed, providers must bill using the individual HCPCS codes of the test(s) performed.

Testing for HIV is covered separately when determined to be medically necessary and ordered by the practitioner.

Only practitioners should order the serum or urine HCG qualitative method when the beneficiary requires preliminary pregnancy testing.

Nurse midwives may order only the laboratory tests listed below. Hospitals are not reimbursed for any other tests ordered by a nurse midwife.

- Acetone and diabetic acid (ketone bodies); qualitative; semi-quantitative
- Albumin; qualitative, semi-quantitative, quantitative (such as Esbach)
- Antibody titer Rh system; albumin, saline and/or AHG technique
- Blood count; RBC, WBC, Hemoglobin, Hematocrit, indices (MCV, MCH, MCHC)
- Blood typing; ABO, Rh(D), RBC antibody screening
- Culture, presumptive (screening), for Neisseria gonorrhea, Candida, Hemophilus, or beta hemolytic Streptococcus group A, etc.
- Culture, urine, definitive; with or without colony count
- Cytopathology, vaginal and/or cervical smears (e.g., Papanicolaou type) screening (cytopathological examination for malignancy, microbial flora, inflammatory features and hormonal evaluation)
- Glucose; qualitative, quantitative, timed specimen, tolerance
- Hemoglobin, electrophoretic separation; qualitative
- Hepatitis B test
- Human immunodeficiency virus detection
- Pregnancy test
- Prenatal laboratory services; routine (Obstetric panel)
- Quantitative sediment analysis and quantitative protein (Addis count); 12- or 24-hour specimen Reticulocyte count, manual
- Rubella test; titer

- Sickle cell slide test
- Skin test, tuberculosis, tine test
- Susceptibility (sensitivity) for aerobes by Kirby-Bauer procedure for specific pathogens, using 10-12 discs per pathogen; also for susceptibility (sensitivity) for anaerobes by generally accepted standard techniques using 5-12 discs per pathogen (specify number of pathogens)
- Syphilis testing, flocculation or precipitin (VDRL, RPR, etc.); qualitative
- Trepanema antibodies, fluorescent, absorbed (FTA-abs)
- Urinalysis, complete (physical appearance, pH, specific gravity, microscopic examination, qualitative chemistry with or without semi-quantitative confirmation)
- Wet mount, smear, tissue; direct microscopic examination

3.16.B. Coverage Limitations

Outpatient hospital coverage is limited to only those laboratory procedures that do not exceed the reimbursement limit of $75.00 per day. Additionally, laboratory payments are not made if rendered by the same provider for the same beneficiary on the same day of service. The following procedures are exempt from the daily reimbursement limit:

- Bone Marrow, smear interpretation
- Comprehensive Pathology Consultation
- Cytogenetics
- Cytopathology
- Electron Microscopy
- Genotype and Phenotype analysis
- Limited Pathology Consultation
- Virtual Phenotype analysis

Payment for these medically necessary services is not included in the reimbursement calculation for a single date of service (DOS).

If the daily limit is exceeded, the outpatient hospital must request an exception to the daily reimbursement limit by submitting documentation of medical necessity from the practitioner for each laboratory procedure with the claim. All services provided on that DOS are manually reviewed for medical necessity and payment is determined accordingly.

Daily reimbursement limits apply to beneficiaries with dual Medicaid and CSHCS eligibility if the laboratory procedures are not related to the beneficiary's CSHCS qualifying diagnosis. They do not apply to beneficiaries with CSHCS eligibility only.

3.16.C. Blood Handling

The fee for blood handling is usually included in the reimbursement for the blood test but it may be billed for situations in which the drawing, packaging, and mailing of a blood specimen are the only services provided. MDCH reimburses for blood handling only under the following circumstances:

- A beneficiary is referred to the outpatient hospital for the sole purpose of drawing, packaging, and mailing a blood sample to MDCH for blood lead analysis. The State provides lead-free vacutainers for the analysis. (Requests for vacutainers and the samples for analysis must be sent to MDCH Blood Lead Laboratory. Refer to the Directory Appendix for contact information.)
- A beneficiary requires blood tests that are not performed in conjunction with other reimbursable services. Whenever possible, the beneficiary should be sent to the laboratory that is to perform the test(s). When this is not possible (i.e., the laboratory is not a local facility), the blood-handling fee may be billed. The blood-handling fee is not a benefit when any other service is reimbursable on the same date of service.
- A beneficiary is referred to an outpatient hospital for the sole purpose of drawing, packaging and mailing a blood sample to MDCH for HIV-1 viral load analysis and/or DC4/CD8 enumeration. The State provides specimen containers and mailing kits for the analysis. (Requests for supplies and samples for analysis should be sent to MDCH Blood Lead Laboratory. Refer to the Directory Appendix for contact information.)

3.16.D. Hematology Studies

A complete blood count (CBC) with white blood cell (WBC) differential includes the RBC and WBC count, Hgb, Hct, MCH, MCHC, MCV, RBC morphology, platelet estimate, and WBC differential only. If automated instrumentation yields additional test parameters, the results are not reimbursable unless medically necessary and specifically ordered by a practitioner.

3.16.E. Microbiology Studies

Reimbursement for gram fluorescent/acid fast is included in the reimbursement for microbiology when performed on the same DOS for the same beneficiary.

3.16.F. Pap Smear

Pap smear screening by a technologist under the supervision of a pathologist is a covered service. If a suspect smear requires additional interpretation by a pathologist, this service is also covered. Only one Papanicolaou test within a 12-month period is covered for each beneficiary, unless medical necessity or history of abnormal findings requires additional studies.

3.16.G. Substance Abuse

For direct-billed laboratory services ordered by an approved CA, Form Locator 83 (referring provider ID number) must be reported on the UB-92 claim. Refer to the Uniform Billing Manual for Medicaid instructions regarding this form locator.

3.17 Mental Health and Substance Abuse Services

Most mental health services provided to Medicaid beneficiaries are covered through the local PIHP/CMHSP. PIHPs/CMHSPs are responsible for direct payment for inpatient psychiatric or partial hospitalization services, related physician services, and specialized community mental health clinical and rehabilitation services that the PIHP/CMHSP has prior authorized. Providers should not bill MDCH for these services.

Medical/physical health care services (beyond the admission history and physical) and/or physician-ordered medical (nonpsychiatric) consultations required for Medicaid beneficiaries while they are receiving psychiatric inpatient or partial hospitalization services are not the responsibility of the PIHP/CMHSP. For FFS beneficiaries, these services are billed directly to MDCH. For beneficiaries enrolled in a MHP, the services must be billed directly to the MHP. These services may require PA.

(Refer to the Mental Health/Substance Abuse Chapter of this manual for additional information.)

3.17.A. Acute Inpatient Medical Detoxification

Medically necessary inpatient detoxification services are covered only in a life-threatening situation. Medicaid does not cover inpatient detoxification if the beneficiary is simply incapacitated and not in a life-threatening situation. Acute medical detoxification services may be provided by a Medicaid-enrolled hospital without authorization from a CA. Acute detoxification services are reimbursed directly by MDCH for both MHP enrollees and FFS beneficiaries.

For additional substance abuse services, hospitals must refer beneficiaries seeking inpatient acute detox services to the local CA.

3.17.B. Inpatient Psychiatric Services

Inpatient stays in a psychiatric unit of a general hospital are covered for beneficiaries of any age. Coverage for inpatient treatment, including related psychiatric visits, in a freestanding psychiatric hospital, both private and state-owned, is limited to eligible beneficiaries under age 21 and age 65 and older. If the beneficiary was an inpatient immediately prior to attaining age 21, he would be eligible to continue as an inpatient until age 22. If the beneficiary is discharged at some time following his 21st birthday, coverage terminates on the discharge date.

All psychiatric admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Mental Health/Substance Abuse Chapter of this manual for specific coverages and authorization requirements.)

3.17.C. Psychiatric Partial Hospitalization

Psychiatric coverage includes partial hospitalization on a day-care or night-care plan for all beneficiaries, regardless of age. To be eligible for partial hospitalization, the beneficiary must be receiving active psychiatric treatment provided under the direction of a psychiatrist.

All partial hospitalization admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Mental Health/Substance Abuse Chapter of this manual for specific coverages and authorization requirements.)

3.17.D. Substance Abuse Services

Medicaid covers acute care detoxification in the inpatient hospital as a FFS benefit. Reimbursement is made directly by MDCH for both FFS beneficiaries and MHP enrollees.

Admission to the acute care setting for a diagnosis of substance abuse must meet at least one of the following criteria as reflected in the physician's orders and patient care plan:

- Vital signs, extreme and unstable.
- Uncontrolled hypertension, extreme and unstable.
- Delirium tremens, (e.g., confusion, hallucinations, seizures) or a documented history of delirium tremens requiring treatment.
- Convulsions or multiple convulsions within the last 72 hours.
- Unconsciousness.
- Occurrence of substance abuse with pregnancy and monitoring the fetus is vital to the continued health of the fetus.
- Insulin-dependent diabetes complicated by diabetic ketoacidosis.
- Suspected diagnosis of closed head injury based on trauma injury.
- Congestive heart disease, ischemic heart disease, or significant arrhythmia as examples of active symptomatic heart disease.
- Suicidal ideation and gestures necessitating suicidal precautions as part of treatment.
- Blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse.
- Blood alcohol level 400 mg/dl with diagnosis of alcohol dependence.
- Active presentation of psychotic symptoms reflecting an urgent/emergent condition.

3.17.E. Other Substance Abuse Services

Medicaid covers other substance abuse services provided to beneficiaries. These services are covered under capitation payments to the PIHPs/CMHSPs. (Refer to the Mental Health/Substance Abuse Chapter of this manual for specific coverages and authorization requirements.)

3.17.F. Coordinating Agencies

The Coordinating Agency (CA) may authorize the following specialized services:

- Outpatient Substance Abuse Treatment
- Assessment, Diagnosis, Beneficiary Placement and Referral
- Intensive Outpatient Counseling
- Federal Drug Administration (FDA) Approved Pharmacological Supports (Methadone; Levo Alpha Acetyl Methadol [LAAM]).

Questions regarding substance abuse services should be directed to the local CA.

3.18 Organ Transplants

MDCH requires PA from the Office of Medical Affairs (OMA) for organ transplants for all beneficiaries, donors, and potential donor services related to organ transplants except for cornea and kidney. (Refer to the General Information for Providers Chapter of this manual for additional information on prior authorization [PA].) PA is required if additional organ(s) transplantation is to occur during the same operative session, such as a cornea or kidney.

PA is not required if Medicare makes payment and Medicaid liability is limited to coinsurance and deductible. If a Medicare application is pending, the provider must indicate that on the PA request and notify MDCH when the determination is made. All other insurance resources must be exhausted before Medicaid is billed. The denial notice(s) must be submitted with the claim.

MDCH reimbursement for the following transplants is at the hospital's Medicaid cost-to-charge ratio:

- Heart
- Bone marrow
- Liver
- Lung
- Simultaneously pancreas/kidney
- Pancreas transplants

For other organ transplant services not described by a specific DRG, the hospital must provide a note/remark on the claim of the type of transplant (i.e., small bowel transplant) performed. All organ transplant claims pend for manual review of documentation. A copy of the PA letter must be submitted with the claims. Providers must note "PA Letter submitted" in the Remarks section of the claim.

For those transplants requiring PA, MDCH requires a beneficiary to be evaluated at an accepted transplant center approved by the OMA to determine if he is a good transplant candidate. If the transplant is to take place at a Medicaid-enrolled, in-state hospital, then only the transplant needs PA. If the transplant is to be performed at an out-of-state hospital, then both the evaluation and the transplant must be separately prior authorized. Results from the evaluation must be submitted to the OMA when requesting PA for the transplant.

If the beneficiary is Medicaid-eligible and the donor is not Medicaid-eligible, providers must bill all services under the beneficiary's ID Number and provide complete documentation. If the donor and beneficiary are both Medicaid-enrolled, providers must bill the services under their respective ID numbers.

3.18.A. Donor Search

When the donor search does not result in an organ acquisition and transplant, MDCH reimburses for a donor search and related charges. These services must be billed as outpatient services, and providers are required to submit a copy of the PA letter for transplant with the claim. Providers must make reference or remark on the claim format that the donor search failed at the time of claim submission.

3.18.B. Transportation and Lodging

MDCH reimburses for transportation and lodging expenses associated with the evaluation and the transplant for the beneficiary and one accompanying individual (e.g., spouse, parent, guardian). The beneficiary's local Department of Human Services (DHS) office should be contacted to make travel arrangements if the beneficiary has Medicaid-only coverage or they are dually enrolled in CSHCS and Medicaid. If the beneficiary has CSHCS coverage only, they must contact the CSHCS office in the LHD of the county where they reside to make travel arrangements. If the beneficiary is enrolled in an MHP, contact the MHP regarding transportation arrangements.

3.19 Psoriasis Treatment Services

MDCH reimburses for outpatient hospital-based psoriasis treatment rendered at an equivalent intensity of service for beneficiaries with severe psoriasis but at a lower cost than inpatient services. This coverage is for conditions that would normally require hospitalization, but the associated medical conditions of the beneficiary allow the same treatment on an outpatient basis. Conditions include severe involvement of the skin that is extensive in body distribution or involves a disabling condition with no complicating conditions, such as joint disease or mental instability.

3.20 Radiology

MDCH reimburses hospitals for medically-necessary radiology services, including diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging services, ultrasound, and other imaging procedures:

- Necessitated by injury or disease, including benign or malignant conditions;
- Needed to diagnose a specific condition, illness, or injury; and
- Ordered by physicians (MD or DO), podiatrists, dentists, nurse practitioners, or nurse midwives.

The medical record must contain documentation of medical necessity to support all radiology services billed.

Reimbursement to the inpatient hospital is through the DRG payment.

Reimbursement for outpatient services is billed using the appropriate HCPCS code and includes the use of the facility, equipment, supplies, and attendant personnel required to provide the service.

MDCH reimburses for diagnostic and therapeutic x-rays and nuclear medical services, including:

Interventional Radiology Procedures	Procedure codes support facility charges and a separate reimbursement for pharmacy, supplies, anesthesia, etc. used during the procedure.
Cardiac Catheterization	Cardiac catheterization procedures must be rendered in a separate sterile environment unit within the hospital and include heart catheterization and coronary angiographies. Diagnostic cardiac catheterization services must be necessitated by disease or injury or be performed to diagnose a specific cardiac condition as documented in the beneficiary's record and identified by a HCPCS/CPT code. All charges related to monitoring vital signs, use of equipment (similar to the operating room [OR]), and other durable items used are considered part of the room charge. Multiple injection procedures may be included in the cardiac catheterization, but MDCH does not reimburse each injection separately. MDCH reimburses Observation Room charges separately as a quantity of one when provided after a cardiac catheterization (or myelogram). MDCH reimburses when acute care recovery is necessary following a cardiac catheterization (or myelogram) when on the same bill as the cardiac catheterization procedure. There is a maximum quantity of eight units (one unit for each 30 minutes) or four hours.
Computerized Axial Tomography (CT) Scanning	If requested by a physician for specific diagnosis and/or localization of lesions, tumors, or trauma. CT scanning is not covered for routine screening, nonspecific diagnoses, or in situations where less costly diagnostic methods are appropriate. CT scanning procedures must be provided on equipment that has an approved Certificate of Need (CON) on file with MDCH. The owner of the equipment must submit proof of CON approval and the date the equipment became operational to Medicaid Payments Division Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)
Multiple Radiological Procedures	Multiple radiological procedures are not covered when an area to be visualized is common to each procedure and there are no substantial spatial differences in the views, unless for trauma or arthritis conditions. (Refer to the Billing & Reimbursement for Institutional Providers Chapter for additional billing information specific to how to bill multiple procedures.)
Contrast Material	The cost of high osmolar contrast material is reimbursed as part of the technical component of diagnostic radiology procedures and is not routinely reimbursed separately. MDCH reimburses additional payment for low osmolar contrast material (LOCM) if used for beneficiaries with at least one of the following characteristics: ▪ A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting;

	▪ A history of asthma or allergy; ▪ Significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension; ▪ Generalized severe debilitation; or ▪ Sickle cell disease. Paramagnetic contrast material used in MRI studies is included in the reimbursement.
Percutaneous Transluminal Coronary Angioplasty (PTCA)	PTCA is covered for those beneficiaries who meet the following criteria: failed maximum medical treatment, intractable angina and single vessel disease with left ventricular function. Charges for disposable supplies, medication and anesthesia in conjunction with a PTCA are reimbursed under the OPH group reimbursement system. Charges for a pre-op holding room are not covered. MDCH covers acute care recovery following this procedure when reported on the same bill as the PTCA procedure. There is a maximum quantity of eight units (each unit equals 30 minutes) or four hours.
Ultrasonography	Ultrasound procedures are reimbursed when there is clinical evidence in the beneficiary's record to substantiate the medical need for such services. Ultrasound procedures are not covered when used as screening procedures or on a routine basis. When billing two ultrasound codes, the diagnosis must reflect the medical need for two procedures. Claims for diagnostic ultrasound procedures that are performed more than once must be documented for medical necessity. Documentation with the claim should clearly state the reason for the repeat procedure. Claims are rejected if the documentation does not support the need for the repeat diagnostic procedure.

Routine follow-up care is included in radiotherapy and nuclear medicine procedures.

3.21 STERILIZATION

A sterilization procedure is defined as any medical procedure, treatment, or operation for the sole purpose of rendering an individual (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under Medicaid's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). The physician is responsible for obtaining the signed Informed Consent for Sterilization form (MSA-1959). (Refer to the Forms Appendix for a sample.)

Sterilizations are reimbursed only if:

- The beneficiary is at least 21 years of age at time of informed consent.
- The beneficiary is not legally declared to be mentally incompetent.
- The beneficiary is not institutionalized in a corrective, penal, or mental rehabilitation facility.

- Informed consent is obtained.
- Informed consent is not obtained while the beneficiary is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.
- Informed consent must be obtained not less than 30 days nor more than 180 days prior to sterilization.

The only exception is in the case of premature delivery or emergency abdominal surgery. If the premature delivery or emergency abdominal surgery occurred before the 30-day waiting period is over, at least 72 hours must have passed between the time of obtaining informed consent and the sterilization procedure.

- In some cases of premature delivery, informed consent must have been given at least 30 days before the expected delivery date. The consent form must indicate the expected date of delivery.
- In cases of abdominal surgery, the emergency nature of the surgery must be clearly identified, e.g., diagnosis, physician's statement, or hospital summary. The nature of the emergency must be included on the consent form.

Federal regulations require that the completed MSA-1959 be submitted to MDCH before reimbursement can be made for any sterilization procedure. A copy must be attached to the claim form unless submitted via fax prior to filing the claim. MDCH allows for submission of Informed Consent to Sterilization forms via fax to encourage electronic billing and reduce administrative burden. This process can also pre-confirm the acceptability of the completed consent form and reduce costly claim rejections. (Refer to the Billing & Reimbursement for Professionals Chapter for information regarding the completion and submission of the MSA-1959.)

3.22 SURGERY

MDCH reimburses for surgeries performed in an inpatient hospital through the DRG payment.

MDCH reimburses for selected surgeries performed in an outpatient hospital.

When an ambulatory surgery is performed in the inpatient hospital setting, the physician must provide exception rationale (outlined below) justifying the need for an inpatient setting. The provider must obtain PA for an elective admission from the Admissions and Certification Review Contractor (ACRC). (Refer to the Utilization Review Section of this chapter for further information. Refer to the Directory Appendix for contact information.) Acceptable rationale includes:

- A medical condition that requires prolonged postoperative observation by skilled medical personnel (e.g., heart disease, severe diabetes);
- A preexisting condition significantly increases the risk of using anesthesia;
- The beneficiary has been admitted to a hospital for another procedure or condition, and the surgeon decides that one of the selected surgical procedures is also necessary;

- An unrelated procedure is being done simultaneously which, by itself, requires hospitalization;
- Another surgical procedure is expected to follow the initial procedure (e.g., gynecological laparoscopy followed by an oophorectomy);
- Technical difficulties, as documented by admission or operative notes; or
- Adequate outpatient facilities are not available within a reasonable distance (i.e., 40 miles) requiring the surgery to be rendered on an inpatient basis. In this case, MDCH allows a one-day inpatient hospital stay, unless a longer stay is medically necessary.

If the physician planned to perform the surgery on an outpatient basis, but more extensive surgery was needed or complications developed and the beneficiary had to be admitted, a Pre-Admission and Certification Evaluation Review (PACER) number is not needed for the admission. This type of admission is considered urgent or emergent. The need for the admission is, however, subject to retrospective review by the ACRC.

Medicaid defines multiple surgical procedures as when two or more consecutive surgical procedures are performed, one immediately following the other during the same operative session. MDCH covers certain procedures included as integral parts of a total procedure and does not reimburse them as separate surgeries.

MDCH does not have a formal process for a second surgical opinion but reimburses for a second surgical opinion if the beneficiary or the physician requests one.

3.22.A. Operating Room

MDCH covers operating room charges for services requiring a sterile environment, specially trained personnel to perform surgical and related procedures, and equipment found in an operating room. MDCH does not cover or separately reimburse charges for preoperative holding rooms or surgical suites used as holding rooms.

Inpatient reimbursement is through the DRG payment.

Outpatient providers must bill the appropriate HCPCS/CPT support code(s) operating room services and surgical supplies. MDCH reimburses up to a maximum quantity of six units total for the operating room (one unit is 30 minutes rounded up to the nearest half-hour) and a percent of the charge for supplies used during a reported surgical procedure.

3.22.B. Recovery Room

MDCH covers post-surgical, medically necessary recovery room charges when provided after a surgical procedure.

Inpatient reimbursement is through the DRG payment.

Outpatient providers must bill the appropriate HCPCS/CPT code and report up to a maximum of eight units (each unit equals 30 minutes) or four hours.

3.22.C. Observation Room

Inpatient reimbursement for Observation Room is through the DRG payment.

Outpatient reimbursement is made for Observation Room only on the same claim for a cardiac catheterization or myelogram. Observation Room is not covered for any other procedures. MDCH only covers a combination of Observation Room and Acute Recovery Care when both services are provided following either a cardiac catheterization or a myelogram on the same claim (same DOS).

3.22.D. Cosmetic Surgery

Hospital charges related to cosmetic surgery are not reimbursable without PA for the surgery. The physician must furnish the hospital with a copy of the PA letter for the surgery, as well as the PACER certification number for the admission.

3.22.E. Minor Surgery

MDCH reimburses for minor surgery (referred to as office-based procedures) performed in the outpatient hospital setting. (Refer to the Billing & Reimbursement for Institutional Providers Chapter for a list of these procedures.)

3.22.F. Special Procedures

MDCH covers certain procedures rendered in designated areas of the licensed hospital where specific procedures (i.e., Cardiac Catheterization Lab, etc.) are performed. Providers are required to use the appropriate revenue code for the service provided within the hospital facility. These services must be supported by the appropriate HCPCS/CPT code describing the procedure or service performed in the designated hospital setting.

3.22.G. Gastrointestinal Services

A gastrointestinal (GI) service provides a range of diagnostic and therapeutic procedures for digestive disorders, and may include upper endoscopy procedures of the esophagus, small and large intestine, and the rectum. MDCH reimburses for GI services rendered in a special designated area of a licensed enrolled hospital and for endoscopic procedures when not performed in the operating room. The hospital must use the appropriate supporting HCPCS code when providing GI services.

3.23 Occupational Therapy

3.23.A. Outpatient Hospital

Refer to the Outpatient Therapy Chapter for standards of coverage and service limitations for therapy provided in the outpatient hospital setting.

3.23.B. Inpatient Hospital

Inpatient hospital OT does not require PA for reimbursement.

OT provided in a general inpatient hospital must meet the following criteria:

- The therapy must be ordered, in writing, by the attending physician (MD, DO) initially, and reordered if additional therapy is deemed necessary. These orders must be signed by the physician and retained in the beneficiary's medical record.
- Services must be rendered by an OTR or COTA under the direct supervision of an OTR.
- Services must be active, restorative, and designed to prevent, correct, or compensate for a specific physical and/or mental problem. (Treatment designed to improve a given environment for a beneficiary's general welfare is considered an activity program and is not a benefit.)

The initial evaluation and treatment plan must include the following information:

- Statement of the problem, i.e., the specific physical entity and functional incapacity involved or the specific diagnosis based upon results of formal/informal testing;
- Baseline condition at initial evaluation, measured in units appropriate to the problem;
- Short-term goals appropriate to the beneficiary's diagnosis, level of severity, prognosis, and functional needs;
- Restorative physical disability proposed technique for reaching goals, including the planned progression from the baseline condition to the goal; and
- Method by which progress is measured.

This and any other additional documentation must include the beneficiary's name and Medicaid ID number, the date, and the hospital's name and Medicaid ID number.

The OTR must keep progress notes on the therapy. Such notes include:

- Treatment provided.
- Date of treatment.
- Name of the individual who rendered treatment.
- Type and length of treatment.
- Beneficiary's response to the treatment.

The progress notes must be included in the beneficiary's medical record.

In addition to the restorative physical disability OT, MDCH covers the development of a self-care program designed by the OTR.

The cost of supplies and equipment needed to increase or replace a specific muscle function, which relates to the total rehabilitation of the beneficiary and is restorative in nature, is considered part of the OT program. Items available to the beneficiary in his community as a normal household item (e.g., bath brushes, can openers, electric toothbrushes) are not considered adaptive equipment and are not covered by MDCH.

3.24 Physical Therapy

Inpatient hospital physical therapy does not require PA for reimbursement. Refer to the Outpatient Therapy Chapter of this manual for standards of coverage and service limitations for therapy provided in the outpatient hospital setting.

3.25 Therapy, Speech-Language Pathology

Speech-language pathology services provided during an inpatient admission do not require PA.

Refer to the Outpatient Therapy Chapter of this manual for standards of coverage and service limitations for therapy provided in the outpatient hospital setting.

3.26 Weight Reduction

MDCH reimburses obesity treatment when done for the purpose of controlling life-endangering complications such as hypertension and diabetes. This does not include treatment specifically for obesity, weight reduction and maintenance alone. The physician must request PA and document that other weight reduction efforts and/or additional treatment of conservative measures to control weight and manage the complications have failed.

The request for PA must include:

- The medical history;
- Past and current treatment and results;
- Complications encountered;
- All weight control methods that have been tried and failed; and
- Expected benefits or prognosis for the method being requested.

If surgical intervention is desired, a psychiatric evaluation of the beneficiary's willingness/ability to alter their lifestyle following surgical intervention must be included.

Mail requests to Office of Medical Affairs (OMA). (Refer to the Directory Appendix for contact information.)

If the request is approved, the provider receives an authorization letter for the service, including billing instructions. A copy of the authorization letter must be attached to all claims submitted to MDCH for weight reduction services.

SECTION 4 – NONCOVERED SERVICES

MDCH does not reimburse hospitals (inpatient or outpatient) for the following services:

- Acupuncture
- Autopsy
- Biofeedback
- Cardiac and pulmonary disease rehabilitation in the outpatient hospital setting

SECTION 5 – UTILIZATION REVIEW

5.1 NONCOVERED ADMISSIONS

For Medicaid reimbursement, all inpatient admissions must be medically necessary and appropriate. MDCH does not cover inpatient hospital admissions for the sole purpose of:

- Cosmetic surgery (unless prior authorized)
- Custodial or protective care of abused children
- Diagnostic procedures that can be performed on an outpatient basis
- Laboratory work, electrocardiograms (ECGs), electroencephalograms (EEGs), diagnostic x-rays
- Observation
- Occupational therapy (OT)
- Patient education
- Physical therapy (PT)
- Routine dental care
- Routine physical examinations not related to a specific illness, symptom, complaint, or injury
- Speech pathology
- Weight reduction; weight control (unless prior authorized)

Hospitals may not bill beneficiaries for any medical charges for goods and services provided during a nonallowable admission. The beneficiary is assumed to be following the physician's advice.

Any accommodations or ancillary services provided during nonallowable admissions or parts of stays will not be reimbursed.

5.2 PRE-ADMISSION AND CERTIFICATION EVALUATION REVIEW DRG INPATIENT ADMISSIONS

A MDCH subcontractor performs inpatient admission and certification reviews. This section contains information on these reviews, the review process and the appeals processes.

Elective admissions, all readmissions within 15 days, and all transfers for surgical and medical inpatient hospital services to and from any hospital(s) enrolled in the Michigan Medicaid Program require authorization through the Authorization and Certification Review Contractor (ACRC). This includes transfers between a medical/surgical unit and an enrolled distinct-part rehabilitation unit of the same hospital. All cases are screened using the Medicaid-approved Severity of Illness/Intensity of Services (SI/IS) criteria, and the clinical judgment of the review coordinator. An ACRC physician advisor makes all adverse determinations using SI/IS criteria and clinical judgment for evaluating the case.

If an admission, readmission, transfer, or continued stay is not approved, MDCH does not reimburse the hospital or attending physician for inpatient services rendered. The provider may request reconsideration by the ACRC, either verbally or in writing. Reconsideration must be requested within three working days of the original denial.

The ACRC performs medical/surgical and rehabilitation admission, readmission, and transfer review through the Pre-Admission and Certification Evaluation Review (PACER) system and assigns PACER numbers.

The attending/admitting physician or representative is responsible for obtaining the PACER number before admitting or readmitting the beneficiary to the hospital or before transferring the beneficiary (with exceptions as noted below). Should the consulting physician become the attending physician, he may obtain the PACER number. Physicians are asked to provide the CPT/HCPCS Procedure Code when a surgical admission/readmission is proposed.

(Refer to the Directory Appendix for the telephone number to obtain PACER authorization.)

Authorization through the ACRC for the hospital admission does not remove the need for PA required by Medicaid for specific services. The hospital must still attach documentation with its claim for such services. (Example: the hospital would still have to attach a copy of the Letter of Authorization from the OMA for cosmetic surgery.) The PA for the service must be obtained before the ACRC authorization is requested.

5.2.A. Admissions that Do Not Require ACRC Approval

- Emergent admissions. All transfers and readmissions do require PACER. (Hospital admission services billed as emergent are reviewed on a post-payment sample basis.)
- Transfers to distinct-part psychiatric units or freestanding psychiatric hospitals.
- Obstetrical patients admitted for any delivery.
- Newborns admitted following a delivery.

Exception: All transfers of newborns following delivery require a PACER. The initial and any subsequent transfers of the newborn must be authorized by the ACRC.

- Admissions of beneficiaries that are eligible for CSHCS only.
- Admissions of beneficiaries that are dually eligible for CSHCS and Medicaid, and the admission is related to the CSHCS qualifying condition.
- Beneficiaries enrolled in a MHP.
- When a beneficiary is admitted to a hospital not enrolled with the Michigan Medicaid Program.
- When a patient is determined Medicaid-eligible after the admission, readmission, transfer, or certification review period for which the ACRC review was required.

When Medicaid eligibility is determined retroactively, "Retroactive Eligibility" must be entered in the Remarks section of the claim.

The physician is not exempted from obtaining PA through the ACRC solely because:

- A beneficiary has any other insurance, including Medicare Part A. A PACER number is needed if the beneficiary has Medicare Part B only or if Part A coverage is exhausted.
- The physician is not enrolled in the Michigan Medicaid Program.

5.2.B. PACER Elective Approval Admission

The physician is responsible for providing the PACER number to the admitting hospital. The PACER number is issued on the day that the admission is approved by the ACRC. This number is valid for the entire medical or surgical admission unless otherwise noted in the manual. PACER authorization must be requested prior to the admission of the patient.

Approval of an admission only confirms the need for services to be provided on an inpatient hospital basis. Payment for the admission is subject to eligibility requirements, readmission, and third-party liability (TPL) reimbursement policy, along with any pre- and post-payment determinations of medical necessity.

5.2.C. PACER Readmissions

To be separately reimbursable, all readmissions (whether to the same or different hospital) for hospital services must be prior authorized through the ACRC. The request for a PACER number for an elective readmission, whether to the same or a different hospital, must be made prior to readmission. The request for a PACER number for an urgent or emergent readmission to the same hospital must be made by the next working day following the readmission. The request for a PACER number for an urgent or emergent readmission to a different hospital must be made prior to the patient's discharge. Medicaid defines readmission, for purposes of review, as any admission/hospitalization of a beneficiary within 15 days of a previous discharge, whether the readmission is to the same or different hospital.

If the hospital intends to combine an admission and a readmission into a single episode for DRG payment purposes, the ACRC should not be contacted for a separate PACER number for the readmission.

Before calling the ACRC, the requestor should assemble as much information as possible regarding the medical condition of the patient upon the first discharge and at the time of the readmission. When called for a PACER number, the ACRC either:

- Agrees that the original admission and the readmission are unrelated, as well as medically necessary, and issues a PACER number so that the stays may be billed and paid separately by the same hospital;
- Authorizes a readmission to a different hospital as medically necessary and issues a PACER number;
- Asks the caller to obtain additional information and call back no later than the next working day; or
- Questions the relatedness of two stays at the same hospital or the medical necessity for the readmission and refers the call to a physician advisor who may issue or deny a PACER number.

If a PACER number is not provided for a readmission due to relatedness (required as a consequence of the original admission), the hospital may combine the two stays into a single episode for DRG payment purposes (using the Leave of Absence revenue code 0180 for the time between discharge and readmission), or request reconsideration of the ACRC physician advisor's decision. If the initial admission has already been billed, the hospital may submit a claim replacement to combine the two stays.

If it is determined a readmission is medically unnecessary, the hospital and physician may only bill for the first admission.

5.2.D. PACER TRANSFERS

If a beneficiary needs to be transferred, authorization for the transfer must be obtained through the ACRC. Authorization for a transfer is granted only if the transfer is medically necessary and the care or treatment is not available at the transferring hospital. Transfers for convenience are not considered. Transfers include any of the following situations:

- Transfer from one inpatient hospital to another;
- Transfer from one unit of an inpatient hospital to another unit of the same hospital (i.e., distinct-part rehabilitation unit) that has a separate Medicaid ID number.

Transfer to a distinct-part psychiatric unit of a general hospital or a freestanding psychiatric hospital is subject to review and approval by the beneficiary's PIHP/CMHSP. Do not contact the ACRC for a PACER number.

The following describes the appropriate requestor and timeframes for transfer authorization:

- Elective transfers – the transferring physician or designee must obtain authorization prior to transfer.
- Emergency transfers – the authorization must be obtained by the transferring physician no later than the next working day, or by the receiving physician or hospital before discharge.

If the transfer is approved, a PACER number is issued. The receiving hospital must use this number when billing. The transferring hospital continues to use the original PACER number if a PACER number was required for the admission.

5.3 Post-Payment Review of Transfers and Readmissions

Transfers and readmissions are reviewed on a post-payment basis utilizing the audit process outlined in the Inpatient Hospital Post-Payment Reviews portion of this section. If it is determined that the information provided to justify the transfer/readmission is not validated by evidence in the medical record, the ACRC may reverse its PACER authorization decision. If, in the post-payment review, the transfer/readmission is determined to be inappropriate, related monies are recovered. If post-payment review indicates that the patient no longer required inpatient care at the time of the transfer/readmission, monies are recovered from the transferring/admitting hospital.

5.4 Inappropriate or Unnecessary Admissions

MDCH does not reimburse the hospital for inappropriate or unnecessary inpatient admissions, readmissions within 15 days, transfers that are not authorized through the ACRC system, and admissions or readmissions that have been inappropriately coded as urgent or emergent. This includes selected ambulatory surgeries inappropriately performed on an inpatient basis or any other inpatient elective admission determined not to have been medically necessary. In addition, the hospital is not reimbursed if errors were made in identification of the beneficiary or the time period of the admission.

If MDCH does not reimburse the physician or hospital, the physician or hospital must not bill the beneficiary, a member of the beneficiary's family, or other beneficiary representatives.

Services during inpatient stays or parts of stays where that stay has been denied as inappropriate or unnecessary may not be resubmitted to MDCH as outpatient charges. Charges resubmitted as outpatient charges are monitored, and any payment made may be recovered during a post-payment audit.

If a PACER number was not requested in a timely manner (as described throughout this chapter), the physician or hospital should call the ACRC as soon as the omission is noted. The ACRC requests a written explanation of the reason for the untimely request. Each case is reviewed individually. The ACRC responds in writing to the hospital.

If the call to the ACRC is not made in a timely manner, the hospital risks denial on that basis unless circumstances causing the late call are explained completely and acceptably.

5.5 Authorization for Non-DRG Admissions to Freestanding Rehabilitation Hospitals

Inpatient stays beyond 30 days in freestanding rehabilitation hospitals require additional inpatient authorization.

- The hospital must call the ACRC between the 27th and 30th day of the stay if the stay is expected to exceed 30 days. If the extended stay is certified, a nine-digit certification number is given. That number must appear on the hospital's claim if the stay is greater than 30 days but less than 60 days.
- The hospital must call the ACRC between the 57th and 60th day of the stay if the stay is expected to exceed 60 days. If the extended stay is approved, the hospital is given another authorization number. This second number must appear on the hospital's claim if the stay is greater than 60 days.

Exceptions	▪ CSHCS Program beneficiaries (including those having dual eligibility for the CSHCS and Medicaid); ACRC approval is required if not related to the qualifying diagnosis. ▪ Admissions covered by Medicare Part A. ▪ Beneficiaries enrolled in a MHP.
Reconsiderations	The attending physician or the hospital may request reconsideration of the adverse determination of the ACRC regarding the need for admission or continued stay. This reconsideration right applies regardless of the current hospitalization status of the patient. Reconsiderations must be requested within three working days of the adverse determination. (Refer to the Directory Appendix for ACRC contact information). If requested by the ACRC, the provider must provide written documentation. The provider is notified of the reconsideration decision within one working day of receipt of the request or the date of receipt of written documentation. If the initial adverse determination is overturned, the adverse determination is considered null and void. If the initial adverse determination is upheld or is modified in such a manner that some portion of the hospital care is not authorized, the hospital is liable for the cost of care provided from the date of the initial determination, unless this determination is overturned in the Medicaid appeals process.
Technical Denials	If the provider fails to request an authorization number on a timely basis (as described previously in this chapter), the provider should make this request as soon as the omission is noted. When the provider contacts the ACRC by telephone with an untimely request, the review coordinator sends the provider a form to complete explaining the circumstances of the untimely request. If upon review of this written documentation the untimeliness is waived, the case is reviewed for medical necessity and the appropriateness of the admission, transfer or readmission. If approved, the ACRC gives the provider a PACER number. If the untimeliness issue is not approved, the attending physician and the hospital are notified in writing within 24 hours of the decision. The hospital may request further review of the ACRC decision by Medicaid relative to timeliness.

Continued Stay Denials	If the ACRC does not authorize the admission or the continued stay for an admission and the patient remains in the hospital for one or more day(s) after Medicaid payment is not authorized, the hospital is at risk of Medicaid nonpayment for those days. The provider may request post-discharge review by the ACRC, regardless of whether reconsideration was requested on the case, in writing within 30 days of the discharge from the hospital. A copy of the medical record must accompany the post-discharge review request. Post-discharge review is conducted on only those days that were not authorized during the telephone review. The ACRC informs the provider, in writing, of the ACRC decision within fourteen days of the receipt of the request and documentation. If some or all of the previously nonauthorized days are approved, a new billing authorization number is issued and included in the notification of the decision. If the initial adverse determination is upheld, the notification includes the previously issued billing authorization number. If the provider is dissatisfied with the decision of the ACRC, the decision may be appealed. The hospital may bill Medicaid only for the days authorized by the ACRC. If the ACRC has made an adverse determination and issued a final billing authorization number, the hospital may submit an invoice with this billing authorization number for only the authorized days while the case is in the reconsideration, post-discharge review, or formal appeals process. Submission of such an invoice does not imply acceptance of the ACRC determination.

5.6 Utilization Review

The objective of utilization review is to ensure that care paid by MDCH is medically necessary and provided in the appropriate setting, that the diagnostic and procedural information is valid, and that the care meets quality standards.

Post-discharge utilization reviews of medical/surgical and rehabilitation stays are conducted by the ACRC as part of the audit process described under the Inpatient Hospital Post-Payment Reviews portion of this section.

Cases are reviewed using Medicaid-approved SI/IS criteria, clinical judgment and generic quality screens.

All reviews include consideration of medical necessity, appropriateness of setting, coding validity/accuracy, and the quality and intensity of care provided to the beneficiary. The ACRC assures that the quality and intensity of inpatient hospital services conform to acceptable standards of medical practice and to Medicaid policies, procedures, and guidelines.

5.7 Inpatient Hospital Post-Payment Reviews

The Admissions and Certification Review Contractor (ACRC) performs periodic statistically-valid random sample audits of claims, by hospital, to verify that the inpatient hospital medical record supports the level of services billed. If a hospital's statistically-valid random sample audit determines that services billed lacked medical necessity/appropriateness, audit findings may be extrapolated to the entire Medicaid population receiving services in that facility for the time period of the audit, and are subject to recoupment and/or adjustment.

DRG Validity	The ACRC verifies the diagnosis and procedure codes on the hospital's claim on a post-payment basis for all claims paid on a DRG basis as part of the audit process.
Medical Necessity / Appropriateness	The ACRC also performs retrospective review for medical necessity of admissions, transfers and readmissions as part of the audit process.

The ACRC contacts the inpatient hospital to be audited by telephone prior to the audit to arrange a date to obtain medical records. This is followed by a confirmation letter. The hospital is provided a list of beneficiaries (including beneficiary name, date of birth, and date(s) of service) to be audited **30 calendar days** prior to the ACRC visit. If a selected beneficiary has multiple admissions during the audit period, records for all admissions are required. If the facility requires an extension of the timeframe to pull records, a request must be submitted via letter, email or fax to MDCH. Contact the ACRC for information regarding the submission process. The ACRC will copy/scan the records utilizing its own equipment. The hospital will be sent a copy of the audit results at the conclusion of the audit review.

5.8 Quality Review

The ACRC performs a review of the quality of care provided to the patient. This review occurs on cases included in the audit sample.

If the ACRC's post-payment review, conducted as part of the audit process, identifies quality of care issues, the attending physician and/or hospital is notified and the peer review procedures for quality review are followed. Ultimately, the ACRC notifies MDCH of any serious quality findings and recommended interventions that may include, but are not limited to:

- Suspending or terminating a provider's Medicaid participation.
- Requiring PA of specific cases.
- Requiring intensified review of specific cases.
- Limiting the provider's scope of Medicaid participation.

5.9 Contractor Monitoring

MDCH monitors the ACRC's review and audit process and case determinations to verify that the ACRC is:

- Appropriately applying review criteria in compliance with Medicaid policy.
- Making proper determination of medical necessity and appropriateness of setting.
- Performing all duties in a manner acceptable to MDCH.

The ACRC may be monitored to assure timeliness of the audit process. Penalties may be assessed if the ACRC fails to maintain timely reviews.

5.10 Confidentiality

As an agent of the State, the ACRC may access all records related to care provided to Medicaid beneficiaries and is subject to the same state and federal confidentiality requirements as Medicaid staff. The failure of a provider to make all records available to the contractor results in denial of that case and subjects that provider to Medicaid participation sanctions. Additionally, the contractor makes allowable disclosures of statistical information after MDCH's review and approval. This information is directly releasable to, and reviewable by, the Health Care Fraud Division of the Department of the Attorney General.

5.11 Planning for Discharge

As part of utilization review, the hospital should consider various alternatives for care of the beneficiary through discharge planning. Refer to the Discharge Planning Section of this chapter for information regarding discharge planning.

5.12 Termination of Benefits

The hospital's utilization review committee may issue a notice of noncoverage to the patient if it determines that the admission or continued stay in the hospital is not medically necessary. The notice should be substantially similar to the sample letters contained in the Forms Appendix of this manual.

If the patient or patient representative disagrees with the notice, the patient or representative may contact the ACRC to appeal the decision. If the ACRC has previously issued an adverse determination for the period of hospitalization covered by the notice, the ACRC informs the patient of concurrence with the hospital decision. If the ACRC has not previously issued an adverse determination for the period, a review of the medical record is conducted. The ACRC contacts the hospital to obtain a copy of the medical record. An ACRC physician advisor reviews the medical necessity of the admission or continued stay. The ACRC reviews and issues a decision on the case within three days of the receipt of the final determination and the related documentation.

If issued, the notice is the responsibility of the hospital's Utilization Review Committee and is not related to any decision that may have been rendered by the ACRC on the case. The decision must be based on the findings of the Utilization Review Committee and not on the determination of the ACRC.

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal provides an administrative hearing to appellants requesting a hearing who do not agree with a decision made by MDCH or a MDCH contracted agency (i.e., any agency, organization, or health plan contracted by the MDCH) that either determines eligibility for a MDCH program, or delivers a service provided under a MDCH program to a beneficiary, patient or resident. The Administrative Tribunal issues timely, clear, concise and legally accurate hearing decisions and orders. The Administrative Tribunal Policy and Procedures Manual explains the process by which each different type of case is brought to completion. Refer to this manual for Administrative Tribunal information. (Refer to the Directory Appendix for contact information.)

5.13 Outpatient Hospital Post-Payment Review

The ACRC performs periodic statistically-valid random sample audits, by hospital, of outpatient hospital services, to verify services provided, amount billed, and appropriateness of setting. Records are reviewed to assure that services were rendered in accordance with professionally recognized standards of care and in compliance with Medicaid coverage. All outpatient hospital services are eligible for this review and billing validation including, but not limited to, emergency department services, surgeries, endoscopies, and other special procedure room services. If a statistically-valid random sample by hospital determines that services billed were at a higher level than supported by the medical records, audit findings may be extrapolated to the entire Medicaid population receiving services in that facility for the designated timeframe of the audit, and are subject to recoupment and/or adjustment.

The ACRC contacts the outpatient hospital to be audited by telephone prior to the audit to arrange a date to obtain medical records. This is followed by a confirmation letter. The hospital is provided a list of beneficiaries (including beneficiary name, date of birth, and date(s) of service) to be audited **30 calendar days** prior to the ACRC visit. All outpatient services provided during the review period (e.g., laboratory, radiology, emergency room, physical therapy, etc.) for the beneficiaries included in the sample for the audit period are required. Some of the services included may be ones that are series billed (e.g., physical therapy). In addition, an itemized list for revenue center codes may be requested. If the facility requires an extension of the timeframe to pull records, a request must be submitted via letter, email or fax to MDCH. Contact the ACRC for information regarding the submission process. The ACRC will copy/scan the records utilizing its own equipment. The hospital will be sent a copy of the audit results at the conclusion of the audit review.

SECTION 6 – DISCHARGE PLANNING

As part of utilization review, the hospital should consider various alternatives for care of the beneficiary through discharge planning. The medical and social services personnel of the hospital should assist in this effort. If so requested by the hospital, the local DHS county office assists in relocating the beneficiary. The following subsections explain possible alternatives for care.

6.1 HOME HELP

The beneficiary is able to remain in his own home. Home Help providers perform unskilled household and personal care tasks that the beneficiary cannot do himself. Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination, as defined in Medicaid policy.

6.2 HOME HEALTH

The beneficiary resides in his own home or other place of residence (e.g., foster care, home for the aged), is under a physician's (MD, DO) care, and requires intermittent nursing care for a specified period of time. Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination, as defined in Medicaid policy.

6.3 HOME FOR THE AGED

The beneficiary (age 62 or older) receives supervision and nonnursing care in a licensed home. Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination, as defined in Medicaid policy.

6.4 ADULT FOSTER CARE HOME

The beneficiary is in a licensed home that provides supervision, assistance, protection, and personal care, in addition to room and board. This type of home does not provide continuous medical care. Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination, as defined in Medicaid policy.

6.5 HOME AND COMMUNITY BASED WAIVER FOR THE ELDERLY AND DISABLED (MI CHOICE WAIVER PROGRAM)

The beneficiary must meet the requirements for the nursing home level of care and at least one waiver service. Referrals are made to regional waiver providers who are responsible for screening and assessing the beneficiary for waiver eligibility. Once determined eligible, the beneficiary receives services in his home to help him remain as independent as possible. These services may include skilled nursing, homemaker, respite care, counseling, etc.

Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination, as defined in Medicaid policy.

Michigan Medicaid Nursing Facility Level of Care Determination
The Michigan Medicaid Nursing Facility Level of Care Determination form must be completed for every Medicaid beneficiary prior to admission to the MIChoice Waiver. The MIChoice Program agent must

verify beneficiary appropriateness for services by completing the electronic web-based version of the form. Beneficiaries who do not demonstrate functional/medical eligibility through the electronic web-based tool are not eligible for the MIChoice Waiver Program.

Information regarding the Michigan Medicaid Nursing Facility Level of Care Determination process, the form, and the Field Definition Guidelines are on the MDCH website. (Refer to the Directory Appendix for website information.)

While the MI Choice Waiver agent is the actual entity that must complete and submit the form, hospitals are encouraged to assess a beneficiary's functional/medical eligibility for the MI Choice Waiver using a copy of the form. A hospital may also use the Telephone Intake Guidelines. The Guidelines are also available on the MDCH website.

6.6 Program of All-Inclusive Care for the Elderly (PACE)

The Michigan Medicaid Nursing Facility Level of Care Determination form must be completed for every Medicaid beneficiary prior to admission to the PACE. The PACE agent must verify beneficiary appropriateness for services by completing the electronic web-based version of the Level of Care Determination form. Beneficiaries who do not demonstrate functional/medical eligibility through the electronic web-based tool are not eligible for PACE.

Information regarding the Michigan Medicaid Nursing Facility Level of Care Determination process, the form, and the Field Definition Guidelines are on the MDCH website. (Refer to the Directory Appendix for website information.)

While the PACE agency is the actual entity that must complete and submit the form, hospitals are encouraged to assess a beneficiary's function/medical eligibility for PACE using a copy of the form. A hospital may also use the Telephone Intake Guidelines. The Guidelines are also available on the MDCH website.

6.7 Private Duty Nursing

The beneficiary requires more individualized and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or skilled nursing facility. Private duty nursing (PDN) enables the beneficiary to remain in their home. This service is a benefit for beneficiaries **under age 21**.

If the beneficiary is enrolled in, or receiving case management services from, one of the following programs, the applicable program authorizes the PDN:

- Children's Special Health Care Services (CSHCS)
- Home and Community-Based Services Waiver for the Elderly and Disabled (MI Choice Waiver)
- Children's Waiver (Community Mental Health Services Program [CMHSP])
- Habilitation/Support Services Waiver (CMHSP)

For a beneficiary not receiving services from one of these programs, the CSHCS Program reviews the **request** for authorization.

The Prior Authorization for Private Duty Nursing (PDN) form (MSA-0732) must be submitted when requesting PDN services for persons with CSHCS or Medicaid coverage. A copy of the form is provided in the Forms Appendix and is also available on the MDCH website. (Refer to the Directory Appendix for website information.) This form is **not** to be used for beneficiaries enrolled in, or receiving case management services from, the Children's Waiver, Habilitation Supports Waiver, or MI Choice Waiver.

For beneficiaries **age 21 and older**, this service is a waiver service that may be covered for qualifying individuals enrolled in MI Choice Waiver or Habilitation/Support Services Waiver.

6.8 NURSING FACILITY

If the beneficiary requires less than acute, continuous medical care, a nursing facility (NF) may be appropriate. This includes a nursing home, medical care facility, or hospital long-term care unit. The Beneficiary Eligibility Chapter of this manual contains information on the Facility Admission Notice. (Any other alternatives for care, e.g., Home Help, may not be provided to the beneficiary while he is in the nursing facility.)

Medicaid's reimbursement (per diem rate) to a nursing facility includes nonemergency transport of beneficiaries being admitted to a nursing facility from the hospital setting.

There are necessary components for determining eligibility for Medicaid nursing facility reimbursement.

- A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be dated and the physician's degree must appear with the signature. The physician must initial a rubber-stamped signature.
- With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (MD or DO) must approve a beneficiary's need for long-term care not more than 30 calendar days prior to the beneficiary's admission to a nursing facility.
- Verification of Medicaid eligibility for nursing facility care as determined by the Department of Human Services (DHS).
- A Pre-admission Screening/Annual Resident Review (PASARR) process must be performed prior to admission to a nursing facility. The purpose of the screening is to prevent placement of beneficiaries with mental illness or mental retardation into a NF unless their medical needs clearly indicate that they require the level of care provided by a nursing facility. Level I screening is documented on the Pre-admission Screening (PAS)/Annual Resident Review (ARR) (Mental Illness/Developmental Disability Identification) form (DCH-3877). The Level I screening is part of the hospital discharge planning process ad must be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or physician.

  The PASARR process is not required when:

  - An individual is admitted to an Intermediate Care Facility for the Mentally Retarded (ICF/MR – Provider Type 65).
  - An individual is admitted to, and residing in, a hospital swing bed. However, the PASARR process must be completed prior to admission if the individual transfers to a nursing facility.

- A resident is readmitted to a nursing facility after a hospital stay. If the Annual Resident Review date occurs during a period of hospitalization, the screening must be completed within 30 days of admission or readmission to the nursing facility.

All individuals identified by Level I screening as possibly mentally ill or mentally retarded (a "yes" response to any question on the DCH-3877) must receive a Level II evaluation, unless it is documented that they meet one of the exemption criteria outlined on the Mental Illness/Developmental Disability Exemption Criteria Certification form, DCH-3878 or MDCH/PIHP/CMHSP finds that the individual does not meet the criteria for a serious mental illness under the PASARR provisions.

(Refer to the Forms Appendix for a copy of the forms.)

- A Michigan Medicaid Nursing Facility Level of Care Determination form must be completed for every Medicaid beneficiary prior to admission to a nursing facility. The nursing facility must verify beneficiary appropriateness for nursing facility care by completing the NF Level of Care Determination electronic web-based form. Beneficiaries who do not demonstrate functional/medical eligibility through the electronic web-based tool are not eligible for nursing facility care.

  Information regarding the Michigan Medicaid Nursing Facility Level of Care Determination process, the form, and the Field Definition Guidelines are on the MDCH website. (Refer to the Directory Appendix for website information.)

  The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the electronic web-based tool for:

  - All new admissions of Medicaid-eligible applicants where reimbursement is requested beyond co-insurance and deductible amounts.
  - All readmissions of Medicaid-eligible applicants where Medicaid reimbursement is requested beyond co-insurance and deductible amounts, and a LOC Determination was not previously completed for the original admission.

    Readmissions in general do not require resubmission of the tool; this applies only if a tool was previously submitted for the resident.

    Example: If a nursing facility resident was transferred to the hospital on November 28, 2004, then readmitted to the nursing facility on December 4, 2004, the LOC Determination must be applied to that resident if he has not been previously screened.

    This protocol must be followed for readmissions from November 1, 2004 through October 31, 2005.
  - Dually eligible beneficiaries who wish to return to their Medicaid nursing facility bed and refuse their Medicare SNF benefit following a qualifying Medicare hospital stay.

Completion of the Michigan Medicaid Nursing Facility Level of Care Determination is not required for:

- Hospice beneficiaries who are being admitted to the nursing facility for any services.
- Nursing facility readmissions where a Michigan Medicaid Nursing Facility LOC Determination was previously completed for the original admission and the beneficiary met the nursing facility criteria.
- Cases where Medicare is the primary payer of the claim and the facility is only billing Medicaid for hospital leave days.

While the nursing facility is the actual entity that must complete and submit the form, hospitals are encouraged to assess a beneficiary's functional/medical eligibility for nursing facility care using a copy of the form. A hospital may also use the Telephone Intake Guidelines. The Guidelines are also available on the MDCH website.

6.9 Special Nursing Facility Placement

6.9.A. Medicaid Ventilator Dependent Care

There may be occasions when a beneficiary no longer requires acute hospital care but requires specialized care in a Ventilator Dependent Care Unit (VDCU). Medicaid authorizes admission of ventilator dependent Medicaid beneficiaries to hospital and nursing facility ventilator units with which it has agreements to provide VDCU services.

A request for placement must show that:

- The beneficiary is dependent on life-supporting mechanical ventilating equipment for at least six hours per day.
- The beneficiary stay normally meets or exceeds the hospital high-day outlier threshold for DRG 475.

Approval for admission to a VDCU will not be given for a beneficiary who is only on CPAP or BIPAP.

If a beneficiary has weaning potential or requires other rehabilitative services (in addition to the respiratory care) and is enrolled in a Medicaid Health Plan (MHP), the MHP is responsible for the first 45 days reimbursement in the post acute setting. If there is no weaning potential and the beneficiary requires only custodial care, disenrollment from the MHP may occur at the time the beneficiary is discharged from the hospital.

In situations where a beneficiary cannot immediately be placed in a nursing facility or hospital VDCU, Medicaid will cover nursing days in the inpatient hospital. The hospital cannot charge a beneficiary the difference between the hospital's charge and MDCH's payment for nursing days.

When the beneficiary is in the hospital setting because a nursing facility placement is not available, Medicaid will cover the ancillary services provided by the hospital.

If a beneficiary refuses an appropriate placement to a VDCU, the beneficiary is responsible for all hospital charges incurred after the date of referral.

To initiate the prior authorization process for VDCU placement, the hospital discharge planner, case manager, or social worker must complete and submit a Medicaid Ventilator Dependent Care Assessment form (MSA-1634) and a Medicaid Ventilator Dependent Care Authorization form (MSA-1635). Copies of the forms are available on the MDCH website. (Refer to the Directory Appendix for website information.)

The beneficiary's physician must sign the MSA-1635, which serves as his attestation as to the medical necessity of the patient transfer from the acute care setting to a nursing facility setting. Physician assistant, medical assistant, or nurse practitioner signatures cannot be substituted for the physician's signature.

The MSA-1634 and MSA-1635 are to be submitted when the patient has exhausted other sources of reimbursement.

6.9.B. Memorandum Of Understanding

The Request for Prior Authorization for a Complex Care Memorandum of Understanding form (MSA-1576) is used to request prior approval (PA) for the placement of a Medicaid beneficiary for whom placement from a hospital has been, or could be, hindered due to the cost and/or complexity of nursing care or special needs. The PA covers an individually negotiated reimbursement rate for the placement. Special individualized placement requests and payment arrangements are based on medical necessity and/or service/supply needs exceeding those covered by Medicaid reimbursement for routine nursing facility care.

Examples include, but are not limited to:

- Ventilator dependent care (for nursing facilities not contracted with MDCH to provide ventilator dependent care)
- Multiple skin decubiti utilizing several treatment modalities
- Tracheostomy with frequent suctioning needs
- Beneficiaries who require intensive nursing care or treatment.

Program requirements:

- Referrals may come from either the acute care hospital or the nursing facility.
- Hospitals must document that at least ten (10) Medicaid certified nursing facilities within a 50 mile radius of the hospital refused to admit the beneficiary due to the complexity of the patient's care needs.
- Nursing facilities may request a MOU after admitting a beneficiary if the hospital failed to accurately document the beneficiary's condition and needs prior to transfer to the nursing facility. The nursing facility must request the MOU within 30 days from the date of admission to the nursing facility.

The following information must be submitted:

- A completed MSA-1576, including any requests for additional nursing, CENA, supplies or equipment. An electronic copy of the form is available on the MDCH website. (Refer to the Directory Appendix for website information.) The Michigan Medicaid Nursing Facility Manual contains information regarding what services are to be provided by the NF as part of the daily per diem reimbursement.
- The beneficiary's medical background, including current medical status, treatment/nursing care plan, and justification for any additional nursing hours and/or special equipment requested. (This information should be included on the MSA-1576).
- Recent (within the past 30 days) lab, x-ray, and diagnostic/therapeutic test results and/or reports.
- A list of nursing facilities within a fifty (50) mile radius that have denied admission due to the complexity of care the beneficiary required, including:
  - Name and address of the nursing facility
  - Contact person's name and title
  - Date of contact
  - Reason for denial
- Documentation of the financial resources available to the beneficiary, including:
  - Medicaid coverage
  - Medicare Parts A and B
  - Other commercial insurance coverage.
  - Name and telephone number of a contact person at the nursing facility requesting the MOU.

It may take up to three weeks for the MOU to be processed. If it appears that a beneficiary, upon discharge, will require intensive nursing care, the hospital's discharge planning coordinator should initiate the prior authorization process for the MOU as early in the beneficiary's hospital stay as possible to ensure a smooth transition to the nursing facility. (Refer to the Directory Appendix for contact information.)

The hospital or nursing facility will be contacted by telephone regarding Medicaid's ability to assist with the beneficiary's placement. If approved, the NF will receive a prior authorization number to be used when billing.

HOSPITAL REIMBURSEMENT APPENDIX

SECTION 1 - OUTPATIENT

1.1 REIMBURSEMENT METHODOLOGY

Reimbursement to hospitals for outpatient services is made in accordance with Medicaid's maximum fee screens, the hospital's usual and customary (U&C) charges, or Medicare's reasonable costs, whichever is less.

1.2 PSORIASIS TREATMENT CENTER REIMBURSEMENT METHODOLOGY

Outpatient hospital psoriasis treatment centers are reimbursed the lesser of the hospital's charge or the established Medicaid rate for the treatment episode. The rate includes all services that may be provided to the beneficiary, except physician services.

Outpatient hospital psoriasis services rendered to beneficiaries who do not meet the specified admission criteria for the outpatient psoriasis treatment center are reimbursed under the current fee-for-service (FFS) system.

SECTION 2 - INPATIENT

2.1 DIAGNOSIS RELATED GROUP ASSIGNMENT

The Medicaid diagnosis related group (DRG) reimbursement system uses the same Grouper logic that the Medicare Program uses to assign DRGs to claims. However, because Michigan Medicaid develops its own weights and prices based on its own paid claims, Medicaid may not use the same version of the Grouper program as Medicare is currently using.

Michigan Medicaid includes alternate weights for DRGs 385 through 390. These weights are used for neonatal intensive care services provided in hospitals with specially designated units approved for the alternate weight payments by the department.

A Grouper implementation schedule appears on the MDCH website. (Refer to the Directory Appendix for website information.) The schedule indicates the current Grouper and recent past Groupers that are used to assign DRGs to claims. There is also a spreadsheet posted on the website for each DRG Grouper that includes all DRGs included within the Grouper, a description of each DRG, the DRG's relative weight, its average length of stay, and low and high day outlier thresholds.

Use of a specific Grouper is determined by the patient's admission date.

2.2 SERVICES INCLUDED IN THE INPATIENT SYSTEM

The following services are included in the inpatient payment:

- All routine services (e.g., room and board, nursing).
- All diagnostic/ancillary services (e.g., radiology, pharmacy, therapists, supplies, pathology).
- While a patient is in the inpatient setting, the facility charges for any services performed by persons or entities other than the patient's hospital (e.g., an independent lab, a second hospital where no transfer occurs) are covered in the payment to the patient's hospital and must not be billed separately. All charges must be included on the inpatient claim of the patient's hospital. Any payments due to the second party are the responsibility of the patient's hospital.
- All pathology services that are performed by the pathologist but do not directly relate to the specific patient's care.
- All emergency room services provided by the hospital that result in an inpatient admission to that hospital. All charges must be included on the inpatient claim.
- An orthosis or prosthesis that is required for inpatient treatment, a surgical postoperative procedure or as a routine service of the hospital should be included as a supply on the inpatient invoice and is reimbursed under the appropriate DRG.

Examples of items that are included in the inpatient payment are:

- Pacemakers
- Hip replacements
- Made-to-measure braces for compression fractures
- Compression stockings (TED, Jobst)
- Halos
- Immediate post-surgical or early fitting of prosthetic devices, etc.

2.3 Services Excluded from the Inpatient Payment

The following services are excluded in the inpatient payment:

- An orthosis or prosthesis that is required for rehabilitation and will be utilized after discharge, and/or is required to address a long term, lifetime, permanent need. An Orthotist/Prosthetist must bill these items separately to Medicaid. Prior authorization (PA) must first be obtained for appropriate procedure codes.
- Except as noted above, outpatient services may not be separately billed while a beneficiary is in the inpatient setting. All charges must be included on the inpatient claim.
- Any services that are covered by Medicaid and excluded from the inpatient payment may be separately billed, if the provider of the service is properly enrolled in the program and a claim is submitted appropriately.

The following are examples of services excluded from the inpatient payment. This list may not be all-inclusive:

- Anatomic pathology services provided directly by a pathologist.
- Orthoses/prostheses required for rehabilitation that will be utilized after discharge, and/or are required to address a long term, lifetime, permanent need. Additional examples of items that are excluded from the inpatient payment are a knee-ankle-foot orthosis or an ankle-foot orthosis.
- Professional services (e.g., practitioner, dental, podiatric, optometric).
- Services provided by a certified nurse midwife (CNM).
- Services provided by a certified registered nurse anesthetist (CRNA).
- Ambulance services.

2.4 Inflation

Unless otherwise indicated, inflation rates are computed from the Data Resources, Inc. PPS-Type Hospital Market Basket Index. Wage adjustor inflation rates are derived from the employee cost component of the Data Resources, Inc. PPS-Type Hospital Market Basket Index. Updates are quarterly for the base year and annually for nonbase years. For hospitals with base year cost reporting periods ending other than the end of the quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.

2.5 Relative Weights

Statewide Relative Weights	A statewide relative weight is assigned to each DRG representing covered services.
Basis for DRG Assignment	DRG assignment is based on the diagnosis and surgical procedure codes included on the inpatient claim. Hospitals should use as many diagnosis and surgical procedure codes as necessary to accurately reflect the patient's condition during the hospitalization.
Calculation of the average Cost Per Episode	The average cost for episodes within each DRG is calculated by dividing the sum of the costs of the episodes by the number of episodes within the DRG.
Calculation of Relative Weights	The relative weight for each DRG is calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes.

The statewide relative weights calculated for the Michigan system utilize Medicaid and Children's Special Health Care Services (CSHCS) inpatient claims for admissions during four consecutive state fiscal years and hospital specific cost report data drawn from three consecutive cost report years used to establish the relative weights.

2.6 Episode File [Change Made 4/1/06]

The episode file is assigned DRG values using the appropriate Grouper and is adjusted to:

- Combine multiple billings for the same episode of service including:
  - Invoices for a single episode of service billed as a transfer from a hospital and an admission to the same hospital caused by a change of ownership and issuance of a new Medicaid identification (ID) number; and
  - Invoices for a single episode of service billed as a transfer from a hospital and an admission to a new hospital created by the merger of two or more hospitals and the assignment of patient bills from multiple hospitals to a single Medicaid ID number.
- Eliminate episodes with any Medicare charges. (For dual Medicare/Medicaid eligible beneficiaries, only claims paid a full Medicaid DRG are included.)
- Eliminate episodes assigned to DRGs reimbursed by multiplying a hospital's operating cost to charge ratio by charges.
- Eliminate episodes without any charges or days.
- Assign alternate weights for neonatal services. Two sets of weights are calculated for the six DRG classifications representing neonatal services (385-390). One set of weights is identified as alternate weights (385.1, 386.1, 387.1, 388.1, 389.1, and 390.1). These alternate weights are calculated from episodes that are assigned to one of these DRGs and include charges for services in an intensive care unit of one of the hospitals designated as having a neonatal intensive care unit (NICU). The remaining claims assigned to these DRGs are used for the other set of weights.

In order to receive the alternate weights, a hospital must have a Certificate of Need (CON) to operate a NICU or a special newborn nursery unit (SNNU) or the hospital must have previously received alternate weight reimbursement by Medicaid for its SNNU.

- Limit episodes to those from Michigan hospitals, including hospitals that are no longer in operation (provided that hospital cost report data is available).
- Limit episodes to those with a valid patient status (incomplete episodes are excluded as are additional pages of a multiple page bill where there is no initial claim containing a valid patient status).
- Eliminate episodes with a zero dollar Medicaid liability.
- Determine the 3rd and 97th percentile length of stays by DRG, the average length of stay, and the maximum length of stay.
  - Set the low day outlier threshold at the greater of one day or the 3rd percentile length of stay.
  - Set the high day outlier threshold at the lesser of the average length of stay plus 30 days or the 97th percentile length of stay.
  - If the DRG has less than an adequate number of episodes (currently 32), the low day threshold is set at one day. The high day threshold is set at the lesser of the average length of stay plus 30 days, the maximum length of stay, or the Medicare DRG 90th percentile length of stay (from the corresponding Grouper as published in the Federal Register). If the Medicare DRG also has an inadequate number of claims, then the threshold is set based upon the expert advice of the MDCH medical staff.
- Eliminate low day outliers. (Low day outliers are those episodes whose length of stay is less than the published low day threshold for each DRG. Since low day outliers are paid under a percent of charge method using the hospital's cost to charge ratio times charges, and do not receive a DRG payment, they are excluded from the weight calculations).
- Calculate the arithmetic mean length of stay for each DRG with each episode's length of stay limited to the high day threshold set above. This serves as the final published average length of stay.
- Limit episodes ending in a transfer to another acute setting to those whose length of stay was at least equal to the published average length of stay for the DRG (for DRGs 385 and 385.1, all transfers are included).
- Bring all charges for admissions in the first and second years of the base period up to third year charges through application of inflation and weighting factors.
- Recognize area cost differences by dividing the charges for each hospital by an area cost adjustor. Hospitals are grouped by U.S. Census Core Based Statistical Areas (CBSAs) as determined by the Centers for Medicare and Medicaid Services for the Medicare program for wage data. MDCH will not use hospital geographic reclassifications made under Section 508 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 to calculate the Medicaid area wage index. Each area cost adjustor is calculated as follows:

Cost Adjustor = 0.71066 x Wage Adjustor + 0.28934

- The cost adjustor formula reflects Medicare estimate of labor-related costs as a portion of total hospital costs as published in the Federal Register.
- Each area wage adjustor is wage per FTE divided by the statewide average hospital wage per FTE. Wage data is collected using the source described in the bulletin for the rate-setting period in question. Contract labor costs, as defined by Medicare, are included in determining a hospital's wage costs. Physician Medicare Part B labor costs are excluded.
- Each hospital's wage costs are adjusted for different fiscal year ends by multiplying the hospital's costs by inflation and weighting factors. All wages are brought to a common point in time.
- For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.
- The wage adjustor is based on a three-year moving average, with the most recent year weighted 60 percent, the second year weighted 24 percent, and the initial year weighted 16 percent.
- If two or more hospitals merge and are operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data is inflated to a common point in time.

- Indirect medical education (IME) charges are removed by dividing each hospital's adjusted charges by an IME adjustor. Each hospital's IME adjustor is calculated as follows:

$$1 + ([(1 + [\text{Interns \& Residents} / \text{Beds}] .5795 - 1] \times 0.5720)$$

(per bulletin MSA 06-15 effective 4/1/06)

  - The number of beds for each hospital is the average number of available beds for the hospital. Available licensed beds are limited to beds in the medical/surgical portion of the hospital. Interns and residents are only those allocated to the medical/surgical portion of the hospital.
  - Data taken from the hospital's cost report for the three fiscal years is weighted as follows: 60 percent for the most recent year, 24 percent for the middle year, and 16 percent for the oldest year.
  - If two or more hospitals merge and are operating as a single hospital, indirect medical education data is computed using the combined cost report data from all hospitals involved in the merger.

- Adjust charges for high day and/or cost outliers to approximate the charges for the nonoutlier portion of the stay.
  - If an episode's length of stay is greater than the high day outlier threshold for the DRG, then it is considered a high day outlier claim. Adjusted charges representing an estimate of the nonoutlier portion of charges for high day outliers are used for the relative weight and price calculations as follows:

$$\text{Adj Chrg} = \text{Chrgs} \times \text{High Day Threshold} / \text{High Day Threshold} + [.6 \times (\text{LOS} - \text{High Day Threshold})]$$

- An episode is a cost outlier if its costs (i.e., charges times hospital's operating cost to charge ratio) are greater than the cost threshold for that DRG (the threshold is set at the larger of twice the DRG payment or $35,000).
  - The cost to charge ratio is each hospital's inpatient operating cost to charge ratio, not to exceed 1.0.
  - The adjusted charges for cost outliers use a cost threshold estimate the greater of:

    Cost Threshold = 2 x Avg. Cost for DRG or $35,000.

  - Adjusted charges are calculated as follows:

    Adj Chrg = Chrgs – ([Chrgs x Cost Ratio] – Cost Threshold) x .85 / Cost Ratio

  - If an episode is both a high day and a cost outlier, the lesser of the two adjusted charges is used in computing the relative weights and DRG prices.

- The adjusted cost for each episode is calculated by multiplying the adjusted charges for the episode by the inpatient operating cost to charge ratio.
  - Each hospital's Title XIX inpatient hospital cost to charge ratio is obtained from the hospital's filed cost report for the fiscal year ending in the second year of the base period. If the cost to charge ratio is greater than 1.0, then 1.0 is used.
  - If two or more hospitals merge, and are operating as a single hospital, a cost to charge ratio for the period is computed using the combined cost report data from all hospitals involved in the merger. Cost and charge data is inflated to a common point in time.
- The average cost for episodes within each DRG is calculated by dividing the sum of the costs for the episodes by the number of episodes within the DRG.
- The relative weight for each DRG is calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes. A table showing the relative weights, average lengths of stay, and outlier thresholds for each DRG is available on the MDCH website. (Refer to the Directory Appendix for contact information.)

2.7 DRG PRICE

The episode file used for DRG price calculations is the same as the file used to set relative weights with the following exceptions:

- The episode file is limited to those hospitals enrolled as of a specified date.
- The case mix is calculated using the sum of all relative weights assigned to each hospital's claims during the base period, divided by the total number of episodes for the hospital during the same period.
- The adjusted cost for each hospital is summed.
- The hospital specific base price (cost per discharge for a case mix of 1.00) is computed.
  - Divide total adjusted costs by the total number of episodes.
  - Divide average costs by the case mix.

- Multiply the result by the applicable inflation factor. Costs are inflated through the rate period. Inflation factors are obtained from the Data Resources, Inc. PPS-Type Hospital Market Basket Index.

Determine the DRG base price by:

- Calculating each hospital's limited base price. This is the lesser of the hospital specific base price or the mean of all base prices, plus one standard deviation.
- Calculating the statewide operating cost limit. This is a truncated, weighted mean of all hospitals' limited base prices divided by base period discharges.
- The lesser of the truncated mean or the hospital specific base price then becomes the DRG base price (before the cost adjustor and incentives are added) for each hospital.

2.7.A. Incentive Calculations

For hospitals with base DRG prices below the operating limit (truncated mean), the hospital's base DRG price is increased by adding 10 percent of the difference between the hospital specific base price and the limit.

2.7.B. Updated Cost Adjuster

Adjust each hospital's DRG base price, plus any incentive, by the updated cost adjustor. The updated cost adjustor is calculated to reflect the most current data available in the same manner as the base cost adjustor, except that:

- Wage data is collected using the source described within the bulletin for the rate-setting period.
- The wage and benefit inflation factors are derived from the employee cost component of the Data Resources, Inc., PPS-Type Hospital Market Basket Index, relative to the period.
- In the event that changes in federal regulations result in incompatible data between the base and update periods, adjustments are made either to the base or the update period to render the data comparable.

2.7.C. Budget Neutrality Factor

A budget neutrality factor is included in the hospital price calculation. Hospital prices are reduced by the percentage necessary so that total aggregate hospital payments using the new hospital prices and DRG relative weights do not exceed the total aggregate hospital payments made using the prior hospital base period data and DRG Grouper relative weights. The calculated DRG prices are deflated by the percentage necessary for the total payments to equate to the amount currently paid.

2.7.D. Summary of DRG Price Calculations

To summarize the above, the DRG price for each hospital is calculated using the following steps:

1. Hospital's adjusted charges.
2. Inpatient cost to charge ratio.
3. Hospital's adjusted costs (line 1 * line 2).
4. Hospital's episodes.
5. Cost per discharge (line 3/line 4).
6. Hospital's case mix.
7. Weighted inflation.
8. Hospital's base price (line 5 * line 7/line 6)
9. Establish the statewide base limit (mean plus one standard deviation).
10. Hospital's limited base price (lesser of lines 8 or 9).
11. Establish the statewide operating cost limit (truncated, weighted mean of line 10).
12. Hospital's DRG base price (lesser of lines 8 or 11).
13. Calculate the hospital's incentive (if line 12 < line 11, 10 percent of line 12 - line 11, otherwise 0).
14. Hospital's DRG base price plus any incentive (line 12 +line 13).
15. Hospital's Area Cost Adjustor.
16. Apply budget neutrality factor.
17. Hospital's final DRG price (line 14 x line 15 x line 16). The DRG price is rounded to the nearest whole dollar amount.

2.8 Special Circumstances under DRG Reimbursement

In some special circumstances, reimbursement for operating costs uses a DRG daily rate. The DRG daily rate is:

(DRG Price x Relative Weight) / Avg LOS for the DRG

The average length of stay for each DRG is listed in the DRG Grouper on the MDCH website. (Refer to the Directory Appendix for contact information.)

2.8.A. High Day Outliers

The high day outlier threshold for each DRG is set at the lesser of the average length of stay plus 30 days or the 97th percentile length of stay; or 50 days, whichever is greater.

Reimbursement for high day outliers is:

DRG Price x Rel Wt + (Outlier Days x [(DRG Price x Rel Wt) / Avg LOS for the DRG] x 60%)

The multiplier for the daily rate is 60 percent for all services, including those provided in children's hospitals and children's distinct part units of at least 150 beds.

If an episode is both a high day and a cost outlier, reimbursement is the greater of the two amounts.

2.8.B. Low Day Outliers

For services where the length of stay is less than the published low day threshold, reimbursement is actual charges multiplied by the individual hospital's cost to charge ratio net of IME, not to exceed the full DRG payment rate. The specific low day outlier thresholds for each DRG are listed in the DRG Grouper on the MDCH website. (Refer to the Directory Appendix for contact information.)

2.8.C. Less than Acute Care

If a claim is a high day outlier and review shows that the beneficiary required less than acute continuous medical care during the outlier day period, Medicaid payment is made at the statewide nursing facility (NF) per diem rate for the continuous subacute outlier days, if nursing care was medically necessary.

2.8.D. Cost Outliers

An episode is a cost outlier when costs (charges x the hospital's operating ratio excluding IME) exceed the computed cost threshold. Claims paid a percent of charge cannot be cost outliers.

Reimbursement for cost outliers is dependent upon the cost threshold.

The cost threshold is the larger of:

- 2 x DRG Price x Rel Wt (twice the regular payment for a transfer paid on a per day basis for episodes getting less than a full DRG), or
- $35,000

Cost outliers will be reimbursed according to the following formula:

(DRG Price x Rel Wt) + ([(Charges x Operating Cost to Charge Ratio) - (Cost Threshold)] x 85 percent)

If an episode is both a high day and a cost outlier, reimbursement is the greater of the two amounts.

2.8.E. Transfers to a Hospital

Payment to a hospital that receives a patient as a transfer from another inpatient hospital differs depending on whether the patient is discharged or is subsequently transferred again.

If the beneficiary is subsequently discharged, the receiving hospital is paid the full DRG payment, plus an outlier payment if appropriate.

Reimbursement is based on discharge in the following situations. If the patient:

- Is formally released from the hospital;
- Is transferred to home health services;
- Dies while hospitalized;
- Leaves the hospital against medical advice; or
- Is transferred to a nursing facility.

If the beneficiary is subsequently transferred again, the hospital is paid a DRG daily rate for each day of the beneficiary's stay. The payment does not exceed the appropriate full DRG payment plus an outlier payment, if appropriate.

2.8.F. Transfers from a Hospital

Except in cases where the DRG is defined as a transfer of a patient (for which a full DRG payment is made, plus an outlier payment, if appropriate) the transferring hospital is paid a DRG daily rate for each day of the beneficiary's stay, not to exceed the appropriate full DRG payment, plus an outlier payment if appropriate.

2.8.G. Readmissions

Readmissions within 15 days for a related condition, whether to the same or a different hospital, are considered a part of a single case/episode for payment purposes.

If the readmission is to a different hospital, full payment is made to the second hospital. The first hospital's payment is reduced by the amount paid to the second hospital. The first hospital's payment is never less than zero for the episode.

Readmissions within 15 days for unrelated conditions, whether to the same or a different hospital, are considered new admissions for payment purposes.

2.8.H. Percent of Charge Reimbursement

The payment amount for claims that fall into DRGs 103, 468, 480, 481, 495, 512 or 513 is hospital charges times the hospital's cost to charge ratio excluding IME.

2.8.I. Hospitals Outside of Michigan

Medical/surgical hospitals not located in Michigan are reimbursed under the DRG system. The DRG price is the statewide operating cost limit (truncated mean of base prices for hospitals located in Michigan).

Hospitals that have charges that exceed $250,000 during a single fiscal year (using the State of Michigan fiscal year-October 1st through September 30th) may be reimbursed the hospital's cost to charge ratio for those Michigan Medicaid DRGs reimbursed by percentage of charge. The hospital's chief financial officer must submit and MDCH must accept documentation stating the hospital's Medicaid cost to charge ratio in the state that the hospital is located. Once accepted, the hospital's actual cost to charge ratio is

applied prospectively to those DRGs and claims subject to percentage of charge reimbursement using the Michigan DRG payment system.

2.8.J. New DRG Hospitals

A new hospital or unit is one for which no Michigan Medicaid Program cost or paid claims data exists during the period used to establish hospital specific base rates or one which was not enrolled in Medicaid when hospital specific base prices/rates were last established. Hospitals that experience a change of ownership or that are created as the result of a merger are not considered new hospitals.

The DRG base price for new general hospitals is the statewide operating limit until new DRG base prices are calculated for all hospitals using data from time periods during which the new hospital provided services to Medicaid patients.

2.9 Hospitals and Units Exempt from DRG Reimbursement

2.9.A. Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units [Change Made 4/1/06]

The per diem prices calculated for the Michigan Medicaid system utilize Medicaid and CSHCS inpatient claims for admissions during four consecutive state fiscal years. Hospital specific cost report data is drawn from three consecutive cost report years.

The claim file is limited to those hospitals enrolled as of the specified date.

The claim file is adjusted to:

- Eliminate episodes with any Medicare charges. (For dual Medicare/Medicaid eligible beneficiaries, only claims paid a full Medicaid payment are included).
- Eliminate episodes without any charges or days.
- Limit episodes to those from Michigan hospitals (provided that hospital cost report data is available for three consecutive fiscal years used for the base period, including hospitals that are no longer in operation).
- Limit episodes to those with a valid patient status (incomplete episodes are excluded as are additional pages of multiple page bills where there is no initial claim containing a valid patient status).
- Eliminate episodes with a zero dollar Medicaid liability.

Total charges and days paid are summed by hospital.

The cost for each hospital is calculated by multiplying the charges for the hospital by the cost to charge ratio for the hospital.

- Each hospital's operating cost to total charge ratio is obtained from weighted filed cost reports for fiscal years ending in the second year of the base period. If the cost to charge ratio is greater than 1.00, then 1.00 is used. For distinct part rehabilitation units, this ratio is unique to the unit.

- If two or more hospitals merge and are operating as a single hospital, a cost to charge ratio for the period is computed using the combined cost report data from all hospitals involved in the merger. Cost and charge data is inflated to a common point in time.

The cost per day by hospital is calculated by dividing the sum of the costs by the number of days for the hospital.

To determine a hospital specific per diem base rate:

- Multiply the cost per day by the applicable inflation factor. Each hospital's costs are inflated to a common point in time. Inflation factors are obtained from the Data Resources, Inc. PPS-Type Hospital Market Basket Index. The inflation update for the quarter in which the hospital's fiscal year ends is used.
- Recognize area cost differences by dividing the cost per day for each hospital by an area cost adjustor factor. Hospitals are grouped by U.S. Census Core Based Statistical Areas (CBSAs) as determined by the Centers for Medicare and Medicaid Services for the Medicare program for wage data. MDCH will not use hospital geographic reclassifications made under Section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to calculate the Medicaid area wage index. Each area cost adjustor is calculated as follows:

  Cost Adjustor = 0.71066 x Wage Adjustor + 0.28934

  - The cost adjustor formula reflects Medicare estimate of labor-related costs as a portion of total hospital costs as published in the Federal Register.
  - Each area wage adjustor is wage per full-time equivalent (FTE) divided by the statewide average hospital wage per FTE. Contract labor costs, as defined by Medicare, are included in determining a hospital's wage costs.
  - Each hospital's wage costs are adjusted for different fiscal year end dates by multiplying the hospital's wage costs by inflation and weighting factors. All wages are brought to a common point in time.
  - For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.
  - The wage data for distinct part rehabilitation units is the same as for the inpatient medical/surgical area of the hospital. The cost reports do not differentiate salaries/hours by unit type.
  - If two or more hospitals merge and are operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data is inflated to a common point in time.
- Remove indirect medical education (IME) costs by dividing by an adjustor for indirect education. Each hospital's IME adjustor is calculated as follows:

  1 + ([(1 + [Interns & Residents / Beds]) .5795 – 1] x 0.5720)
  (per bulletin MSA 06-15 effective 4/1/06)

- Distinct part rehabilitation units report this data separately. The IME adjustor is unique to the unit.
- Data taken from the hospital's cost report for the three fiscal is weighted as follows: 60 percent for the most recent year, 24 percent for the middle year, and 16 percent for the oldest year.
- If two or more hospitals merge and are operating as a single hospital, indirect medical education data is computed using the combined cost report data from all hospitals involved in the merger.

To determine the per diem rate:

- Calculate the statewide operating cost limit (by provider type). This is a weighted mean of all hospitals' specific base prices weighted by base period days (truncated mean), multiplied by the appropriate percentage.
  - For freestanding rehabilitation hospitals, the percentage is 150 percent.
  - The 50th percentile is determined by calculating a standardized rate for each unit. The standardized rate for all enrolled Michigan units are sorted in ascending order. The standardized rate of the first unit after the 50 percent of the units listed becomes the statewide 50th percentile.
  - For distinct part rehabilitation units, the percentage is 200 percent.
- Calculate the statewide operating cost minimum (by provider type). This is a truncated, weighted mean of all hospitals' specific base prices divided by base period days multiplied by 70 percent.
- The per diem base rate is the lesser of:
  - The greater of the hospital specific base price or the statewide operating cost minimum; or
  - The statewide operating cost limit.

Adjust each hospital's per diem base rate by the updated cost adjustor (to reflect a hospital specific per diem rate). The updated cost adjustor is calculated to reflect the most current data available in the same manner as the base cost adjustor, except that:

- The updated year data is the most recent completed Medicare audited wage data.
- The wage and benefit inflation factors are derived from the employee cost component of the Data Resources, Inc. PPS-Type Hospital Market Basket Index.
- In the event that changes in federal regulations result in incompatible data between the base and update periods, adjustments are made either to the base or the update period (whichever is more practical) to render the data comparable.

Calculate the final per diem rate by rounding to the nearest whole dollar.

2.9.B. Hospitals Outside of Michigan

Freestanding rehabilitation hospitals and distinct part rehabilitation units are reimbursed using a per diem rate. The per diem rate is the statewide weighted average per diem (truncated mean) for this provider type.

2.9.C. New Freestanding Hospitals and Distinct Part Units

If a hospital at least doubles the number of licensed beds in its distinct part unit and the number of licensed beds in the unit increases by at least 20, the entire unit is treated as a new distinct part unit for determining the per diem rate. In order for this provision to apply, the hospital must request in writing that the unit is treated as a new unit. The new unit per diem rate becomes effective on the date that the number of licensed beds doubles and the increase is at least 20 beds, or the date on which the request is received by MDCH, whichever is later.

New freestanding hospitals and distinct part units are reimbursed using the statewide average (weighted by days during the base period) per diem rate for the provider type.

A hospital/unit specific per diem rate is established when new rates are calculated using data from time periods during which the new hospital/unit provided services to Medicaid patients.

2.10 Frequency of Recalibrations

MDCH normally recalibrates hospital prices and ratios according to the following schedule. However, MDCH reserves the right to alter the schedule at any time without further notice to hospitals.

- Relative weights are recalibrated annually.
- DRG prices are rebased every three years and updated annually.
- Per diem rates are rebased every two years and updated annually.
- Cost to charge operating ratios are recalculated with each DRG/Per Diem rebasing.

2.11 Mergers

2.11.A. General Hospitals

In the event of a merger between two or more hospitals between DRG rebasing periods, the DRG price for the surviving hospital is computed as follows:

- Cost to charge ratio, IME, and wage data is inflated to a common point in time (for the surviving entity).
- No changes are made to the relative weights.
- The DRG price is computed with the same methodology as described in the section covering the computation of the DRG price, with the following exceptions:
  - No change is made to the statewide operating cost limitation.

- No change is made to the statewide average used to compute the update base wage adjustor.
- No change is made with respect to the statewide average used to compute the update wage adjustor.

- As part of recalibration or rebasing, all data is combined prior to adjusting the invoice file, as discussed in the section covering the recalibration/rebasing.

2.11.B. Freestanding Rehabilitation Hospitals / Distinct Part Rehabilitation Units

In the event of a merger between two or more hospitals between per diem rebasing periods, the resulting per diem rate for the surviving hospital is computed as follows:

- Cost to charge ratio, IME, and wage data are inflated to a common point in time (for the surviving entity).
- The per diem rate is computed using the same methodology as described in the section covering the computation of the DRG rates, with the following exceptions:
  - No change is made to the statewide operating cost limit.
  - No change is made to the statewide operating cost minimum.
  - No change is made to the statewide average used to compute the base wage adjustor.
  - No change is made to the statewide average used to compute the update wage adjustor.
- As part of recalibration or rebasing, all data is combined prior to adjusting the invoice file, as discussed in the section covering the recalibration/rebasing.

SECTION 3 - SPECIAL INPATIENT SITUATIONS

3.1 MEDICARE/MEDICAID CLAIMS

For patients treated in the inpatient setting with either Medicare Part A coverage or Medicare Part B coverage, no reimbursement is made for capital.

Exception: Where a patient is dually eligible for Medicare/Medicaid and his Medicare Part A benefits have exhausted, Medicaid reimburses the hospital for capital.

Prior to final settlement, hospitals must identify claims eligible to receive capital costs as a result of the patient's Medicare Part A benefits being exhausted. A copy of the Medicaid invoice and the Medicaid Remittance Advice (RA) page showing approval must be provided for these claims. The hospital must also provide a copy of the Medicare Explanation of Benefits (EOB) showing that the patient's Part A benefits have been exhausted. Failure by the hospital to provide this information results in these claims being excluded from its final settlement.

For patients with Medicare Part B coverage and no Medicare Part A coverage, the Medicaid payment amount is determined by subtracting the Medicare Part B payment from the Medicaid inpatient amount that would otherwise be approved (either under DRG or per diem).

For patients with Medicare Part A coverage, the Medicare payment and contractual adjustment is compared to the Medicaid inpatient amount that would otherwise be approved (either under DRG or per diem)

- If the Medicare amount is greater, no additional payment is made, even though a coinsurance or deductible amount may be due.
- If the Medicaid amount is greater, the difference is paid, up to a maximum of the Medicare coinsurance and deductible amounts due for the claim.

3.2 SUBACUTE VENTILATOR-DEPENDENT CARE

Payment for services provided to patients in Subacute Ventilator-Dependent Care Units (SVDCU) is made using a negotiated prospective per diem rate that includes capital and direct medical education costs. The per diem rate is based on cost estimates for the upcoming year. The negotiated per diem rate is not to exceed the average outlier per diem rate that would be paid for outlier days between DRG 541 and DRG 542. The payment rate for patients in subacute ventilator-dependent care units is an all-inclusive facility rate. No additional reimbursement is made for capital or direct medical education costs. These units are not eligible for indigent volume adjustor or indirect medical education adjustor payments.

The provider agrees to maintain separate accounting records for all costs associated with the dedicated ventilator-dependent unit using special procedures and instructions provided by MDCH.

- Providers must maintain a separate cost center consistent with the requirements of MDCH for all costs directly associated with the SVDCU, such as salaries, ancillary costs and others. The capital costs and other indirect costs are to be allocated to SVDCU using the method in accordance with Medicaid Long Term Care Cost Reporting requirements.
- SVDCU patient days and discharges must be reported separately under an inpatient cost center identified as SVDCU patient care on the cost report.
- Cost reporting for this separate SVDCU must be consistent for Medicaid and Medicare cost reporting.

3.3 Michigan State-Owned Hospitals

Reimbursement to Michigan state-owned hospitals is based on allowable costs as defined by Medicare principles of reimbursement (with TEFRA limits applied).

SECTION 4 - HOSPITAL REIMBURSEMENT BY MEDICAID HEALTH PLANS

4.1 MEDICAID HEALTH PLAN PAYMENTS TO OUT OF NETWORK HOSPITALS

Medicaid Health Plans are to reimburse out of network medical/surgical hospitals at Medicaid FFS DRG hospital prices. MHPs are to reimburse out of network freestanding rehabilitation hospitals and distinct-part rehabilitation units at Medicaid per diem rates. MHPs are to use the Medicare Grouper in use by Medicaid for the date of service to process out of network inpatient hospital claims, assign DRGs to determine relative weights, outliers, and average lengths of stay.

The hospital Medicaid operating cost to charge ratios in effect for the date of service are to be used in the calculation of low day outliers, cost outliers, and organ transplants (except kidney transplants which are paid under relative weights). With the exception of bone marrow, which is to be reimbursed based on the cost to charge ratio in each hospital, organ acquisitions are to be reimbursed at 100% of charges.

In addition to the DRG or per diem payment, a separate capital payment must be made for each out of network medical/surgical admission at the per discharge rate. A separate capital payment must also be made for each day a patient receives care in an out of network freestanding rehabilitation hospital and distinct-part rehabilitation unit. Capital payments for acute care and rehabilitation units and for freestanding hospitals will be updated annually.

4.2 TERMS OF SERVICE AND PAYMENT BETWEEN NONCONTRACTING HOSPITALS AND MHPS

To assure that all Medicaid beneficiaries have universal access to medically necessary covered hospital services, MDCH, in cooperation with Medicaid enrolled Hospitals and MHPs, developed a set of mutually identified obligations and a process to assure these obligations are met.

To acknowledge the responsibilities of MHPs and hospitals in noncontracting circumstances, a Hospital Access Agreement and MHP Obligations document were developed. Each Hospital is encouraged to execute the Hospital Access Agreement. Although execution of this Agreement is voluntary on the part of each Hospital, MDCH expects that substantially all Hospitals will sign and return the Agreement. Signed copies of the Hospital Access Agreement are to be submitted by Hospitals to MDCH. The Hospital Access Agreement is not a contract with a MHP.

4.2.A. DEFINITIONS

The definitions of terms used in this section and in the Hospital Access Agreement, MHP Obligations, and Rapid Dispute Resolution Process (RDRP) are as follows:

Authorization or Prior Authorization (PA)	Documented approval by a MHP for the medical services rendered to an Enrollee by a Hospital, based on clinical information provided to MHP and Pursuant to the Terms set forth in this chapter.
Beneficiary	An individual who has been determined eligible for Medicaid.

Certificate of Coverage	Certificate of Coverage means the written document approved by OFIS, which explains the scope of benefits, limitations of coverage and exclusions governing the Enrollee's health care benefit coverage pursuant to the MHP's Medicaid Contract with the State of Michigan.
Clean Claims	Clean Claims as defined in PA 187 OF 2000, being MCL 400.111i and OFIS bulletin 2000/09.
Covered Services	All required services for Medicaid Enrollees as defined by: ▪ Section 400.105 of the Michigan Compiled Laws, ▪ Title XIX of the federal Social Security Act, 42 USC 1395 et. seq., ▪ MDCH Program Manuals and Bulletins, ▪ The Contract between MHPs and the Michigan Department of Management and Budget for services rendered to Enrollees, and ▪ The Certificate of Coverage.
Emergency Medical Condition	Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: ▪ Serious jeopardy to the health of the individual or in the case of a pregnant woman, the health of the woman or her unborn child; ▪ Serious impairment to bodily functions; or ▪ Serious dysfunction of any bodily organ or part.
EMTALA	The Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd, that requires a Hospital to perform a medical screening examination of any individual presenting in its emergency department (ED) to determine if an emergency medical condition exists and to stabilize the individual's medical condition.
Enrollee	A Medicaid-eligible beneficiary who is enrolled in a MHP and who is either eligible at the time of service or determined retroactively eligible.
Hospital	Hospital means the licensed entity that executed the Hospital Access Agreement included below and which has the inpatient capacity that is necessary to provide covered services.
Medicaid Health Plan	MHP means a Medicaid managed care plan that provides medical assistance through the delivery of covered services to beneficiaries and that holds a Comprehensive Health Care Program Medicaid Contract with the State of Michigan.

Medicaid Rates	The entire amount payable by MDCH to Hospitals for covered medical services provided to Medicaid beneficiaries who are not enrolled in MHPs. It includes, without limitation, DRG payments, per diem payments for exempt units, outpatient fee screen payments and applicable pass-through payments. Any other available resources, such as Medicare or other insurances, reduce the amount payable.
Noncovered Service	A medical or health care service that is: ▪ Not covered by Medicaid, ▪ Not medically necessary; ▪ Not described in a MHP's Certificate of Coverage, ▪ Provided before or after a beneficiary is an enrollee in a MHP, or ▪ Nonemergency services for which the Hospital did not secure PA.
OFIS	OFIS means the Office of Financial and Insurance Services (OFIS) in the Michigan Department of Labor and Economic Growth (MDLEG).
Rapid Dispute Resolution Process	The process implemented by MDCH to administer and resolve claim disputes according to the terms set forth in the Rapid Dispute Resolution Process (RDRP).

4.2.B. Hospital Access Agreement

The Hospital Access Agreement (HAA) is between MDCH and the hospital, and applies when a hospital provides services to Medicaid beneficiaries who are enrolled in a MHP with which the hospital does not have a contract. Where a hospital and MHP have a contract, the terms of that contract governs each relationship, and the HAA does not apply. When a hospital and a MHP have a limited services contract, the HAA applies for all covered services outside the scope of the limited services contract. Since the HAA is not a contract between a hospital and MHP, it is expected that health plans will continue to use network-contracted providers where appropriate.

The HAA is based on the following principles:

- It is intended to provide access for all covered services that are available at a hospital for all Medicaid enrolled beneficiaries, and to provide for the payment and billing policies and procedures for those services, where the hospital and the enrollee's MHP have not entered into a contract.
- MDCH, hospitals, and MHPs believe that it is essential to encourage contracting as the preferred relationship between health plans and hospitals, and to preserve the freedom of contract between hospitals and MHPs.
- The hospital will be entitled to payment by a health plan for all covered services provided in accordance with the HAA, at Medicaid Rates.
- In the event a MHP does not make the payment to a hospital as required under the HAA, MDCH will deduct the unpaid amount from future health plan capitation payments and make such payment to the hospital in accordance with the HAA.

- MDCH requires that the contracts between the State and each MHP include a provision that each MHP will comply with the terms of the HAA.

The agreement covers:

- Provision of Covered Services
- Health Plan Payment
- MDCH Payment
- Authorization Requests-Post Stabilization
- Prior Authorization-Elective Admissions and Services
- Data Coordination
- Quality, Utilization and Risk Management (Q/U/RM)
- Orderly Transfer
- Claims
- Disputed Claims
- Payment
- Enrollee Hold Harmless
- Termination of the Agreement
- Parties to This Agreement
- Governing Law
- Notice of Change

A copy of the Hospital Access Agreement is available on the MDCH website. (Refer to the Directory Appendix for website information.)

4.3 MHP Obligations

The MDCH contract with each MHP contains an amendment regarding the MHP's obligation to a hospital when the MHP does not have a contract with the hospital to provide services to the MHP's Medicaid beneficiaries and where the hospital has signed a Hospital Access Agreement with MDCH.

The MHP makes efforts to utilize network-contracted services where appropriate.

The contract amendment specifies MHP requirements for:

- Timely processing of claims
- Authorization requests-post stabilization
- Disputed claims
- Claim payment
- Claims data coordination

- Quality, Utilization and Risk Management (Q/U/RM)
- Orderly transfers
- Dispute Resolution

A copy of the MHP contract and the Health Plan Obligation Amendment are available on the MDCH website.

4.4 Disputed Claims

A Rapid Dispute Resolution Process (RDRP) was developed to provide a method for hospitals and MHPs to resolve disputed claims when the parties cannot reach an agreement. The process is included and/or attached to both the Hospital Access Agreement and MHP contract with the State of Michigan.

SECTION 5 - CAPITAL

The initial reimbursement for capital is paid by separate Capital Interim Payment (CIP). CIPs are made using a semimonthly schedule (24 payments per year). The CIP amount is set using the most recent available cost data and an estimated impact of any applicable limits on capital. CIP amounts are set annually at the beginning of the hospital's fiscal year. CIPs may be adjusted due to significant changes in capital costs that are not reflected in the most recent cost report. Hospitals wishing to request a CIP adjustment must submit a written request to MDCH Hospital & Health Plan Reimbursement Division. (Refer to the Directory Appendix for contact information.)

Medicare's Principles of Reimbursement are used to determine Medicaid's share of allowable capital costs. MDCH policy is used to determine capital reimbursement.

5.1 DISTINCT PART REHABILITATION UNITS

If a hospital has a separate distinct part rehabilitation unit, a separate CIP, a separate comparison to actual costs and a separate determination of appropriate limits are made for the distinct part unit and the balance of the inpatient hospital.

5.2 CIP MONITORING

CIP is monitored based on quarterly reports submitted by the provider. These reports are due 30 days after the end of the quarter. Adjustments to CIP are made quarterly where significant changes in utilization are shown.

5.3 LIMITS ON CAPITAL

The limits on capital described in this section apply for fiscal years beginning on and after October 1, 1990. The net licensed bed days calculation for hospitals whose fiscal year begins after September 30, 1990 and before January 1, 1991 and that reduce their licensed bed capacity by delicensing beds or using the rural banked beds option before January 1, 1991 is made as if the reduction occurred on October 1, 1990.

5.4 CAPITAL COST SETTLEMENTS

For capital cost settlements for hospitals with fiscal years ending on and after January 1, 2002, filed cost reports, instead of audited cost reports, are used to complete a hospital's desk review and settlement prior to issuing a Notice of Program Reimbursement. Medicaid no longer waits for Medicare to complete its audit of a hospital's cost report before Medicaid does its cost settlement. In order to capture the maximum paid claims data, Medicaid final settlements are not calculated earlier than 27 months after the end of a hospital's fiscal year end.

For settlements prior to January 1, 2002, should the Medicare fiscal intermediary fail to provide an audited cost report for a hospital's fiscal year, Medicaid uses the hospital's filed cost report to complete its settlement.

5.5 Net Licensed Beds

Net licensed beds are used to determine net licensed bed days for capital reimbursement and include all beds temporarily delicensed, except for rural banked beds, with rural as defined below. Net licensed bed days are:

Total Licensed Bed Days - Rural Banked Bed Days

A hospital may apply for a reduction in net licensed bed days to subtract bed days unavailable due to construction or renovation. Such a reduction is only available for beds which are taken out of service for construction or renovation for a limited period of time and which are returned to active inpatient service at the end of the construction or renovation project. Documentation of the construction or renovation project is required.

Occupancy is:

Total Inpatient Days (Including Nursery Days) / Net Licensed Bed Days

5.5.A. Sole Community Provider Eligible Hospitals

If the hospital is eligible for sole community provider status (as defined by Medicare standards), the Medicaid share of allowable capital costs is reimbursed in full.

5.5.B. Rural Hospitals

If a hospital is located in a rural area, as defined below, capital reimbursement is limited if occupancy in the hospital is less than 60 percent during the hospital's fiscal year. A hospital is considered a rural hospital if it is located outside a city of 40,000 or more people by a distance of 10 miles or more (U.S. Census Bureau population data is used). For hospitals with occupancy less than 60 percent, the Medicaid reimbursement for capital is:

(Occupancy / 0.6) x Medicaid Share of Capital

If occupancy is at least 60 percent, the Medicaid reimbursement for capital is 100 percent of the Medicaid share of capital.

5.5.C. Other Hospitals

If a hospital is not eligible to be a sole community provider and is not located in a rural area, capital reimbursement is limited if occupancy in the hospital is less than 75 percent during the hospital's fiscal year. For hospitals with occupancy less than 75 percent, the Medicaid reimbursement for capital is:

(Occupancy / .75) x Medicaid Share of Capital

If occupancy is at least 75 percent, the Medicaid reimbursement for capital is 100 percent of the Medicaid share of capital.

5.5.D. Hospitals Outside of Michigan

Medical/surgical hospitals not located in Michigan receive a per case add-on amount to cover capital cost.

Freestanding rehabilitation hospitals and distinct part units of hospitals not located in Michigan receive a per diem add-on amount to cover capital cost.

The add-on amounts are an estimate of the statewide average paid to hospitals located in Michigan. Capital payments to out-of-state hospitals are not cost settled.

SECTION 6 - MEDICAID INTERIM PAYMENTS

Medicaid Interim Payments (MIPs) are available on a voluntary basis to all inpatient hospitals. MIPs are made on the second and fourth payroll of each month.

For hospitals electing MIP, at the beginning of each hospital's fiscal year, annual program liabilities are set for Title XIX and Title V. Separate amounts are computed for each of a hospital's inpatient provider numbers (e.g., if a hospital has a DRG type 30 ID number and a type 30 rehabilitation unit ID number, two sets of MIP amounts are calculated and made).

The MIP rate is adjusted to reflect any significant change in DRG price, per diem rate, or reimbursement method that affects the amount of a hospital's reimbursement.

6.1 DRG

If DRG reimbursed, calculation of gross program liability is as follows:

- (DRG Price x Discharges x Case Mix) + Other Payments.
- Discharges are from the most recent filed cost report.
- Case mix is hospital specific and drawn from MDCH paid claims files.
- Other payments is an MDCH estimate of the additional amount that is paid to the hospital for high day outliers, percent of charge reimbursed claims, and a deduction for estimated other insurance and patient-pay amounts.

6.2 PER DIEM

If per diem reimbursed, calculation of gross program liability is as follows:

- (Per Diem x Days) - (Other Insurance + Patient-Pay)
- Days are from the most recent filed cost report

6.3 LIMITS

For both DRG and per diem reimbursed hospitals/units, the MIP amount is based on a percentage of inpatient charges approved to inpatient charges filed from the prior year. Further, the MIP amount is limited based on application of a charge ceiling.

6.4 RECONCILIATION

An initial MIP reconciliation is done for operating costs only. Fifteen months after a hospital's fiscal year ends, reconciliation is done to compare the amount paid by MDCH to the claims approved for the fiscal year reviewed.

6.5 Data Corrections

MIP is an estimate of the amount due a provider in the interim. There is no appeal process. If there is a calculation mistake, the hospital must contact the Hospital & Health Plan Reimbursement Division (HHPRD) in writing explaining the situation. (Refer to the Directory Appendix for contact information.)

6.6 Monitoring

Hospitals that wish to receive MIPs must file quarterly utilization reports. MDCH specifies the format and time frames for the filing of these reports.

MIP is monitored based on the quarterly reports submitted by the provider. These reports are due 30 days after the end of the quarter. Adjustments to MIP are made quarterly where significant changes in utilization occur.

Hospitals may elect to be removed from MIP and receive payments for claims processed weekly. Hospitals removed from MIP are not allowed to reenter the MIP process.

If the MIP payment significantly exceeds the amount approved for two consecutive years, the hospital may be removed from MIP.

Hospitals under bankruptcy are automatically removed from MIP and are reimbursed for claims processed through the Claims Processing (CP) System.

SECTION 7 – SPECIAL PAYMENTS

7.1 DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Indigent volume data is taken from each hospital's cost report and from supplemental forms that each hospital must file with its cost report. Data from the most recent available filed cost report are used to calculate a disproportionate share adjustor. New adjustors are calculated and become effective concurrently with annual inflation updates. Separate indigent volume data is collected for and separate adjustors are applied to distinct part psychiatric units and distinct part rehabilitation units.

Indigent volume is measured as the percentage of inpatient indigent charges to a hospital's total inpatient charges. Indigent charges are the annual charges for services rendered to patients eligible for payments under Medicaid, CSHCS and Adult Benefits Waiver (ABW) plus uncompensated care charges. Uncompensated care is limited by Medicare standards and is offset by any recoveries.

No Medicare charges and no Medicaid obligation to cover premiums, co-payments, coinsurance and/or deductibles for beneficiaries who are dually eligible for both Medicaid and Medicare are to be included as a Medicaid charge for the purpose of calculating the amount of indigent volume to be reported on any line of a hospital's Indigent Volume Report. Also excluded are charges for Medicaid patients who have other insurance coverage and for whom the full payment, except for co-payment, coinsurance and/or deductible, comes from the insurance payer.

Uncompensated care, bad debt recovery, and/or Hill-Burton offset may be apportioned using the ratio of total inpatient medical-surgical charges to total charges, the ratio of total distinct part rehabilitation unit charges to total charges, the ratio of total distinct part psychiatric unit charges to total charges, and the total of outpatient charges to total charges.

7.1.A. INDIGENT VOLUME REPORT AND DISPROPORTIONATE SHARE ELIGIBILITY FORM

Each hospital must complete the Indigent Volume (IV) Report and Disproportionate Share Eligibility Form as a requirement for complete filing of its annual Medicaid cost report.

The cost report will not be accepted without the IV Report and the Disproportionate Share Eligibility Form.

In order to receive a disproportionate share adjustor other than 1.00, hospitals must also meet at least one of the four criteria on the Disproportionate Share Eligibility Form.

The IV Report is sent to the hospital by MDCH as part of the annual cost report package to be completed by the hospital and returned to MDCH.

In addition to completion of the IV Report, hospitals must complete the Disproportionate Share Hospital (DSH) Eligibility format in order to be eligible to receive DSH payments.

An example of the format follows.

Disproportionate Share Hospital (DSH) Eligibility

Hospital: _____
City: _____
Date: _____ FYE: _____

In order to receive a disproportionate share adjustor other than 1.00, hospitals must also meet at least one of the eligibility criteria (Items 1 - 4). Please indicate which of the following applies to your hospital as of the end of your current fiscal year.

1_____At least two (2) obstetricians with staff privileges at this hospital have agreed to provide obstetric services to individuals who are eligible for Medicaid services.

2_____This hospital is located in a rural area (as defined for purposes of section 1886 of the Social Security Act) and at least two (2) physicians with staff privileges at this hospital have agreed to provide obstetric services to individuals who are eligible for Medicaid services.

3_____This hospital serves as inpatients a population predominantly comprised of individuals under 18 years of age.

4_____On December 22, 1987, this hospital did not offer obstetric services to the general population, except in emergencies.

_____None of the above apply. The hospital is not eligible for a disproportionate share adjustor.

Each year, this form must be submitted to MDCH along with your cost report.

7.1.B. Medicaid Utilization Rate

In addition to the minimum requirements specified in the form, each hospital must have a Medicaid utilization rate of at least 1 percent. Medicaid utilization is measured as:

$$\frac{\text{Medicaid Inpatient Days (Whole Hospital, including Subproviders)}}{\text{Total Hospital Days (Whole Hospital, including subproviders)}}$$

Days are taken from filed hospital cost reports for fiscal years ending during the second previous state fiscal year. All charge, cost and payment data must be on an accrual basis for each hospital's cost reporting period ending during the second previous state fiscal year (i.e., DSH payments for state FY 1998 are calculated using data collected in state FY 1996).

7.2 Regular DSH Payments

7.2.A. $45 Million Pool

Medicaid inpatient DSH payments are made annually in a single distribution, based on charges converted to cost, using the hospital's cost to charge ratio. The payment will normally be made during the first half of the state fiscal year.

Each hospital's indigent volume is taken from hospital cost reporting periods ending during the second previous state fiscal year.

Title XIX charges used for computing DSH payments are the sum of Title XIX charges and Title XIX MHP charges from hospital IV Reports for cost periods ending during the second previous state fiscal year. Data for cost periods of more or less that one year is proportionately adjusted to one year.

Hospital total cost ratios are taken from hospital cost reporting periods ending during the second previous state fiscal year. If a hospital has more than one cost reporting period ending within this range, data from the two periods are added together and a single ratio is computed. If the ratio is greater than 1.00, a ratio of 1.00 is used.

1. DRG Reimbursed Hospitals ($37,500,000 allocated)

   The DSH payments for DRG reimbursed hospitals are split into two pools.

   A. Hospitals with at least 50 percent IV ($7,300,000). The share of the DSH payment for hospitals with at least 50 percent IV is based on a DSH share computed as follows:

      Title XIX Charges x Operating Ratio x (IV-0.5)

   B. Hospitals with at least 20 percent IV ($30,200,000). The share of the DSH payment paid to hospitals with at least 20 percent IV is based on the following DSH share amount. This is in addition to the amount from A. above.

      Title XIX Charges x Operating Ratio x (IV-0.2)

2. Per Diem Reimbursed Hospitals and Units ($7,000,000 allocated)

   The share of the DSH payment paid to hospitals with IV of at least 20 percent is based on a DSH share based on the following:

   Title XIX Charges x Operating Ratio x (IV-0.2)

3. Distinct-Part Rehabilitation Units ($500,000 allocated).

   The share of the DSH payment paid to hospitals with IV of at least 20 percent is based on a DSH share of the following:

   Title XIX Charges x Operating Ratio x (IV-0.2)

4. For items 1 through 3 above, the determination of the share of the allocated DSH pool is made using the DSH share of the following:

   (Hospital's DSH Share / Σ DSH Shares for the Group) x Allocated DSH Pool

5. The payment amount for each hospital is determined by comparing the results of the formula above to the individual hospital payment limit. Any amount not paid to a hospital because of the OBRA 1993 limits is returned to the pool and redistributed using the same formula as the initial distribution with hospitals over the ceiling removed from the calculation. This process continues until the entire pool is distributed. DSH amounts that cannot be paid because of the ceiling are withheld from hospitals in the following order:

   - **Distinct-Part Rehabilitation Unit DSH Payment**. Any hospital that is above the DSH ceiling that is eligible for payment from the distinct-part rehabilitation unit DSH pool forfeits DSH payments from the distinct-part rehabilitation unit pool in an amount necessary to get to the limit.
   - **DRG Reimbursed Hospital**. If a hospital is not eligible for a distinct-part rehabilitation unit DSH payment, or if forfeiting that unit's DSH payment is not sufficient to put the hospital below the DSH ceiling, the hospital forfeits DSH payments from the DRG hospital pool in an amount necessary to get to the limit.
   - **Per Diem Reimbursed Hospitals and Units**. If the two steps above are not sufficient to get the hospital below the DSH ceiling, the hospital forfeits DSH payments from the per diem reimbursed hospital and unit pool in an amount necessary to get to the DSH limit.

7.2.B. $5 Million Small Hospital DSH Pool

A total of $5 million in funding will be distributed annually to qualifying unaffiliated hospitals and hospital systems that received less than $900,000 in DSH payments from the regular $45 million DSH pool in state fiscal year 2004. Hospital systems were identified based on the most current information available to MDCH Medical Services Administration at the time the policy was established. A list of hospitals receiving payments under this pool is available on the MDCH website. (Refer to the Directory Appendix for website information.)

Medicaid inpatient DSH payments from the $5 million Small Hospital DSH Pool are made in a single distribution based on Title XIX charges and Medicaid utilization.

Title XIX charges used for computing DSH payments from this pool are the sum of Title XIX charges and Title XIX MCO charges from hospital cost reports for cost periods ending during the second previous state fiscal year.

The Medicaid utilization rate is based on the proportion of Medicaid inpatient days to total hospital days as specified in the Medicaid Utilization Rate subsection of this appendix. Each hospital's Medicaid utilization is taken from hospital cost reports for cost period during the second previous state fiscal year.

The formula to calculate the distribution of payments from the Small Hospital DSH Pool is as follows:

1. Hospital Title XIX Charges x Hospital Medicaid Utilization = Hospital Pool Factor
2. (Hospital Pool Factor / Σ of all Hospital Pool Factors) x Small Hospital DSH Pool Allocation

7.3 Special DSH Payments

7.3.A. Public Hospitals

Determination of annual special DSH payments for public hospitals is based on 100 percent of Medicaid and uninsured costs. Each public hospital's maximum payment is calculated as follows:

([Title XIX Costs + Uninsured Care Costs] - [Title XIX Payments + Uninsured Care Payments]) - Regular DSH payment

The maximum payment amount may be reduced if funds are not available to finance the payment.

7.3.B. Geographic Areas with Indigent Care Agreements

Annual DSH payments are made to hospitals for geographic areas covered by an Indigent Care Agreement (ICA) approved by MDCH. Separate pools will be established based upon local funds transferred to the state by one or more counties specifically for this purpose, a proportionate share of state dollars appropriated for the geographic area covered by the ICA, and federal financial participation funds. Pool size will be determined annually.

DSH payments will be made to hospitals with approved ICAs between themselves and nongovernmental entities established to provide medical care for the indigent population in eligible counties.

Payments will be made quarterly to eligible hospitals. To be eligible, hospitals must meet federal requirements for Medicaid DSH payments and have an approved ICA in place. Minimum federal requirements may be found above in this section. The DSH payment ceiling must be specified in the ICA. All local funds must be transferred to the state before payments by the state are made.

7.3.C. University with both a College of Allopathic and a College of Osteopathic Medicine

A DSH payment of up to $5 million is made annually to a hospital that has an agreement approved by MDCH that meets the following criteria:

- Meets the minimum federal requirements for DSH eligibility listed in item 1 of the Regular DSH Payments subsection above.
- Has in place an agreement between a university with a college of allopathic medicine and itself approved by MDCH. The agreement must include provisions for the

development of cancer prevention and control programs to be conducted using the funds provided by the hospital through the agreement.

- The agreement must include a schedule of activities and a budget.

Only one agreement per year is approved by MDCH for this purpose.

7.3.D. Indigent Funds DSH Pool

MDCH will annually fund an Indigent Funds DSH (IFDSH) Pool. The size of the pool is $45 million. To participate in distribution of funds from this pool, a hospital must be located in a county with a population greater than two million and meet the following criteria:

- Serve primarily children with at least $100 million in annual Medicaid charges; or
- Perform a minimum of at 6,000 Medicaid newborn deliveries.

Charges include those from both the Medicaid FFS and MHP programs. The paid claims file used to rebase hospitals on April 1, 2002 is used to determine which hospitals had at least 6,000 newborn deliveries. No agreement is needed to participate in this pool.

In computing the individual hospital's maximum payment from the IFDSH Pool, all other DSH payments that a hospital receives are counted against the hospital's DSH ceiling before allocating payments from the IFDSH Pool.

Funds from the pool are distributed equally to all hospitals meeting the initial criteria above up to each hospital's DSH ceiling. Once all hospitals meeting the initial criteria have reached their individual DSH ceilings, funds are then distributed equally to those hospitals meeting the second criteria. Funds continue to be distributed to hospitals in the second group until all hospitals have reached their DSH ceilings or until the pool is exhausted of funds. Any funds remaining in the pool after distributions to all eligible hospitals have been made lapse back to the state. Federal matching funds are not claimed on any funds that lapse. Any funds from this pool that lapse back to the state are not redistributed to any other DSH pools.

Aggregate Medicaid reimbursement to Medicaid inpatient hospitals is not allowed to exceed the federally imposed upper payment limit for DSH payments. Payments are made only to those hospitals that have accepted cost reports on file with MDCH by August 31st of the state fiscal year prior to the one in which the payment is made.

7.4 Calculation of DSH Ceiling

All charge, cost and payment data must be on an accrual basis for each hospital's cost reporting period ending during the second previous state fiscal year. Data should be separated by subprovider.

1. **Base Year Data**

   - Title XIX Charges – Base year Title XIX charges include Title XIX charges for those beneficiaries enrolled in MHPs and beneficiaries dually enrolled in Title V and Title XIX.

- Title XIX Costs – Multiply total base year Title XIX charges times the hospital's Title XIX cost to charge ratio for the cost reporting period to determine Title XIX Costs. (The cost to charge ratio should be inclusive of capital and medical education costs.)
- Uninsured Charges – Uninsured charges are charges for services provided to beneficiaries who do not have any insurance coverage or for services not covered by the patient's insurance coverage. (Services covered by Medicare and/or Medicaid are not included as uninsured charges.)
- Uninsured Costs – Multiply total base year uninsured charges times the hospital's cost to charge ratio to determine uninsured costs. (The cost to charge ratio should be inclusive of capital and medical education costs.) Hospitals may designate the appropriate ratio for this calculation as either the Title XIX cost to charge ratio or the overall hospital cost to charge ratio.
- Title XIX Payments – Title XIX Payments made by MDCH or MHPs for services are included in computing the base year Title XIX charges. (Payments must include capital and medical education payments.)
- Uninsured Payments – Uninsured payments are those made by or on behalf of an individual beneficiary for the services included in computing base year uninsured charges.

2. Adjustments to Base Year Data

- Special Adjustors – Payments made from special Title XIX pools must be subtracted from the base year Title XIX payments. These include, but are not limited to, special DSH payments made to publicly owned hospitals, special outpatient pool payments, and special outpatient adjustors paid to publicly owned hospitals. Anticipated current year special adjustor payments must be added to base year data.
- Base Year Cost Inflation – Inflation of base year costs (inpatient and outpatient) is computed using the DRI index of inflation for the entire hospital. Hospital costs are inflated to a common FYE and then to the state base year. Inflation of payments is computed from the hospital's rate change over time.

3. Selection of Ceiling Option

For purposes of the DSH ceiling, hospitals may elect to use only inpatient data or may combine inpatient and outpatient data. Unless hospitals specify otherwise, MDCH assumes that each hospital elects the option allowing the largest possible DSH payment.

The DSH ceiling calculation is:

Base Year (BY) Title XIX charges x Title XIX cost to charge ratio = BY Title XIX costs

BY Title XIX costs x inflation = Current Year (CY) Title XIX costs

BY uninsured charges x hospital specified cost to charge ratio = BY uninsured costs

BY uninsured costs x inflation = CY uninsured costs

BY Title XIX payments – BY DSH payments – BY special outpatient adjustors = BY adjusted payments

BY adjusted payments x inflation = BY inflated payments

BY inflated payments + BY special outpatient adjustor payments = BY payments for the uninsured
= BY payments

The ceiling is then:

CY Title XIX costs + CY uninsured costs – CY payments = CY DSH ceiling

7.5 Distribution of DSH Payments for Merged Hospitals

When two or more hospitals merge, eligibility for DSH payments after the merger is based on the combined cost report data of the merged hospitals. However, the surviving hospital may make a one-time election to receive its DSH payment based on the cost report data submitted by the individual hospitals prior to the merger. The surviving hospital must provide written notice of its election to MDCH within 30 calendar days of the effective date of the merger. If the surviving hospital's election is received by MDCH after the DSH distribution for the state fiscal year has been finalized, then it becomes effective in the following state fiscal year. The surviving hospital's one-time election continues to apply until the year data used to compute DSH eligibility and payment is drawn from a single cost report.

7.6 Medicaid Access to Care Initiative

To ensure continued access for Medicaid patients to high quality hospital care, MDCH established special funding pools. The pool dollar amounts are renewed annually and posted on the MDCH website.

To keep payments within the Medicare upper payment limits, separate pools are established for privately owned or operated hospitals and nonstate government-owned or operated hospitals for both inpatient and outpatient hospital services. Only hospitals located within Michigan, enrolled in Medicaid, open, treating, and admitting Medicaid FFS and MHP patients 10 days prior to a scheduled payment are eligible to receive distributions from these pools.

7.6.A. Pool Descriptions

7.6.A.1. Privately-Owned or Operated Inpatient Hospital Pool

This inpatient pool is computed based upon the total number of privately owned DRG reimbursed hospitals and distinct part rehabilitation units. Privately owned freestanding rehabilitation hospitals with Medicaid FFS payments also participate in this pool.

Hospitals with Medicaid inpatient FFS payments share proportionately in this pool based on each hospital's total Medicaid FFS inpatient payments divided by the total Medicaid FFS inpatient payments for all privately owned or operated hospitals and units.

7.6.A.2. Privately-Owned or Operated Outpatient Hospital Pool

This outpatient pool is computed based upon the total number of privately owned outpatient units of DRG reimbursed hospitals and privately owned outpatient hospital rehabilitation units.

Hospitals with Medicaid outpatient FFS payments share proportionately in this pool based on each hospital's total Medicaid FFS outpatient payments divided by the total Medicaid FFS outpatient payments for all privately-owned or operated hospitals and units.

7.6.A.3. NONSTATE GOVERNMENT-OWNED OR OPERATED INPATIENT HOSPITAL POOL

This inpatient pool is computed based upon the total number of nonstate government-owned DRG reimbursed hospitals and distinct part rehabilitation units. Nonstate government-owned freestanding rehabilitation hospitals with Medicaid FFS payments participate in this pool also.

Hospitals with Medicaid inpatient FFS payments share proportionately in this pool based on each hospital's total Medicaid FFS inpatient payments divided by the total Medicaid FFS inpatient payments for all nonstate government-owned or operated hospitals and units.

7.6.A.4. NONSTATE GOVERNMENT-OWNED OR OPERATED OUTPATIENT HOSPITAL POOL

This outpatient pool is computed based upon the total number of nonstate government-owned outpatient units of DRG reimbursed hospitals and outpatient hospital rehabilitation units.

Hospitals with Medicaid outpatient FFS payments share proportionately in this pool based on each hospital's total Medicaid FFS outpatient payments divided by the total Medicaid FFS outpatient payments for all nonstate government-owned or operated hospitals and units.

7.6.B. POOL SIZES

A historical list of MACI pool sizes is maintained on the MDCH website. (Refer to the Directory Appendix for website information.)

7.6.C. DISTRIBUTIONS

The distribution from these pools will supplement hospitals' regular DRG and per diem payments (for rehabilitation units and hospitals), and are not considered part of a hospital's FFS reimbursement. Medicaid payers that normally match MDCH's FFS payments to medical providers are not required to match the distribution payments from these pools as part of their FFS payments.

The pool dollar amounts will be renewed annually. The dollar amounts of the new pools will equal the previous year's total, plus an added inflation factor for the current year. The inflation factor will be taken from the Health Care Cost Review published quarterly by Global Insight. The report published for the calendar third-quarter prior to the beginning of the fiscal year being calculated will be used. The factor will be taken from the new CMS Hospital Prospective Reimbursement Market Basket (federal fiscal year) table. The moving average change for the final quarter of the fiscal year being

calculated will be used. The current year inflation factor will be added to the following year's base for each pool.

7.6.D. Payment Share

The inpatient and outpatient hospital files used to distribute MACI payments will include FFS payments made on behalf of both Medicaid and CSHCS eligible beneficiaries.

7.6.D.1. Inpatient Paid Claims File

To determine each hospital's share of a pool, MDCH will use paid claims for the fiscal year ending two years prior to the current fiscal year. Claims will be restricted to those paid by June 30th of the following year (e.g., paid claims from FY 2004 paid by June 30, 2005 will be used to calculate the FY 2006 MACI payments). The paid claims file will include all FFS payments made through the Medicaid Invoice Processing System including DRG and per diem payments, DRG outlier payments, and claims paid based on a percent of charge. Paid claims will include those with other insurance and patient-pay amounts. Inpatient services will include both acute and rehabilitation services provided through distinct part rehabilitation units, freestanding rehabilitation hospitals, and subacute ventilator-dependent care units. Services paid to LTC providers will not be included, with the exception of services paid to subacute ventilator-dependent care units with beds licensed as hospital beds. Revenue from licensed hospital beds utilized at less than an acute or rehabilitation level of care will be excluded from the paid claims file, with the exception of revenue from subacute ventilator-dependent care beds licensed as hospital beds. Payments made outside the Invoice Processing System, such as capital, graduate medical education (GME), and disproportionate share hospital (DSH), will not be included in the paid claims file used to distribute the MACI hospital pools.

7.6.D.2. Outpatient Distribution Data

MDCH will allocate payments from the outpatient hospital pools based on Medicaid FFS outpatient payments reported on the hospitals' Michigan Medicaid Forms (MMFs) for fiscal years ending two years prior to the current fiscal year. The MMFs must be submitted by June 30th of the following year the data is drawn from (e.g., data taken from the Michigan Medicaid Forms for FY 2003 submitted by June 30, 2004 will be used to calculate FY 2005 payments). Outpatient services will include both acute and rehabilitation services for Medicaid eligible beneficiaries. Payments will include other insurance and patient-pay amounts. Payments made outside the Invoice Processing System, such as capital, graduate medical education (GME), or disproportionate share hospital (DSH), will not be included in the payments used to distribute the MACI pools.

7.6.E. Allocation of Pools

MACI distributions are made prospectively based on historical data. Eligible hospitals will share disproportionately from each pool based upon a hospital's total paid claims (inpatient)/MMF payments (outpatient), divided by the total Medicaid paid claims/MMS payments for all eligible hospitals, times the dollar amount of the individual pool. If a hospital closes or is determined ineligible to receive distributions from a pool, its MACI distribution will be redistributed to the remaining eligible hospitals based on the original

distribution formula. In the event the MACI distributions would result in aggregate Medicaid payments exceeding the UPL, the size of the pool(s) will be reduced to bring the aggregate Medicaid payments within the UPL.

7.6.F. Limits to Individual Hospitals

Total Medicaid payments are limited by federal regulation to a hospital's charges for inpatient services and by state policy to the lower of charges or costs for outpatient services. These limits apply by hospital fiscal year for FFS reimbursed services. Hospitals may elect to receive less (but not more) than its calculated quarterly MACI payment. The amount by which a hospital elects to reduce its payment will be redistributed to the remaining eligible hospitals based on the original distribution formula until the respective MACI pools are empty. All MACI payments are final. If charge/cost limits are exceeded, the amounts in excess of the limits will be recovered from hospitals at the time of final settlement. Any funds recovered from hospitals at final settlement will not be redistributed.

Prior to the first quarterly MACI payment for each state fiscal year, each hospital will be notified of the amount of its calculated quarterly MACI payments. A hospital electing to reduce a portion of any MACI payment to avoid exceeding charge/cost limits must inform the state of the amount to be reduced by no later than two weeks prior to the scheduled payment date.

7.6.G. Payment Schedule

MACI payments are made within 45 days of the beginning of each quarter. Quarterly payments are made in four equal installments based on the annual amount each hospital is eligible to receive. However, if a hospital elects to reduce a portion of any MACI payment to avoid exceeding charge/cost limits, then that payment is reduced to the amount specified by the hospital.

7.7 Special Outpatient Hospital Adjuster Pools

7.7.A. Children's Hospital Pool

Qualifying children's hospitals will share annually in an outpatient adjuster pool of $695,000.

Eligibility for the pool is restricted to freestanding children's hospitals that incurred outpatient indigent hospital charges in excess of $20,000,000 (for hospital fiscal years ending in the second previous state fiscal year). Payments will be made only to hospitals that have accepted cost reports on file with MDCH by August 31st of the state fiscal year previous to the one in which the payment is made. These data are subject to review and appeal and will not be changed.

The pool of up to $695,000 will be distributed to eligible freestanding children's hospitals based on payments for services provided during the second previous state fiscal year (excluding the special indigent pool payments). Each eligible hospital will share in the pool proportionately using the ratio of the hospital's fiscal year Title XIX outpatient

charges (updated for inflation to September 30th in the state fiscal year in which the payment is made) to the sum of Title XIX outpatient charges for all qualifying hospitals.

7.7.B. PUBLIC HOSPITAL ADJUSTER POOL

Qualifying public hospitals will share annually in an outpatient adjuster pool.

Eligibility for the pool is restricted to public hospitals with outpatient indigent volume of at least 32% and incurred outpatient indigent charges of at least $35,000,000 (for hospital fiscal years ending in the second previous state fiscal year). Payments will be made only to hospitals that have accepted cost reports on file with MDCH by August 31st of the state fiscal year previous to the one in which the payment is made. These data are subject to review and appeal and will not be changed.

SECTION 8 - GRADUATE MEDICAL EDUCATION

8.1 SERVICE OF TEACHING PHYSICIANS

Medicaid uses the Medicare Principles of Reimbursement to determine Medicaid allowable costs in the hospitals setting. The administrative costs associated with teaching physician services as well as payment for direct patient care services provided by an intern, resident, or fellow in a teaching setting and supervised by a teaching physician are subject to guidelines and conditions developed and published by Medicare.

Teaching institutions and teaching physicians within those institutions must abide by the CMS physician guidelines which explain when services provided in a teaching setting can be billed to Medicaid on a FFS basis or must be reported as allowable medical education costs on the hospital's cost report. The most recent guidelines for when the program may be billed directly are found in 42 CFR §415.

The guidelines require the presence of the teaching physician during the key portion of the performance of a service in which a resident is involved for which payment is sought by the teaching physician (or the hospital on behalf of the physician). The medical record must fully support the physician presence and participation in the service provided. There are exceptions and other considerations that may apply. Consult the full text of the guidelines to be sure you are in compliance for both Medicare and Medicaid.

Medicaid covers preventative medicine services that Medicare does not cover. For Medicaid, preventative medicine evaluation and management services are identified by procedure codes 99381 through 99397. These preventative medicine services may be provided without the presence of the teaching physician as long as all other requirements for the "presence" exception for E/M services furnished in certain primary care centers are met. Follow-up for any abnormal findings during a preventative medicine visit is subject to the teaching physician guidelines for all E/M services.

8.2 FORMULA PAYMENTS TO HOSPITALS FOR HEALTH PROFESSIONS EDUCATION

Payments are made directly to hospitals by formula from three pools of funds. Payments are fixed, prospective payments, made in full, not subject to future cost settlement, or appeal. Payments are made only to hospitals that provide requested information by the dates required.

8.3 DISTRIBUTION OF GME FUNDS

Distribution of graduate medical education funds is calculated annually for three formula pools: the Dental and Podiatry, the GME and the Primary Care. In order to receive funds for GME, a hospital must have operated a nationally accredited medical education program(s) in the fiscal year that data is drawn from the hospital cost reports used to calculate the GME payments. Payments are fixed, prospective payments, made in full and are not subject to future cost settlement or appeal. Payments are made only to hospitals that provide requested information by the dates required. Payments are made quarterly by gross adjustment. Separate gross adjustments are made for each pool payment.

Only intern and resident full time equivalents (FTEs) in approved programs as specified in *Federal Regulations* (see 42 CFR §413.86) are eligible for inclusion in the data used to calculate the distribution of the Dental and Podiatry, the GME and Primary Care Pools.

- To obtain an average FTE payment for dental and podiatry residents, the GME liability for hospitals operating dental and podiatry residency programs only are summed. Hospital GME liability data is drawn from calendar year 1995 filed hospital cost reports used to calculate GME payments made to hospitals between July 1, 1997 and December 31, 2001. The summed total of these liabilities is divided by the total number of dental and podiatry FTEs as reported by the same hospitals and from the same filed cost reports that the GME liability data is drawn. The product is an average dental and podiatry FTE payment that is made to all hospitals reporting these FTEs.
- Annually, each hospital reporting dental and podiatry FTEs is reimbursed the average dental and podiatry FTE payment, as calculated above, for each dental and podiatry FTE it reports. Data for each hospital's dental and podiatry FTE count is drawn from the hospital cost report (Worksheet E-3, Part IV, line 3.11). If the cost report is changed, equivalent data is used. Dental and podiatry FTEs are drawn from hospital cost reports for the same state fiscal year that FTEs are drawn to distribute the GME and Primary Care Pools.
- The dental and podiatry FTE payments made to all hospitals are summed and the total is deducted from the GME Pool before any other distributions are made from this pool.
- Once the dental and podiatry FTE payments have been deducted, the remaining funds in the GME Pool are distributed as described later in this section.
- Each hospital's dental and podiatry FTE count and the total dollar amount allocated to pay hospitals for dental and podiatry FTEs is updated annually. The average dental and podiatry FTE dollar payment is not. The average dental and podiatry FTE dollar payment is adjusted only when the GME Funds and Primary Care Pools are adjusted. Any adjustment to the average dental and podiatry FTE dollar payment is proportional to the changes in these two pools.

To distribute funds from the GME and the Primary Care Pools, data is drawn from accepted hospital cost reports for the most recent fiscal year that data is available. For the GME Pool, the unweighted FTE count is used (line 3.05 from E-3, Part IV). For the Primary Care Pool, the weighted FTE count for primary care physicians is used (line 3.07 from E-3, Part IV). If the cost report is changed, equivalent data is used.

Both the hospital and its residency programs must be operating during the funding period in order to receive GME funds. Hospitals must notify MDCH in writing at least 30 days prior to the termination date of any of its residency programs. Funds distributed to ineligible hospitals are subject to recovery.

GME payments to hospitals that merge are combined, provided that the surviving hospital continues to operate all residency programs that the pre-merger hospitals operated. The surviving hospital must notify MDCH within 30 calendar days after the merger is completed of any reductions or terminations to its residency programs. The GME payments to the surviving hospital are reduced proportionately to the reduction in its GME programs. Overpayments to surviving hospitals based on reductions in GME programs are subject to recovery.

GME funds not distributed during an academic year because a hospital closes or because one of its residency programs is terminated or is reduced in size are added to the GME Innovations Grants Pool for distribution during the next GME Innovations Grants awards cycle.

8.4 GME Pool [Change Made 4/1/06]

Adjustments made to the amount of the GME Pool due to legislative action or executive order are posted on the MDCH website. (Refer to the Directory Appendix for website information.)

The dollar amount of this pool is appropriated annually by the legislature. To calculate each eligible hospital's share of the GME Pool, the following formulas are used:

FTEs x Casemix x (Hospital's Title V & Title XIX Days / Hospital's Total Days) = Adjusted FTEs

$150,459,500 x (Adjusted FTEs / Σ Adjusted FTEs) = Hospital's Distribution
(per bulletin MSA 06-14 effective 4/1/06)

8.5 Primary Care Pool [Change Made 4/1/06]

Adjustments made to the amount of the Primary Care Pool due to legislative action or executive order are posted on the MDCH website. (Refer to the Directory Appendix for website information.)

The dollar amount of this pool is appropriated annually by the legislature. To calculate each hospital's share of the Primary Care Pool (P.C. Pool), the following formula is used:

FTEs x (Hospital's Title V & Title XIX Outpatient Charges/Hospital's Total Charges) = Adjusted FTEs

$18,495,300 x (Adjusted FTEs / Σ Adjusted FTEs) = Hospital's Distribution
(per bulletin MSA 06-14 effective 4/1/06)

8.6 Definitions/Notes

Title V & Title XIX Days	Includes FFS and managed care days. Days include those from distinct-part psychiatric and distinct-part rehabilitation units.
Title V & Title XIX Outpatient Charges	Includes FFS and managed care outpatient charges. Charges include those from distinct-part psychiatric units.
Hospital's Case Mix	The sum of the hospital's payments for all Medicaid admissions divided by the number of Medicaid admissions during the period covered. This figure is then divided by the hospital's price or rate.
# of Hospital Eligible Resident FTEs	Number of Hospital Eligible Resident FTEs for the GME Funds and Primary Care Pools FTE data is drawn from hospital cost reports as indicated above.

8.7 Three Year Phase-In of Revised GME Formula

In order to reduce the short-term impact that the revised formulas and distributions of GME funds will have on any hospital, MDCH will use a three-year phase-in period. During the first full year (FY 03), GME payments will be based three-quarters on the prior distribution as established in MDCH Bulletin 96-15, issued December 16, 1996, and one-quarter based on the revised formula published in this manual. During the second year (FY 04), the ratios will be one-half each. In the third year (FY 05), payments will be based on one-quarter of the old formula and three-quarters of the new formula. In the fourth year, GME payments will be made based entirely on the new formula.

8.8 Payment Schedule

Payments from the GME and Primary Care Pools will be made in four equal quarterly amounts by gross adjustment. Payments from the Dental and Podiatry Pool will be made once annually.

8.9 GME Innovations Grants

To encourage the innovative training of future health care professionals, a special pool may be established that will be distributed to projects or organizations to develop creative, new health professions education programs. The pool may be established bi-annually. The size of the pool is subject to the availability of funds. Competitive grants are awarded to qualified applicants that respond to a request for proposal (RFP) issued by MDCH for this purpose. Grants are awarded to projects that support public policy goals and priorities included in the RFP that is issued.

Grants are awarded only to health professions education programs that are accredited by national and/or regional accrediting agencies. Improved care and treatment of Michigan Medicaid patients must be the focus of any grant awarded. Payments are limited to enrolled Medicaid providers that will act as the fiduciary for the grantee. Grants may be awarded for multi-year periods. Additional details will be included in the RFP released for the grants.

SECTION 9 - COST REPORTING REQUIREMENTS

Each hospital, unless specifically exempt, is required to submit a Medicaid Cost Report package to the MDCH Hospital & Health Plan Reimbursement Division (HHPRD) on or before the last day of the fifth month following the close of its cost reporting period. The HHPRD grants extensions only when a hospital's operation is adversely affected due to circumstances beyond its control (e.g., staffing turnovers are considered within the control of the hospital, whereas fires and floods would be considered beyond its control). If a hospital fails to submit a completed cost report package on time and has not been granted an extension of the time limit, a notice of delinquency is issued. If the cost report package is not submitted within 30 calendar days from the date of the notice of delinquency, the hospital's interim payments are terminated until the cost report package is received and accepted by MDCH. Payments withheld due to late submission are paid upon acceptance of the cost report package.

The cost report package covers a 12-month cost reporting period unless the Medicare and Medicaid Programs have granted prior approval. Approval for filing a cost package for a period less than 12 months may be granted when a hospital changes the end date of its cost reporting period. In such case, the hospital is required to file a cost report package for the period between the end of the original cost reporting period and the beginning of the new cost reporting period.

Hospitals with subacute ventilator dependent care units must obtain Medicaid approval to file cost report packages treating the unit as a subprovider in accordance with the HIM-15 2336, 2336.1, 2336.2, and 2336.4. Medicaid approval must be requested in writing from the HHPRD and must be obtained prior to the start of the first hospital fiscal year during which the exemption applies.

Each hospital's cost report data must include an itemized list of all expenses recorded from the formal and permanent accounting records of the facility. The accrual method of accounting is mandated for all facilities not owned by government. Generally accepted accounting principles must be followed. All of the hospital's accounting and related records including the general ledger, books of original entry, and statistical data must be maintained for at least three years after receipt of final settlement (42 CFR § 405.406 and Provider Reimbursement Manual §2304.85; 42 CFR §405.1885). These records must be made available for verification during on site visits by state or federal audit staff. All cost report packages are retained by MDCH for at least three years following the date of settlement.

MDCH will notify providers by letter of the specific information needed to file an acceptable Medicaid cost report package. The cost report package must include:

- The HCFA 2552 Medicare standardized electronic cost report (ECR) filed in the manner required by MDCH for Medicaid reporting.
- Medicaid specific filed data report, with worksheets including, but not limited to: General Hospital Information, Settlement Summary Page, Capital Cost, GME, Rehab Unit Settlement, Outpatient Education Settlement, the Indigent Volume Report form for both Title V and Title XIX, and Managed Care Organization (MCO).
- Supplemental compatible spreadsheet forms for the calculation of Other Direct Medical Education Costs and Outpatient Education Costs.
- A signed Medicaid Certification form produced by the Medicaid filed Data Report Application for both Title V and Title XIX.

- The hospital's audited Financial Statements.

Instructions for filing all Medicaid specific forms and reports are detailed in the document Michigan Medicaid Filing Forms Instructions. This document and a copy of the blank forms are included with the MDCH notification letter. The cost report package must be sent to MDCH HHPRD. (Refer to the Directory Appendix for contact information.)

The cost report package is only accepted if all the following conditions are met:

- All the electronic and paper documents are included in the package in a usable format.
- MDCH can generate a full HCFA 2552 cost report from the electronic cost report file. MDCH uses the Peat Marwick CompuCost/CompuMax system to generate cost reports.
- Data entered in the Michigan Medicaid filed Data Report Application must tie to the HCFA 2552 cost report numbers as described in the instruction document included with the forms.
- The signed Certification form for Title V and Title XIX tie to the Medicaid settlement summary forms.
- Data is provided for all authorized Medicaid units and programs (Medical/Surgical, Rehabilitation, Outpatient, Psychiatric, Clinic for Title XIX and/or Title V).
- Data meet a set of reasonableness checks or variations are explained.

SECTION 10 - AUDITS

The audit and settlement process determines the amount of reimbursement to which an individual hospital is entitled. The field audit assures that only allowable costs and allowable revenues are recognized. Cost settlements are made to assure payment of the Medicaid share of reimbursable cost. The audit and settlement process begins with the receipt of the hospital's annual cost report and ends with the issuance of the Notice of Amount of Program Reimbursement, a letter that conveys the results of the audit.

10.1 DESK AUDIT

The audit process includes desk audit procedures and audit scope determinations for both Medicaid audit verification purposes and, under the Common-Audit Agreement with the Medicare fiscal intermediary, determination of allowable costs. All cost reports are examined to:

- Verify the completeness and arithmetic accuracy of all schedules in the report;
- Reconcile reported hospital program data with MDCH approved data;
- Identify the need for supporting documentation and arrange to receive same;
- Identify the need for field audit examination necessary to conclude final cost settlement calculations; and
- Compare reported data with industry norms as an aid to the audit desk scope determination.

10.2 FIELD AUDIT

Field audits are performed in accordance with the U. S. Department of Health and Human Services (HHS) requirements for federal participation and include appropriate auditing procedures and techniques, defined by the Common-Audit Agreement and/or the Field Audit Section of the HHPRD. Field audit findings are submitted to the HHPRD to be used for the settlement process.

Audits are performed for Michigan inpatient hospital services provided on and after February 1, 1985 to determine program cost for capital using Medicare Principles of Reimbursement.

10.3 MALPRACTICE

Medicaid accepts the audited Medicare cost report that includes 8.5 percent of malpractice cost in the administrative and general cost center. In a manner that differs from Medicare policy, the remaining 91.5 percent of malpractice cost, the risk factor, is apportioned based on Medicaid utilization that is the ratio of Medicaid inpatient program charges, outpatient program charges, and subprovider program charges to total hospital charges.

For intermediary reopenings applicable to cost reporting periods beginning on or after July 1, 1979, Medicaid accepts the audited Medicare cost report amendment that apportioned 8.5 percent to the administrative and general cost center. The 91.5 percent risk factor is apportioned as stated above. All appropriate cost limitations and disincentives apply to cost reports reopened by the intermediary.

Audited cost reports that are received from the Medicare intermediary with court decisions incorporated are accepted by Medicaid.

SECTION 11 - SETTLEMENTS

Settlement is based upon processed invoices for services rendered to Medicaid beneficiaries during the cost reporting period.

11.1 SETTLEMENT - INPATIENT

After the end of the hospital's fiscal year, the total amount paid for inpatient capital is settled. Any corrections of DRG or per diem prices not reflected in claim adjustments are incorporated at this time. Further, total payments for inpatient services are limited to the lesser of operating amount approved (DRG, per diem, and the operating portion of any percent of charge payments), plus capital less any limits that apply, or full charges. This limitation is applied separately by program against the aggregate operating amount approved and capital.

11.2 SETTLEMENT - OUTPATIENT

For testing against the Medicare upper limits, the outpatient amounts approved are compared to allowable outpatient charges and to allowable outpatient costs. Final reimbursement is limited to the lesser of these items. Separate settlements are made for each program and each provider number within a hospital.

11.3 SETTLEMENT - OUTPATIENT DIRECT MEDICAL EDUCATION

Medicaid pays the Medicaid share of the cost of approved outpatient medical educational programs at the time of final settlement. This policy covers costs incurred after November 1, 1983 and prior to July 1, 1997, and is for Medicaid only. ABW and CSHCS outpatient direct medical educational costs are not reimbursed.

Individual departments calculate the Medicaid portion of outpatient direct medical education costs. Approved Medicaid outpatient charges are multiplied by the ratio of approved direct medical education costs to total charges from the audited Medicare cost report.

11.4 INITIAL SETTLEMENT(S)

Initial settlements may be calculated using the cost information determined from the cost report and from charges for services to Medicaid beneficiaries as accumulated by MDCH.

11.4.A. UNDERPAYMENTS TO A HOSPITAL

MDCH pays the full amount of an initial settlement due a hospital through a debit gross adjustment. However, MDCH retains the right to withhold a portion of an initial payment based on individual circumstances.

11.4.B. OVERPAYMENTS TO A HOSPITAL

Once a determination of overpayment has been made, the amount so determined is a debt owed to the State of Michigan and is recovered by MDCH through a credit gross adjustment after notice has been furnished to the hospital.

11.5 Final Settlement

Once MDCH audit staff and/or the Medicare fiscal intermediary complete a field audit, there is an additional settlement. After review of the cost report and any statistical and audit findings pertaining to it, the HHPRD calculates the final settlement amount to be reimbursed for the period covered by the cost report and sends the hospital a Medicaid audit adjustment report. Once this is done, the Medicare/Medicaid CMS 2552 report will not be amended.

11.5.A. Underpayments to a Hospital

MDCH pays the full amount of the final settlement through a debit gross adjustment.

11.5.B. Overpayments to a Hospital

Once a determination of overpayment has been made, the amount so determined is a debt owed to the State of Michigan and is recovered by MDCH through a credit gross adjustment after notice has been furnished to the hospital.

11.6 Post-Audit Conference

The Post-Audit Conference is an informal process by which the audit staff and the hospital may resolve differences prior to a formal hearing and/or appeal. The process is initiated by the hospital after the receipt of the Audit Adjustment Report. The HHPRD concludes the process on the day the Notice of Amount of Program Reimbursement is mailed to the hospital.

11.7 Audit Adjustment Report

The Audit Adjustment Report contains a descriptive list of all program data adjustments made to a cost report by the HHPRD audit staff.

In the event a hospital has any disagreement with adjustments made by the Medicare fiscal intermediary on the Medicare audited cost report, such differences must be appealed to the Medicare Program. All other adjustments are subject to review under the applicable Medicaid reimbursement program.

11.8 Notice of Amount of Program Reimbursement

The Notice of Amount of Program Reimbursement is the notice of final determination and is considered the offer of settlement for all reimbursement issues for the cost reporting period under consideration. A hospital that takes exception to the Notice of Amount of Program Reimbursement with respect to any adjustment may request a formal hearing.

11.9 Settlement Appeal

A request for a hearing must be filed within 180 calendar days after the Notice of Amount of Program Reimbursement is mailed by MDCH to the hospital. Upon the timely receipt by the MDCH of an Application to Appeal Amount of Program Reimbursement, rules R400.3408 through R400.3424 shall be invoked.

11.10 Hospital Accepts Audit Adjustment Report

If the hospital accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the hospital should sign the report and mail it to the HHPRD. A Medicaid Notice of Amount of Program Reimbursement is then mailed to the hospital.

11.11 Hospital Rejects Audit Adjustment Report

If the hospital rejects any or all of the findings contained in the Audit Adjustment Report, the hospital must indicate in writing to the HHPRD the area of disagreement, stating the appropriate regulation and/or other decisions supporting the hospital's position.

The HHPRD responds by letter to issues raised by the hospital. If the hospital does not agree with the audit adjustments after receiving the HHPRD's response, the hospital may request a Bureau Conference.

11.12 Hospital Does Not Respond to Audit Adjustment Report

The Audit Adjustment Report must be accepted or rejected by the hospital within 30 calendar days of the mailing date. If the hospital has not responded within this time period, the HHPRD will issue a Medicaid Notice of Amount of Program Reimbursement.

11.13 Reopening of Settlements

For all reopenings of settlements, Medicaid has adopted and follows all applicable provisions of the Medicare Provider Reimbursement Manual (HIM-15), Part 1, Sections 2931 and 2932, as well as all applicable provisions of 42 CFR Section 405.1885 et. seq.

For all reopenings, there is a three-year statute of limitations that begins on the date of the original Medicaid Notice of Amount of Program Reimbursement. The three-year time period ends on the third anniversary of that date.

A separate Notice of Reopening will be required for each provider and each cost year at issue.

If Medicaid mails its Notice of Reopening before the expiration of the three-year period, the three-year requirement will be considered met. After this point, the reopened settlement should be completed in a timely fashion.

Neither the existence of a Common Audit Agreement between Medicaid and the Medicare Intermediary nor whether the Medicare Intermediary provides timely notice to Medicaid of a Medicare settlement reopening will affect the application of the three-year time limit on Medicaid settlement reopenings.

To reopen a completed settlement using a filed cost report for an issue with Medicaid program data, the same reopening criteria regarding time limits will be used. However, once the final settlement has been calculated and the Medicaid audit adjustment report has been sent to the hospital, the Medicare/Medicaid CMS 2552 report will not be amended.

New laws, regulations, policy directives, or the interpretation of such issued subsequent to a settlement will not serve as basis to reopen a settlement. Nor can any of the above be introduced as part of a reopened settlement. The sole exception is when Medicaid is directed to do so by court order.

SECTION 12 - APPEALS

12.1 DATA CORRECTIONS

Once a hospital report (e.g., cost, indigent volume, and/or data) has been reviewed and provisionally accepted by MDCH, the hospital is notified in writing of MDCH's acceptance of the report. The hospital then has 30 calendar days in which to notify MDCH of any errors or corrections to the report/data. After the 30-day notification period, the report is deemed accepted by MDCH and will be used to rebase or update the hospital's pricing components as appropriate.

Only those reports on file and accepted nine months prior to the beginning of a new rate period are used for rebasing.

12.2 PRICE APPEALS

MDCH considers appeal requests received within 30 calendar days from the date of notice to the hospital advising it of a change in its pricing components. Appeal requests must be submitted in writing to MDCH. Requests must clearly state the item(s) being appealed, the remedy being sought, and must include all necessary documentation to support the hospital's position. Appeal requests received after 30 calendar days are not accepted. Appeal requests may not be used as a means to delay submission or fail to produce cost reports in the format and within the time frame required. Failure to include all necessary documentation to support the hospital's position may result in a hospital's appeal request being rejected.

Items subject to appeal include:	Items not subject to appeal include:
▪ Interpretations and/or application of program: ➢ Policy ➢ Procedures ➢ Formulas ➢ Pertinent laws and regulations (e.g. Code of Federal Regulations, HIM-15, etc.) ▪ Incorrect data and/or paid claims information used in price calculations – excluding data and paid claims information from the hospital's annual cost report previously submitted by it and accepted by MDCH.	▪ Data previously submitted by the hospital and accepted by MDCH ▪ The establishment and use of DRGs ▪ The Medicare Principles of Reimbursement (e.g. 42 CFR, HIM-15, etc.) as adopted by MDCH and used to reimburse providers ▪ The use of relative weights as part of the DRGs ▪ Interim payment rates which are in compliance with state and/or federal regulations, and ▪ Nonprogram related issues

Appeal requests must be sent to MDCH Appeals Section. (Refer to the Directory Appendix for contact information.)

12.3 Appeal Process

Upon receipt of an appeal request, a bureau conference is scheduled and conducted by MDCH staff from the Administrative Tribunal Appeals Section. During this conference, the MDCH staff and hospital representatives discuss the issues related to the appeal.

Failure to appear at a scheduled bureau conference without good cause and reasonable advance written or telephone notification to MDCH staff person assigned to the appeal is considered an abandonment of the appeal.

After the bureau conference, a final determination notice is sent to the hospital outlining the MDCH position on the item(s) appealed.

A price appeal decision may include a correction to the data used to set rates. If so, the corrected data is used beginning with the rate period for which the appeal was filed. Data corrections and any resultant price component changes that are accepted through pre-hearing conference or prevail at hearing are made for the current base period only for the hospital filing the appeal. MDCH may make changes to price components that affect all providers in subsequent rebasing periods.

Hospitals wishing to proceed to the next level of the appeal process have two options:

- The hospital may elect to appeal through an administrative hearing as provided in MDCH's Administrative Rules, R400.3406 through R400.3424. Administrative appeal requests must be sent to MDCH Administrative Tribunal and Appeals Division. (Refer to the Directory Appendix for contact information.)
- The hospital may waive its right to appeal through the administrative rules, R400.3406 through R400.3424, and instead elect to request a hearing before the State Hospital Appeal Panel. A waiver statement, signed by a duly authorized representative of the hospital, must accompany the appeal request. Appeals to this panel must be sent to MDCH State Hospital Appeals Panel Coordinator. (Refer to the Directory Appendix for contact information.)

Only issues raised at the bureau conference are accepted for review at either of the two hearing processes. Appeal requests must be received by MDCH within 30 calendar days from the date of the final determination notice sent to the hospital subsequent to the bureau conference. Failure to submit an appeal request within 30 calendar days shall be deemed an abandonment by the hospital of all further administrative appeal rights.

12.4 Administrative Hearings

Hearings conducted by MDCH's Administrative Tribunal follow MDCH's Medicaid Provider Reviews and Hearings Rules found at R400.3406 through R400.3423.

12.5 State Hospital Appeal Panel

The State Hospital Appeal Panel shall consist of one member chosen by the hospital, one independent member (selected by MDCH from a list of prospective members supplied or approved by the hospital industry), and one representative of MDCH.

The appeal panel coordinator will schedule the times and places for the pre-hearing conference and the appeal panel hearing. Written notice of the hearing will be mailed to the parties not later than 30 calendar days from the date the appeal request is received by the appeal panel coordinator. The pre-hearing conference and panel hearing will be held in Lansing. Failure to appear at a scheduled pre-hearing conference or hearing without good cause and reasonable advance written or telephone notification will be deemed an abandonment of the appeal. Actions described in the final determination notice will then be implemented without further notice to the hospital.

All time requirements for appeal to the panel may be extended by mutual agreement of the parties involved.

Each party must submit a position paper to the appeal panel along with all necessary documentation to support its position. In order to be considered, the appeal panel coordinator must receive the position papers and supporting documentation no later than 15 calendar days prior to the scheduled hearing date.

The appeal panel will give each party an adequate amount of time to present its evidence and arguments. The appeal panel reserves the right to exclude testimony or evidence which it deems to be immaterial, repetitious, or irrelevant.

Each party is entitled to call persons to testify at the hearing.

A licensed Certified Electronic Reporter maintains a complete record of the hearing. The record may be transcribed and reproduced at the request of either party. The transcription cost is the responsibility of the party making the request.

The appeal panel may affirm, modify, or reverse a bureau conference decision upon the affirmative vote of two or more of its members.

The appeal panel will issue a written recommendation no later than 60 calendar days after the closing date of the hearing. The written recommendation will include findings of fact and relevant conclusions of law.

The recommendation decision of the appeal panel will be forwarded to the MDCH director with copies mailed to the hospital and appropriate MDCH appeals staff.

Either party may file exceptions to the recommended decision. Exceptions must be filed within 20 calendar days of the issuance of the appeal panel's recommended decision. Such exceptions must be submitted to MDCH director with copies sent to the opposing party and the appeal panel coordinator. Exceptions filed after 20 days are not considered.

MDCH director may accept, modify or reverse the recommended decision of either the panel or the administrative law judge. The decision of the MDCH director will be binding unless the hospital wishes to appeal the decision to a court of appropriate jurisdiction.

If an appeal results in a change that affects claims already processed, three alternatives to implement the change shall be available:

- The hospital may elect to submit claim adjustments through the normal billing process.
- The hospital may request an early initial settlement for the entire hospital. The initial settlement incorporates the appeal decision in determining the gross program liability. Initial settlements are done only after the end of a hospital's fiscal year end.
- The impact of the appeal decision may be incorporated into the hospital's final settlement process.

LABORATORY

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SECTION 1 - GENERAL INFORMATION

This chapter applies to Independent Clinical Labs (Provider Type 16).

Medicaid reimburses laboratories only for those services it is certified by the Clinical Laboratory Improvement Act (CLIA) to perform and for those services ordered by physicians (MD or DO), certified nurse practitioners (CNPs), certified nurse midwives (CNM), podiatrists (DPMs), or dentists (DDOs). The ordering practitioner must document the medical necessity of laboratory tests in the beneficiary's medical record, regardless of where the test(s) is performed. Medicaid covers only those medically necessary laboratory tests needed to diagnose a specific condition, illness, or injury. Medicaid does not cover any laboratory tests ordered by a chiropractor.

The ordering practitioner is held responsible if they order excessive or unnecessary laboratory tests, regardless of who actually renders the laboratory services. The ordering practitioner is also held responsible for the medical necessity of every laboratory test that is ordered as part of a custom- or laboratory-designed profile. The ordering practitioner may be subject to corrective action related to these services, including recoupment of funds. The laboratory also may be subject to corrective action, including the recoupment of funds, if it submits a claim for laboratory services not specifically ordered by a practitioner.

Screening or routine laboratory testing, except as specified for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, or by Medicaid policy, is not a benefit. Ordering or rendering of "profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition are considered random screening and are not covered. Multiple laboratory tests carried out as a part of the evaluation of the beneficiary, when the results of the history and physical examination do not suggest the need for the tests, are considered screening and are not covered.

Laboratory services performed by a laboratory or its employees may not be billed to the ordering practitioner.

SECTION 2 - BILLING INFORMATION

Refer to the Billing & Reimbursement for Professionals Chapter of this manual for more information about billing.

2.1 MEDICAL NECESSITY

The medical record and claims (with applicable attachments) must contain documentation of medical necessity describing the beneficiary's symptoms and other findings that led the practitioner to order the laboratory test(s). An explanation of the laboratory testing method or the results of the diagnostic tests, whether normal or abnormal, is not documentation of medical necessity. For approval of payment, the laboratory procedure(s) must be specific and appropriate to the beneficiary's documented condition and diagnosis.

2.2 PHYSICIAN SELF-REFERRAL

Stark Legislation or Physician Self-Referral Legislation, 42 USC 1395nn, limits certain physician referrals made to entities where the physician has a financial interest. A physician should make no referrals of laboratory tests to a laboratory in which the physician (or the physician's immediate family members) has a financial interest unless the referral falls under the "in-office ancillary services" exception.

The Michigan Department of Community Health (MDCH) defines the following terms as they relate to the Physician Self-Referral portion of the Stark Legislation:

2.2.A. PHYSICIAN'S OFFICE LABORATORY

A Physician's Office Laboratory (POL) meets the following parameters:

- A physician or a group practice owns the laboratory.
- The laboratory performs testing only on specimens generated by the physician owner.

The laboratory is subject to the following policies:

- Laboratory claims must be billed using the physician's billing provider identification (ID) number.
- Laboratory claims are subject to the practitioner daily laboratory limit.
- The laboratory must not accept referrals from physicians outside of the physician's practice or group practice.

2.2.B. DUAL PHYSICIAN'S OFFICE / INDEPENDENT LABORATORY

A dual physician's office/independent laboratory meets the following parameters:

- A physician or a group practice owns the laboratory.
- The laboratory is a physician's office laboratory for those specimens generated by the physician owner.

- The laboratory is an independent laboratory for those specimens that are referred by physicians outside of the physician's practice or group practice.

Dual physician's office/independent laboratories are subject to the following policies:

- Laboratory claims generated by the physician owner must be billed using the physician's billing provider ID number. These claims are subject to the practitioner daily laboratory limit.
- Laboratory claims generated by physicians outside of the physician's practice or group practice must be billed using the independent laboratory ID number. These claims are subject to the independent laboratory daily limit.
- The laboratory must not accept referrals from immediate family members.

2.2.C. Independent Laboratory

An independent laboratory meets the following parameters:

- It may be owned by:
  - A physician or a group practice.
  - A nonphysician.

The physician-owned independent laboratory is subject to the following policies:

- The laboratory must not accept referrals from the physician owner or their immediate family members.
- Laboratory claims are billed using the independent laboratory ID number.
- Laboratory claims are subject to the independent laboratory daily limit.

The nonphysician owned independent laboratory is subject to the following policies:

- The laboratory must not accept referrals from the owner or their immediate family members.
- Laboratory claims are billed using the independent laboratory ID number.
- Laboratory claims are subject to the independent laboratory daily limit.

2.3 Clinical Laboratory Improvements Act Certification

All providers that submit claims must have Clinical Laboratory Improvements Act (CLIA) certification and the CLIA number must be present on the claims. Providers are limited to billing the lab services that they are CLIA-certified to perform. This includes the specialties as listed under their CLIA certificate.

When billing Medicaid for services rendered, providers performing tests that use waived methodologies must enter the QW modifier with the appropriate Current Procedural Terminology (CPT) code to denote the waived test.

Questions regarding CLIA certification should be addressed to the state-licensing agency. (Refer to the Directory Appendix for contact information.)

2.4 Procedure Codes

Laboratories should refer to the current edition of the CPT manual published by the American Medical Association (AMA) for the appropriate procedure code to use when billing Medicaid. The laboratory is also subject to the pathology and laboratory guidelines that provide definitions and/or instructions for specific sections in the manual.

2.5 Component Billing

Most pathology procedures are billed together as a total service and a single charge is made for both professional and technical components. Some pathology procedures are composed of professional and technical components that are billed separately by the facility and the provider. In these instances, the procedure code requires the use of a two-character modifier to accurately identify the service provided. Do not bill for component services when the entire procedure is performed.

Payment for the technical component to the laboratory includes personnel, materials, space, equipment, report of test results, and other items.

The professional component represents the professional services of a pathologist/hematologist. These are limited to certain services as noted on the Clinical Laboratory Database located on the MDCH website. (Refer to the Directory Appendix for contact information.) Payment for this component includes:

- Examination of the beneficiary, when indicated.
- Performance and supervision of the procedure.
- Reading, interpretation, and written report of the findings.
- Consultation with the referring physician.

When the laboratory performs services for hospital inpatients, only the pathologist can bill the professional component (the pathologist's services) directly to Medicaid. The technical component is included in the reimbursement to the hospital for the inpatient services.

2.6 Medicare Related Billing

Medicaid reimburses laboratories for the coinsurance and deductible amounts subject to Medicaid's reimbursement limitations on all Medicare-approved claims even if Medicaid does not normally cover the service.

SECTION 3 - REIMBURSEMENT LIMITATIONS

Reimbursement for laboratory services includes the collection of the specimen(s), the analysis, and the lab test results. Medicaid performs pre- and/or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders.

A beneficiary cannot be charged for any covered laboratory procedures, including those that are determined not to be medically necessary and those laboratory procedures that exceed the laboratory daily reimbursement limit.

Medicaid limits laboratory payments when rendered by the same provider, for the same beneficiary, on a single date of service. Coverage is limited to only those laboratory procedures that do not exceed the daily reimbursement limits specified in the following table.

Provider Type	Provider Description	Daily Limit
10 or 11	Physician (MD, DO), Certified Nurse Midwife (CNM), Certified Nurse Practitioner (CNP)	$50
13	Podiatrist (DPM)	$50
23	Family Planning Clinic	$50
77	Medical Clinic	$50
16	Independent Laboratory	$125
40	Outpatient Hospital	$75

The following selected laboratory services identified by CPT procedure codes (or code ranges) are exempt from the daily dollar limit. Payment for these medically necessary services is not included in the reimbursement calculation for a single date of service.

Exempt Procedure Code(s) or Code Ranges	Laboratory Service
80500	Limited Pathology Consultation
80502	Comprehensive Pathology Consultation
85097	Bone Marrow, smear interpretation

Exempt Procedure Code(s) or Code Ranges	Laboratory Service
88104-88108	Cytopathology
88141 - 88199	Cytopathology
88230 - 88299	Cytogenetics
88348	Electron Microscopy
87901-87904	Genotype and Phenotype analysis
0023T	Virtual Phenotype analysis

If the coverage limit is exceeded, the laboratory must request an exception to the daily reimbursement limit by submitting documentation of medical necessity for each laboratory procedure. All services provided on that date of service (DOS) are manually reviewed for medical necessity and payment determined accordingly.

When it is determined that Medicaid payments for testing ordered from a laboratory exceed the coverage limit, the ordering practitioner must forward medical necessity documentation to the laboratory for submission with the claim.

When billing Medicaid for services rendered, the DOS indicated on the claim must be the date the specimen is collected. For prompt payment of laboratory procedures that exceed the coverage limit, all claims for a single DOS should be submitted together with one copy of the accompanying documentation for each invoice.

SECTION 4 - SPECIAL COVERAGE

4.1 CHILDREN'S SPECIAL HEALTH CARE SERVICES COVERAGE

The coverage limits do not apply to beneficiaries with Children's Special Health Care Services (CSHCS) only eligibility.

The coverage limits do apply to beneficiaries with dual Medicaid and CSHCS eligibility if the laboratory procedures are not related to the beneficiary's CSHCS qualifying diagnosis.

4.2 BLOOD HANDLING

The fee for blood handling is usually included in the reimbursement for the blood test. Situations in which the drawing, packaging, and mailing of a blood specimen are the only services provided are rare and include:

- A beneficiary that is referred to a laboratory for the sole purpose of drawing, packaging, and mailing a blood sample to MDCH for blood lead analysis. The State provides lead-free vacutainers for the analysis. Requests for vacutainers and the samples for analysis should be sent to MDCH Blood Lead Laboratory. (Refer to the Directory Appendix for contact information.)
- A beneficiary occasionally requires blood tests that are not performed in conjunction with other reimbursable services. Whenever possible, the beneficiary should be sent to the laboratory that is to perform the test(s). If this is not practical (i.e., the laboratory is not a local facility) and the sole purpose of a visit is to draw, package, and mail the sample to a laboratory, the blood-handling fee may be billed by the practitioner. The blood-handling fee is not a benefit when any other service is reimbursable on the same date of service.
- A beneficiary may be referred to a laboratory for the sole purpose of drawing, packaging, and mailing a blood sample to MDCH for HIV-1 viral load analysis and/or CD4/CD8 enumeration. The State provides specimen containers and mailing kits for the analysis. Requests for supplies and samples for analysis should be sent to MDCH Blood Lead Laboratory. (Refer to the Directory Appendix for contact information.)

  When billing Medicaid for services rendered, blood handling may be billed if the drawing, packaging, and mailing of a blood sample are the only services provided as described above. Procedure Code 36415 (routine venipuncture for collection of specimen[s]) and the U&C charge for the service must be used.

SECTION 5 - PROCEDURE GUIDELINES

5.1 HEMATOLOGY STUDIES

A practitioner's order for a complete blood count (CBC) with white blood cell (WBC) differential includes the red blood cell (RBC) and WBC count, Hgb, Hct, MCH, MCHC, MCV, RBC morphology, platelet estimate, and WBC differential only. If three or more of the component tests are performed on a single blood sample, the code that most closely represents the entire procedure must be reported. If automated instrumentation yields additional test parameters, the results are not reimbursable unless medically necessary and specifically ordered by a practitioner.

Any payment for a differential includes payment for routine cell morphology and platelet estimation.

5.2 MICROBIOLOGY STUDIES

Isolation and presumptive ID procedure codes are meant to cover the usual methods recommended for the culture set up, isolation of suspected pathogens and the presumptive ID of any pathogens.

Definitive culture procedure codes may not be billed in combination with other microbiology codes that duplicate the ID of a microbe. Any reported organisms must be identified as to group, genus and species according to procedures recommended by the American Society for Microbiology (ASM), the College of American Pathologists (CAP) or the Centers for Disease Control (CDC).

Anaerobic culture procedure codes should only be reported for methods recommended by the ASM, CAP, CDC or the Virginia Polytechnic Institute (VPI) using special anaerobic media.

Microbiology smear procedure codes are to be reported only for microscopic examination of the original specimen and are not to be reported when inoculum from a culture or subculture is examined as part of the ID of an organism.

Special attention should be given to the antimicrobial susceptibility procedure code definitions when reporting the quantity. Depending on the code, the quantity is determined by the number of agents, number of plates or number of enzymes tested.

5.3 TEST REPORTS

Specimen Source	The tested entity may be from any source, unless the source is specified in the procedure code description.
Calculated Results	The mathematical calculation of two or more results to produce an index or ratio or any other result may not be billed as a separate independent test.
Test Results	Reimbursement is made for tests performed using a method that yields quantitative results unless the nomenclature specifies a different method.

Panel Tests	Only AMA-approved organ- or disease-oriented panels may be billed. All tests within the panel must be medically necessary. Unless the complete panel is ordered and performed, bill as individual tests.
Complete Procedures and Unbundling	In some instances, a procedure is listed both in its entirety and also with component services specified. If the entire procedure is performed, the code for the entire procedure must be reported. Do not bill for component services when the entire procedure is performed.
Urinalysis	In the event a single urine specimen is tested for the same entity (chemical, element, compound, substance) by more than one method, the procedure code used to denote the entity may be reported only once.
Anatomic Pathology	Cryopreservation (frozen cell storage and thawing) is a covered service for bone marrow transplants only.
Arsenic Testing	This testing is not covered for hair and nail sources.
Evocative/ Suppression Testing	Medicaid does not cover these codes. Report the individual tests.

5.4 Pathology Consultation

Clinical pathology consultation may be billed by a hematologist/pathologist for the review of abnormal laboratory test results, but cannot be billed for routine quality control review. (Refer to the current CPT manual for the guidelines for the provision of this service.)

SECTION 6 - FACILITY SERVICES

6.1 DIALYSIS RELATED LAB SERVICES

Payment for laboratory services related to maintenance dialysis is included in the composite rate regardless of whether the tests are performed in the facility or an independent laboratory. The following tests are considered to be a routine part of maintenance dialysis and may not be billed separately unless it is medically necessary to perform them in excess of the frequencies indicated

Laboratory tests for Hemodialysis, Peritoneal Dialysis, and Continuous Cycling Peritoneal Dialysis (CCPD) that are included in the composite rate:

Per Treatment:	Weekly:	Monthly:
▪ All hematocrit or hemoglobin tests and clotting time tests	▪ Prothrombin time for patients on anticoagulent therapy ▪ Serum Creatinine ▪ BUN	▪ CBC, including platelet count and additional indices ▪ Serum Calcium ▪ Serum Chloride ▪ Serum Potassium ▪ Serum Bicarbonate ▪ Serum Phosphorus ▪ Total Protein ▪ Serum Albumin ▪ Alkaline Phosphatase ▪ SGOT ▪ LDH

Laboratory tests for Continuous Ambulatory Peritoneal Dialysis (CAPD) that are included in the monthly composite rate include:

BUN	Creatinine
Sodium	CO2
Calcium Magnesium	Phosphate
Potassium	Total Protein
Albumin	Alkaline Phosphatase
LDH	AST, SGOT
HCT	Hgb
Dialysate Protein	

Laboratory tests not listed above may be separately billed by the dialysis facility or CLIA-certified lab performing the test.

6.2 ICF/MR Facilities

Reimbursement for laboratory services provided to patients in intermediate care facilities for the mentally retarded (ICF/MR) is included in the per diem rate paid to the ICF/MR. Laboratories may not bill MDCH for these services.

LOCAL HEALTH DEPARTMENTS

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION

This chapter applies to all Local Health Departments (LHDs).

1.1 REGULATORY AUTHORITY

A public facility is defined in the following Sections of the Michigan Public Health Code (PA 368 of 1978, as amended):

- Section 333.2413
- Section 333.2415
- Section 333.2421

Local health departments (LHDs) may participate as providers in the Medicaid Program as Public Clinics. Statutory basis for their participation is pursuant to 42 CFR 431.615 (Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees), thereby implementing Sec. 1902(a)(11) and (22)(C) of the Social Security Act.

A Title V grantee means an agency, institution, or organization that receives federal payments for part or all of the cost of any service program or project authorized by Title V of the Social Security Act, including:

- Children and youth projects;
- Children's Special Health Care Services (CSHCS);
- Maternal and child health services;
- Maternal and infant care projects; and
- Projects for the dental health of children.

1.2 PROVIDER ENROLLMENT

Each LHD employed or subcontracted physician (MD, DO), dentist, nurse practitioner (NP), and certified nurse midwife (CNM) must be enrolled with the Michigan Department of Community Health (MDCH) as a Medicaid provider to be reimbursed for covered services rendered to Medicaid eligible beneficiaries. (Refer to the General Information for Providers Chapter of this manual for additional information.)

The LHD must enroll any new physician, dentist, NP, CMN, and subcontractors joining the LHD by completing and submitting a Medical Assistance Provider Enrollment & Trading Partner Agreement (DCH-1625). The LHD must also notify the Hospital & Health Plan Reimbursement Division (HHPRD) of the enrollment. The MDCH Provider Enrollment Unit assigns a provider identification (ID) number accordingly. The LHD must also advise the Provider Enrollment Unit and HHPRD in writing of any terminated physician, dentist, NP, CNM, or subcontractor, listing the provider's name, Medicaid provider ID number, and termination date. (Refer to the Directory Appendix for contact information.)

SECTION 2 - BENEFITS

Covered services provided by LHDs include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a public facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.

2.1 COVERED SERVICES [CHANGE MADE 4/1/06]

LHDs receive full cost reimbursement for the following services:

Breast and Cervical Cancer Control Program Services	Home Health (HH) Care Services
Child Health and Primary Care Services	Immunizations**
Communicable Disease Services (e.g., Tuberculosis [TB])	Maternal and Child Health Lab Services
Dental Services*	Maternal Infant Health Program (MIHP) Services
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (including blood lead testing and follow-up services)	Prenatal Care Clinic Services
Family Planning Clinic Services	Sexually Transmitted Disease Services
Hearing and Vision Screening **(per bulletin MSA 06-08 effective 4/1/06)**	

* Refer to the Dental chapter of this manual for details regarding dental service coverage and limitations.

** An immunization administered for travel to a foreign country is not a covered benefit.

2.2 ADDITIONAL INFORMATION ON BLOOD LEAD TESTING

LHDs are not required to obtain a referral or receive PA to obtain a blood lead sample from Medicaid-covered children up to six years of age, whether they are enrolled in a MHP or are FFS beneficiaries. To prevent duplication of services, the LHD must make reasonable effort to assure that a blood lead test has not been obtained by the child's primary care provider (PCP).

All blood lead draws must be provided in compliance with Medicaid policy. Refer to the Medicaid EPSDT periodicity table in the Practitioner Chapter of this manual regarding guidelines for age-appropriate blood lead testing intervals.

A LHD may complete a maximum of one blood lead draw per year for a child. The LHD must instruct the laboratory completing the blood lead analysis to send all blood test results to the child's PCP and health plan, if enrolled in managed care. Should a positive test be found, the LHD must collaborate with the PCP to assure the appropriate follow-up care is provided. The PCP is responsible for any additional blood lead testing.

The LHD must obtain an order or a referral from the child's PCP or health plan, if enrolled in managed care, for subsequent blood lead draws completed during the year. Health plans will be responsible for providing reimbursement for the subsequent blood lead draws for their managed care enrollees.

If a capillary blood specimen is obtained, the LHD may bill MDCH using procedure code 36416 for both MHP enrolled and FFS beneficiaries. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional information.)

The LHD may send the sample to the state laboratory for analysis or to any clinical laboratory that is CLIA-certified to perform blood lead analysis. The information accompanying the sample to the laboratory must include the name of the PCP, if known, and the name of the health plan for those children enrolled in managed care.

The LHD may complete the blood lead analysis if they are CLIA-certified to do so. If the LHD completes the blood lead analysis, procedure code 83655 should be billed. The reimbursement includes payment for the capillary or venipuncture blood lead draw.

2.3 Additional Information on Objective Hearing & Vision Screening [New Subsection 4/1/06]

To be eligible to provide and bill for services, all LHD screening staff must be qualified to administer preschool objective hearing and objective vision screening by the MDCH Public Health Administration. This service coverage is limited to LHD providers when performed either on-site or in the community setting. Prior to submitting claims, LHDs must complete and submit form MSA-1533 (Local Health Department Assurance of Service Provision for Objective Hearing and Vision Screens) which provides assurance that screens are conducted by qualified staff.

Objective hearing screening and objective vision screening may be performed on eligible Medicaid preschool-aged children (ages 3-6 years) by qualified LHD staff. LHDs may provide objective hearing and/or vision screening services and accept referrals for screening from physicians and from Head Start agencies. The objective hearing and/or vision screening results must be reported to the child's primary care provider (PCP). If the LHD is unable to report the results to the child's PCP, the LHD must clearly document why this could not be accomplished. The results must also be shared with the Head Start agency if that agency was the referral source. **(per bulletin MSA 06-08 effective 4/1/06)**

2.4 Administrative Services [Renumbered 4/1/06]

Full cost reimbursement is not allowed for Medicaid administrative services and should not be included on the Medicaid Cost Report.

LHDs providing Medicaid administrative services should report costs for these services on their quarterly Financial Status Report in accordance with federal regulation to qualify for Federal matching funds. These reports must be submitted to the MDCH Contract Management Section. Questions regarding reimbursement of administrative services should be directed to the Contract Management Section. (Refer to the Directory Appendix for contact information.)

Refer to the Medicaid Outreach Activities section for reporting requirements, and billing and reimbursement information related to outreach activities.

2.5 Medicaid Health Plan Services [Renumbered and Change Made 4/1/06]

LHDs must obtain PA from a Medicaid Health Plan (MHP) for any Medicaid covered service provided to a Medicaid beneficiary enrolled in a health plan, **except** for the following services:

- Immunizations

- Sexually Transmitted Disease (STD) services
- TB Diagnosis and Treatment
- Family Planning Services
- Blood lead draws for children up to six years of age
- Hearing and vision screening **(per bulletin MSA 06-08 effective 4/1/06)**

Except for blood lead draws, payment for covered services is based on the terms of the contract between the LHD and health plan, if the LHD and a MHP have entered into a contract. In the absence of a contract, payment is based on the Medicaid fee-for-service (FFS) rates in effect on the date of service (DOS). Medicaid encourages contractual relationships between these entities.

SECTION 3 – MEDICAID OUTREACH ACTIVITIES

3.1 ALLOWABLE ACTIVITY CATEGORIES

Local Health Departments may perform the following Medicaid outreach activities and receive reimbursement through their Comprehensive Planning, Budgeting and Contracting (CPBC) Grant Agreement with MDCH.

All outreach activities must be specific to the Medicaid program. In addition, activities that are part of a direct service are not claimable as an administrative service.

3.1.A. MEDICAID OUTREACH AND PUBLIC AWARENESS

Activity Category Description

This category is when staff performs activities that inform eligible or potentially eligible individuals about Medicaid and how to access Medicaid programs. This category is also used for describing the services covered under Medicaid and how to obtain Medicaid preventive services.

It includes related paperwork, clerical activities, or staff travel required to perform these activities:

- Informing families and distributing literature about the services and availability of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and the many different Michigan Medicaid programs, such as Healthy Kids and Children's Special Health Care Services.
- Informing and encouraging families to access Medicaid managed care systems, i.e., Medicaid Health Plans.
- Informing families about the EPSDT and Medicaid health-related programs and the value of preventive health services and periodic exams.
- Assisting the Medicaid agency to fulfill outreach objectives of the Medicaid program by informing individuals and their families about health resources available through the Medicaid program.
- Conducting Medicaid outreach campaigns and activities (such as health fairs) that provide information about services provided by entities such as the Community Mental Health Services providers, Medicaid Health Plans, Local Health Departments, etc.
- Conducting a family planning health education outreach program or campaign, if it is targeted specifically to Medicaid-covered family planning services.
- Contacting pregnant and parenting women about the availability of Medicaid services, including referral to family planning and well baby care programs and services.
- Providing referral assistance to families with information about the Medicaid program.

- Providing information about Medicaid screenings that will help improve the identification of medical conditions that can be corrected or ameliorated through Medicaid services, such as the Breast and Cervical Cancer Control Program.
- Notifying families of EPSDT program initiatives, such as Medicaid screenings.
- Coordinating with the local media (newspaper, TV, radio, video) to inform the public about EPSDT screenings, health fairs and other health related services, programs and activities organized by the LHD.
- Coordinating or attending health fairs that emphasize preventive health care, and promoting Medicaid services by presenting Medicaid material in locations with the likelihood of high Medicaid eligibility.
- Presenting and informing families about the availability of Medicaid providers, specific covered services, and how to effectively utilize services and maintain participation in the Medicaid program.

Supplemental Description of Activity

This category includes activities staff or contractors perform to inform families, parents and community members about the Medicaid program, Medicaid covered services, how to obtain Medicaid preventive services, as well as assisting an individual or family in becoming eligible for Medicaid.

Examples of these activities include explaining the Medicaid program to families, giving a family a Medicaid application form, helping an individual complete a Medicaid application form, making a referral to a local or county Michigan Department of Human Services office, or helping someone gather and collect documentation to support a Medicaid application.

These outreach and application assistance activities are allowable ONLY with respect to Medicaid and Medicaid-covered services.

3.1.B. Facilitating Medicaid Eligibility Determination

Activity Category Description

This category is for assisting an individual to become eligible for Medicaid. This category does not include the actual determination of Medicaid eligibility.

It includes related paperwork, clerical activities, or staff travel required to perform these activities:

- Verifying an individual's current Medicaid eligibility status.
- Facilitating eligibility determination for Medicaid by planning and implementing a Medicaid information program.

- Participating as a provider of Medicaid eligibility outreach information.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Referring an individual or family to the local Michigan Department of Human Services or other appropriate sources to make application for Medicaid benefits.
- Assisting individuals or families to complete the Michigan Medicaid eligibility application.
- Assisting the individual or family in collecting/gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.

Supplemental Description of Activity

This category includes activities staff perform to inform individuals, families, parents and community members about the Medicaid program, Medicaid covered services, how to obtain Medicaid preventive services, as well as assisting an individual or family in becoming eligible for Medicaid.

Examples of these activities include explaining the Medicaid program to individuals or families visiting the LHD for other services, giving a family a Medicaid application form, helping an individual complete a Medicaid application form, making a referral to a local or county Michigan Department of Human Services office, or helping someone gather and collect documentation to support a Medicaid application.

These outreach and application assistance activities are allowable ONLY with respect to Medicaid and Medicaid-covered services.

3.1.C. Program Planning, Policy Development, and Interagency Coordination Related to Medical Services

Activity Category Description

This category is used for performing activities associated with the collaborative development of programs with other agencies that assure the delivery of Medicaid-covered medical/dental/mental health services to Medicaid beneficiaries. It applies only to employees whose position descriptions include program planning, policy development and interagency coordination, and/or those staff specifically appointed to appropriate committees/programs performing required activities.

It includes related paperwork, clerical activities or staff travel required to perform these activities:

- Defining the scope of each agency's Medicaid services in relation to the other, and identifying gaps or duplication of medical/dental/mental health programs.
- Analyzing Medicaid data related to a specific program, population, or geographic area and working with Medicaid resources, such as the Medicaid Health Plans, to locate and develop EPSDT health services referral relationships to populations of need.
- Creating a collaborative of health professionals (medical and dental) to provide consultation and advice on the delivery of health care services to the Medicaid population and developing methods to improve the referral and service delivery process by Medicaid providers.
- Containing Medicaid costs by reducing overlap and duplication of Medicaid services through collaborative efforts with Medicaid Health Plans, local Community Mental Health Services providers and Local Health Departments.
- Monitoring and evaluating policies and criteria for performance standards of medical/dental/mental health delivery systems in LHDs and designing strategies for improvements.
- Overseeing the organization and outcomes of the coordinated medical/mental health services provision with Medicaid Health Plans.
- Developing internal referral policies and procedures for use by staff so that appropriate coordination of health care services occurs between the various Medicaid providers and entities, such as Community Mental Health Services providers, Medicaid Health Plans, and the respective LHDs.
- Designing and implementing strategies to: identify individuals who may be at high risk for poor outcomes because of poverty, dysfunctional families, and/or inappropriate referrals, and who need medical/dental/mental health interventions; identify pregnant beneficiaries who may be at high risk of poor health outcomes because of drug usage, lack of appropriate prenatal care, and/or abuse or neglect; and assuring individuals with any significant health problems are diagnosed and treated early.
- Presenting specific provider information about Medicaid EPSDT screening that will help identify medical and dental conditions that can be corrected or ameliorated by services covered through Medicaid.
- Developing procedures for tracking and resolving family requests for assistance with Medicaid services and providers. This does not include the actual tracking of requests for Medicaid services.
- Developing new health programs with local community health agencies for the Medicaid population, as determined by a needs assessment and geographic mapping.

These activities relate to the program and not for a specific individual.

Supplemental Description of Activity

This category includes activities staff performs in collaboration with agencies or organizations outside of the LHD to assure the delivery of Medicaid covered medical/dental/mental health services to Medicaid beneficiaries.

The focus of these activities is to enhance, improve or streamline health care service delivery systems in the community.

In order to perform these activities, staff may be representing the LHD by sitting on a committee or task force such as a Multi-Purpose Collaborative Body.

3.1.D. Referral, Coordination and Monitoring of Medicaid Services

Activity Category Description

This category is for developing appropriate referral sources for program-specific services for LHDs and monitoring the delivery of Medicaid services within the health department. It also is used for coordinating programs and services at the LHD level.

It includes related paperwork, clerical activities or staff travel necessary to perform these activities:

- Making referrals for, and coordinating access to, medical and dental services covered by Medicaid.
- Identifying and referring individuals who may be in need of Medicaid family planning services.
- Making referrals for and/or scheduling appropriate Medicaid-covered immunizations, vision and hearing testing, but not to include the child health screenings (vision, hearing and scoliosis) and immunizations that are required for all children.
- Providing information about Medicaid EPSDT screening (e.g., dental, vision, hearing) that will help identify medical conditions that can be corrected or improved by services through Medicaid.
- Contacting Medicaid providers of pediatric services in lower income areas to determine the scope of EPSDT services available.
- Reviewing clinical notes of staff by a designated clinician to identify medical referral and follow-up practices, and making recommendations to supervisors for improvements as needed.
- Conducting quality assurance reviews of specific Medicaid-related program objectives.
- Providing both oral and written instructions about the referral policies and procedures between the LHDs and other Medicaid provider entities for appropriate coordination of health services.
- Coordinating medical/mental health services with managed care plans as appropriate.
- Developing professional relationships for the purposes of referral of Medicaid-eligible individuals for EPSDT and other Medicaid related services.

- Developing strategies for containing healthcare costs and improving services to children as part of the goals of the EPSDT program.
- Working with agencies providing Medicaid services to improve the coordination and delivery of clinical health care services, to expand access to specific populations of Medicaid eligibles, and to improve collaboration around early identification of medical/dental problems. Activities include the development, implementation, and amending of Interagency Agreements related to Medicaid services.

Activities that are part of a direct service are not claimable as an administrative service.

Supplemental Description of Activity

- **Health-Related Referral Activities**
  - This category includes activities that LHD staff or contractors perform during the referral process for a potential health-related issue.

    Examples of these activities include locating individuals with potential health-related needs.
  - This category also includes activities LHD staff perform in order to develop referral sources for the health department, such as a list or brochure of the physicians, dentists or HMOs in the area who accept Medicaid patients for evaluation or treatment, or a list of other health agencies providing Medicaid services to whom families may be referred.
- **Programmatic Monitoring and Coordination of Medical Services**
  - This category includes activities that LHD staff or contractors perform to coordinate programs and services at the LHD. It also could include activities such as monitoring, or follow-up on the systematic delivery of health-related services within the health department.
  - This category includes program- or system-wide monitoring and coordination of services; it does NOT include beneficiary-specific activities such as individual service coordination or monitoring of services of a particular individual. These activities are often completed by a coordinator or supervisor of quality assurance activities or others with a broader scope related to health-related services provided within the health department.

3.1.E. Medicaid-Specific Training on Outreach Eligibility and Services

Activity Category Description

This category is for coordinating, conducting, or participating in training events and seminars for staff who provide outreach services regarding the benefits of the Medicaid program, including how to assist families to access Medicaid services, and how to more effectively refer individuals for services.

It includes related paperwork, clerical activities or staff travel required to perform these activities:

- Participating in or coordinating training that improves the delivery of Medicaid services.
- Participating in or coordinating training that enhances early identification, intervention, screening and referral of children with health needs for EPSDT services.
- Coordinating training to assist families to access Medicaid services.
- Participating in or presenting training that improves the quality of identification, referral, treatment and care of children, e.g., talking to staff about the EPSDT referral process, available EPSDT and health-related services.
- Disseminating information on training sessions and conducting all related administrative tasks.
- Conducting seminars and presentations to staff related to Medicaid-covered services; providing information on where and how to seek assistance through the Medicaid program.
- Developing and preparing information about Medicaid-covered services, specific health standards and criteria associated with identification/detection of certain illnesses required by the Medicaid program.
- Developing, participating in, or presenting training that addresses the clinical importance of pediatric or other clinical standards for preventive care offered through the Medicaid program.

Supplemental Description of Activity

This category includes activities such as conducting or participating in training events and seminars for staff or contractors regarding general Medicaid information, including the benefits of the Medicaid program, how to assist families in accessing Medicaid eligibility and services, and how to more effectively refer individuals for services.

Allowable training activities must be associated in some way with connecting individuals and families to the Medicaid program or to Medicaid services.

3.1.F. Arranging for Medicaid-Related Transportation

Activity Category Description

This category is for assisting an individual to obtain transportation for Medicaid-covered services. This does not include the provision of the actual transportation service, but rather the administrative activities involved in providing transportation. This activity also does not include activities that contribute to the actual billing of transportation as a medical or dental service, nor does it include accompanying the Medicaid-eligible individual to Medicaid services as an administrative activity.

It includes related paperwork, clerical activities or staff travel required to perform these activities:

- Scheduling or arranging transportation for Medicaid-covered services.
- Assisting or arranging for transportation for the family in support of the referral and evaluation activities.

Supplemental Description of Activity

This category includes activities staff perform in assisting an individual to obtain transportation in order to access Medicaid health-related services.

3.1.G. Arranging for Provision of Medicaid-Related Translation Services

Activity Category Description

This category is for LHD employees who provide translation services related to Medicaid-covered services as an activity. Translation may be allowable as an administrative activity if it is not included and paid for as part of a medical assistance service.

It includes related paperwork, clerical activities or staff travel required to perform these activities:

- Arranging for or providing translation services that assist the individual to access transportation and medical/dental/mental health services.
- Arranging for or providing translation services that assist the individual to "communicate" with service providers about medical/dental services being provided.
- Arranging for or providing translation services that assist the individual to understand necessary care or treatment.
- Assisting the individual to define/explain their symptoms to the physician/dentist.
- Arranging for or providing signing services that assist family members to understand how to provide necessary medical support and care to an individual.

Supplemental Description of Activity

This category also includes the arranging for or providing of translation/interpretation services to enable an individual to access Medicaid health-related services.

3.2 Reporting Requirements

LHDs that bill for Medicaid Outreach Activities must provide a quarterly summary report of Medicaid outreach activities. Guidelines and reporting requirements are described in the CPBC Grant Agreement.

3.3 Billing And Reimbursement

3.3.A. Grant Agreement

In FY 04/05, the CPBC Grant Agreement will be amended to include the new Medicaid Outreach Activities provision. In subsequent years, this provision will be part of the standard CPBC Grant Agreement language.

Each fiscal year MDCH will identify Medicaid outreach priorities. LHDs that bill for Medicaid outreach activities must focus, at a minimum, on one of the identified outreach priorities.

3.3.B. Billing

The LHDs bill for these outreach activities on a quarterly basis in a single column on a Financial Status Report (FSR). The column should be titled Medicaid Outreach Activities. The FSR is part of the LHDs quarterly CPBC FSR submission to MDCH. MDCH aggregates all of the quarterly amounts billed for LHD Medicaid outreach activities and submits a claim for the federal portion of the costs. MDCH reimburses the LHDs after MDCH receives the reimbursement of the federal claim.

These Medicaid Outreach Activities are claimed at the 50% administrative match rate.

Full cost reimbursement is not allowed for Medicaid administrative services and should not be included on the Medicaid Cost Report.

3.3.C. Cost Allocation Plans

MDCH requires the LHDs to certify that their existing cost allocation plan is in compliance with OMB Circular A-87 and that the plan identifies Medicaid outreach activities as a specific element of the plan. The certification is accepted by MDCH as documentation to continue this administrative claiming. Each cost allocation plan is subject to MDCH review for compliance with A-87.

3.3.D. CERTIFICATIONS

The LHD Cost Allocation Plan certifications are kept on file and should be submitted to the MDCH Contract Management Section. (Refer to the Directory Appendix for contact information.)

New certifications are required if a modification occurs in the LHD's cost allocation plan that impacts the Medicaid Outreach Activities element or upon a Department review that results in a finding of non-compliance. If neither of these conditions exist, the certification remains valid in subsequent fiscal years.

SECTION 4 – ENCOUNTERS

Encounters are counted and reported by LHDs on the Michigan Medicaid Local Health Department (LHD) Cost Report in order to receive full cost reimbursement. The reported encounters include the health department's total facility encounters and as a subset of total encounters, the total Medicaid encounters at the LHD clinic.

In order to determine a rate per encounter, the total costs of facility services are divided by the total encounters, resulting in a rate per encounter. The rate per encounter is multiplied by the number of Medicaid encounters to determine the total Medicaid costs to be reimbursed.

4.1 DEFINITION OF ENCOUNTER

An encounter is a face-to-face contact between a patient and the provider of health care services who exercises independent judgment in the provision of health care services. For a health service to be defined as an encounter, the health service must be recorded in the patient's record.

The following examples help to understand and define an encounter:

- To meet the encounter criterion for independent judgment, the provider must be practicing within the scope of practice defined in the Michigan Public Health Code. The provider must be acting independently and not be assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample is not credited with a separate encounter.
- Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, filling and/or dispensing prescriptions, in and of themselves, do not constitute encounters. However, these procedures may accompany professional services performed by medical, dental, or other health providers, which do constitute encounters.
- A provider may be credited with no more than one encounter with a given patient during a single day, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. For example, when a patient sees a physician for flu symptoms early in the day and then later the same day sees the same physician for a broken leg, then visits may be classified as two encounters.
- A LHD may bill for different types of encounters on the same day. For example, if a patient first sees a physician at the LHD and then sees a dentist, the visits may be classified as two encounters.

The encounter criteria are not met in the following circumstances:

- When a provider participates in a community meeting or group session that is not designed to provide health services.
- When the only service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program.

- The following services are **not** classified as encounters:

Allergy injection(s)	Performing laboratory tests
Collecting urine specimens	Refilling prescriptions
Dispensing prescriptions	Taking a history
Drawing a blood sample	Taking vital signs
Filling out insurance forms, etc.	Taking x-rays

4.2 MHP Provider Encounters [Change Made 4/1/06]

Medicaid covered services provided by a LHD to Medicaid beneficiaries enrolled with a MHP are subject to full cost reimbursement, if all of the following conditions are met:

- The LHD and MHP must be signatories to a contract that states the LHD will provide Medicaid covered services to the MHP enrollee;
- The contract must be effective at the time the services are rendered; and
- The contract must provide for the MHP to reimburse the LHD at a fair market or Medicaid rate for similarly situated enrollees served by a non-full cost provider. Except when services are provided on an out-of-plan basis, the contractor must implement a payment method equal to, or above that of, other affiliated subcontracting arrangements when entering into a subcontract with a LHD.

The following out-of-plan services do not require a contract or prior authorization between the LHD and the MHP:

- Immunizations
- STD and/or Communicable Disease Diagnosis and Treatment
- TB Diagnosis and Treatment
- Family Planning Services
- Blood lead
- Hearing and vision screening **(per bulletin MSA 06-08 effective 4/1/06)**

The LHD must request that MDCH pay full cost for these MHP enrollees. Completing the sections of the annual cost report related to managed care encounters and payments fulfills this request.

If requested, the LHD must forward a copy of the MHP contract to the HHPRD at the onset of the subcontracting time period. (Refer to the Directory Appendix for contact information.)

Given verifications, the difference between LHD cost and MHP payments is full cost reimbursed by MDCH.

The LHD may not bill Medicaid FFS codes for MHP enrollees. MDCH pays its share of reimbursement owed LHDs on a quarterly basis.

The contract, as well as all LHD and MHP services, is subject to audit and verifications.

4.3 Medicare/Medicaid Encounters

Services for Medicare and Medicaid dual beneficiaries are eligible for full cost reimbursement, and these encounters are considered Medicaid encounters.

4.4 Other Insurance Encounters

Medicaid services provided to FFS beneficiaries with other commercial health insurance carriers are eligible for full cost, and the encounters are considered Medicaid encounters. Medicaid requires beneficiaries' other insurance resources and their network providers to be utilized for all services covered under the private coverage before billing Medicaid. Even if the other insurance payment for a specific service exceeds the amount Medicaid would pay, providers must still bill the FFS procedure code and enter the other insurance payment on the claim. The claim showing other insurance reimbursement or zero payment must be processed through the FFS claim system in order to be counted as a Medicaid encounter. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual for additional information.)

SECTION 5 – COST REPORTING REQUIREMENTS

5.1 FULL COST METHODOLOGY

The term full cost reimbursement as used in this chapter means the cost of providing Medicaid services, as determined by information provided on the Michigan Medicaid Cost Report for LHDs. Full cost is derived from reimbursement to the LHD from Medicaid FFS claims, MHPs, other third party insurers, quarterly payments, and initial and final settlements. A combination of local and state general funds provide the basis for full cost reimbursement and are used for claiming federal financial participation pursuant to 42 CFR § 433.51 and 42 CFR § 431.615.

To receive full cost reimbursement, qualified providers must supply the HHPRD with a Medicaid cost report.

5.2 COST SETTLEMENTS

Cost settlements are performed annually to ensure that the payments were made at reasonable and allowable full cost. As necessitated by the cost settlement process, any financial adjustments are made with the LHD. Settlements are performed for each LHD for each fiscal year.

5.3 REASONABLE AND ALLOWABLE COSTS

Reasonable and allowable costs are determined using the applicable Medicare cost reimbursement principles detailed in 42 CFR, Part 413.

5.4 FILING COST REPORTS

LHDs must file a Michigan Medicaid cost report with the HHPRD annually. The authorized individual must sign the cost report and related Medicaid supplemental documents. The LHD cost report is due five months after the end of the normal fiscal period.

- A 30-day extension of the due date may, for good cause, be granted if a written request is received by HHPRD prior to the expiration of the original five months.
- The LHD cost report may be filed for more or less than an annual period only when necessitated by facilities terminating their agreement with MDCH, or by a change in ownership, or a change in fiscal period.

Improperly completed or incomplete filings are returned to the LHD for proper completion and must be resubmitted to MDCH within 30 days of receipt of the cost report.

If the required cost report and supplemental documents are not submitted within the required time limit (including approved extensions), no cost settlement for full cost reimbursement occurs for that fiscal period. By not submitting a cost report, it is understood that the LHDs are withdrawing from the full cost program. This action remains in effect until proper submission of all the required documents in a subsequent fiscal period.

If LHDs do not file a cost report, any interim payments are recovered for the year in which the LHD did not participate in the full cost reimbursement program.

5.5 Amending Cost Reports

LHDs may amend a cost report by requesting the amendment in writing and submitting a revised cost report to the HHPRD. The revised cost report must be submitted no later than one year from the original filing date. The letter must explain why the cost report requires revision, and how it was changed.

5.6 Accounting and Record Keeping

Each LHD operating a clinic in the State of Michigan and seeking payment under the LHD provisions must complete LHD cost reports.

The Medicaid supplemental documents must be filed using the modified accrual method of accounting. These documents must be forwarded to MDCH, Contract Management Section. (Refer to the Directory Appendix for contact information.)

The LHD must maintain, for a period of not less than six years from the end of the fiscal year of the LHD cost report, financial and clinical records for the period covered by the cost report which are accurate and in sufficient detail to substantiate the cost data reported. If there are unresolved issues at the end of this six-year period, the records must be maintained until these issues are resolved. Expenses reported as reasonable costs must be adequately documented in the financial records of the LHD or they are disallowed.

HHPRD maintains each required LHD cost report and supplemental documents submitted by the provider for six years following the date of submission of the report. In the event there are unresolved issues at the end of this six-year period, the cost report is maintained until such issues are resolved.

Financial and clinical records of the LHD must be available for review by authorized personnel of MDCH, the Health Care Fraud Division of the Michigan Department of Attorney General, or the United States Department of Health and Human Services (HHS) in conformity with the provisions of the Social Security Act.

SECTION 6 – INTERIM PAYMENTS, SETTLEMENTS AND APPEALS

6.1 SETTLEMENT(S) OF LOCAL HEALTH DEPARTMENTS

An initial settlement is calculated annually from the cost of providing Medicaid covered services to Medicaid beneficiaries enrolled in the FFS program and MHPs. Calculations are determined from the filed Medicaid LHD cost report.

FFS encounters are verified for the cost settlement from the MDCH paid claims data. Encounters for MHP or private HMO enrollees are recorded in the cost report. An initial settlement generally is completed within three months of the receipt of a complete and acceptable cost report. MDCH retains the right to withhold a portion of an initial payment based on individual circumstances.

Final settlements for LHDs generally are completed within one year of the fiscal year end using updated Medicaid data for the period covered by the LHD cost report. This allows sufficient time for all claims to clear the MDCH payment system. Medicaid data is updated using MDCH approved claims payment data, all other payments for Medicaid services, and Medicaid visits.

Settlements with amounts due to the LHD are paid with a payment voucher. Settlements showing an overpayment to the LHDs must be repaid to the State of Michigan as noted in the settlement letter.

6.2 AUDIT ADJUSTMENT REPORT

An Audit Adjustment Report showing adjustments to the filed cost report is sent with the final settlement. If the LHD accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the LHD signs the report and mails the report to HHPRD. (Refer to the Directory Appendix for contact information.)

6.3 MEDICAID PROVIDER APPEALS

Medicaid providers have the right to appeal any adverse action taken by MDCH unless that adverse action resulted from an action over which MDCH had no control (e.g., Medicare termination, license revocation). Appeals must be submitted in writing and mailed to MDCH Administrative Tribunal and Appeals Division. (Refer to the Directory Appendix for contact information.)

The appeals process is outlined in MDCH's Medicaid Provider Reviews and Hearings rules R400.3401 through R400.3424 in the Michigan Compiled Laws. Any questions regarding the appeal process should be directed to the Administrative Tribunal and Appeals Division.

MATERNAL INFANT HEALTH PROGRAM

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SECTION 1 – GENERAL INFORMATION

This chapter applies to certified Maternal Infant Health Program (MIHP) providers (Provider Type 77). This program was formerly known as Maternal and Infant Support Services.

The purpose of the Maternal Infant Health Program is to reduce infant mortality and morbidity. This is an objective of both the State of Michigan and the federal government who fund these programs. The goal of the MIHP is to alleviate social and psychosocial problems, health education deficits and transportation needs for medical appointments, and to aim for a delivery of a healthy baby at full term, as well as to work with the parent of a high-risk infant to help the baby to stay healthy, obtain appropriate well baby visits, medical care, immunizations and link families with community agencies.

Accordingly, MIHP services are intended to help those pregnant Medicaid beneficiaries most likely to experience serious health problems due to psychosocial or nutritional problems. Services are intended to supplement regular prenatal/infant care and to assist the following providers in managing the beneficiary's health and well-being:

- Physicians (MD, DO)
- Certified nurse midwives (CNM)
- Pediatric nurse practitioners (PNP)*
- Family nurse practitioners (FNP)*

*Enrolled in the Medicaid Program per Michigan Department of Community Health (MDCH) guidelines.

1.1 PROGRAM SERVICES

MIHP services are preventive health services provided by an agency that is certified by MDCH. MIHP services include:

- Psychosocial and nutritional assessment.
- Plan of care development.
- Professional intervention services by a multidisciplinary team consisting of a qualified:
  - Social worker;
  - Nutritionist;
  - Nurse; and
  - Infant mental health specialist (if available).
- Arranging transportation as needed for health care, substance abuse treatment, support services, and/or pregnancy-related appointments.
- Referral to community services (e.g., mental health, substance abuse).
- Coordination with medical care providers.
- Childbirth or parenting education classes.

Program services consist of social work, nutrition, nursing services (including health education), counseling/social casework, and beneficiary advocacy services.

Infant mental health specialists should be involved with infant cases, if at all possible and available in the geographic area. If not available, the provider must carefully consider how to provide this service.

1.2 DURATION OF COVERAGE

Maternal Services	Infant Services
Pregnant Medicaid beneficiaries may qualify for MIHP at any time during the pregnancy. The pregnant woman is the focus of these services. After delivery a new MIHP case cannot be opened. For purposes of case closing, services may be provided for up to 60 days after the pregnancy ends or the end of the month in which the 60th day falls. Some services to postpartum women are available through the Medicaid Home Health Program. Support services are available through MIHP to the infant for mothers meeting the risk criteria.	MIHP services for an infant may begin after the infant's birth. When infants are enrolled for the MIHP, services are exclusively for the benefit of the infant on Medicaid, primarily by working with the infant's family.

MIHP for women and infants focus on the family, encompass essentially the same services, and are generally provided to the same individual (pregnant woman/mother). In some situations, MIHP services for the mother and infant may need to be blended because the beneficiary meets the qualifying criteria for both services at the same point in time. In these situations, providers must bill for services under the mother's ID or infant's ID, but not under both when one professional intervention, albeit a "blended one", is provided. As an exception, transportation services may be billed under the mother's ID for the pregnant woman and under the infant's ID for the infant.

It is the responsibility of the MIHP provider to target these services to Medicaid beneficiaries most in need of this assistance.

SECTION 2 – PROGRAM COMPONENTS

2.1 RISK CRITERIA

Maternal Services	Infant Services
MIHP referrals for pregnant women are encouraged given the presence of any of the following conditions, which are likely to adversely affect the pregnancy: ▪ Homeless or dangerous living/home situation. ▪ Negative or ambivalent feelings about the pregnancy. ▪ Mother under age 18 with no family support. ▪ Need for assistance to care for mother and infant. ▪ Mother with cognitive, emotional or mental impairment. ▪ Nutritional problems. ▪ Abuse of alcohol or drugs or smoking. ▪ Need for transportation to keep medical appointments. ▪ Need for childbirth education classes. Only pregnant women meeting the above risk criteria should be enrolled in MIHP. Medicaid eligibility by itself is not a qualifying condition for enrollment in MIHP.	MIHP referrals for the infant are encouraged given the existence of any one of the following conditions with the mother or infant: ▪ Abuse of alcohol or drugs (especially use of cocaine), or smoking. ▪ Mother under the age of 18 with no family support. ▪ Family history of child abuse/neglect. ▪ Failure to thrive. ▪ Low birth weight (less than 2500 grams). ▪ Mother with cognitive, emotional or mental impairment. ▪ Homeless or dangerous living/home situation. ▪ Any other condition that may place the infant at risk for death, illness or significant impairment identified by a physician.

2.2 RISK SCREENING

A risk screening form (MSA-1200) must be completed to determine if a pregnant beneficiary is eligible for MIHP services. This is a required form, and each beneficiary screened subsequent to December 1, 2005 must have this form in her MIHP record. One of the three MIHP disciplines (i.e., social worker, nutritionist, or nurse) must work face-to-face with the beneficiary to complete the form. The form must be signed and dated by the person completing the form.

The screening form must be completed to determine beneficiary MIHP eligibility prior to enrollment in the program. When reviewing the form with a beneficiary, providers must assure that the screening form is fully completed in order to receive reimbursement for screening services.

MIHP eligibility determination will be based on the beneficiary's response to the various questions on the MSA-1200 screening form. Throughout the screening form, an asterisk(*) is placed next to the responses that, if indicated by the beneficiary, would identify a risk. If a beneficiary's answer results in checking, at a minimum, one box where the corresponding response has an asterisk, they are automatically eligible for MIHP services. In the event a beneficiary completes the new screening form and their responses do not identify a risk, they may still be assessed and eligible for the program based on the MIHP provider's judgement. Under these circumstances, MIHP providers must clearly document the need for services in

the beneficiary's record. After eligibility is determined, MIHP providers must complete the Prenatal Services Assessment form (DCH-1192).

The exception to this is if the only risk factor identified is the need for childbirth or parenting education classes, then an assessment is not necessary. Provider sources that can facilitate a referral to the MIHP program, include but are not limited to, Women, Infants, and Children Supplemental Food Program (WIC), community agency, medical care provider, etc.

If a maternal services case subsequently becomes an infant services case, the infant risk screening form (DCH-1194) must be completed, signed and dated.

Providers (MDs, DOs, CNMs, other agencies, etc.) may still use the DCH-1191 form to refer beneficiaries to MIHP providers for further screening. MIHP providers are no longer required to have form DCH-1191 in their records. The signature of a medical care provider (physician, CNM, Medicaid enrolled PNP or FNP) or a MIHP provider is required to authorize the initiation of services.

2.3 Medicaid Health Plans

Medicaid Health Plans (MHPs) must ensure their enrollees have access to the MIHP. MHPs have the option of becoming certified and enrolled as a MIHP provider or contracting with a certified MIHP provider.

2.4 Reimbursement

MIHP providers receive separate reimbursement for each prenatal screening form completed, even if it is determined that the beneficiary is not eligible for MIHP services. Reimbursement is limited to one screen per pregnant woman during her pregnancy. Due to factors such as premature termination of a pregnancy or a subsequent pregnancy in the same year, a MIHP provider may screen a beneficiary and receive reimbursement twice in the same year. In such instances, the provider must indicate "second pregnancy" in the Remarks section of the claim.

MDCH reimburses providers directly for services provided to beneficiaries enrolled in the Medicaid fee-for-service (FFS) program. The MHP reimburses MIHP providers for services provided to MHP enrolled beneficiaries.

The MIHP provider must have a signed, written referral on file prior to billing for services. A medical care provider (physician, CNM, Medicaid enrolled PNP or FNP) or MIHP clinical staff is authorized to sign referrals for services. When billing for MIHP services, providers must use the procedure codes listed in the MDCH Maternal Infant Health Program Database located on the MDCH website. (Refer to the Directory Appendix for contact information.)

2.5 Psychosocial / Nutritional Assessment

After completion (or receipt) of the risk screening form, the MIHP provider must complete a structured psychosocial/nutritional assessment to determine the scope of the beneficiary's service needs. The assessment is to validate that the beneficiary meets the prerequisite risk criteria and to determine whether MIHP services are needed. If the assessment does not indicate the need for MIHP services, then no follow-up services should be provided. If a need is indicated, an appropriate plan of care must be developed that clearly outlines the beneficiary's risk(s) and the intervention(s) to address the risk(s).

If a MIHP case subsequently becomes a MIHP infant case, an additional risk assessment must be completed to determine eligibility for the infant (mother and infant activity).

The beneficiary must be assessed for transportation needs, childbirth/parenting education classes, health education needs, and family planning services. The assessment must precede any professional visits. Only one assessment per pregnant woman and only one assessment per infant is covered. Due to factors such as premature termination of a pregnancy or a subsequent pregnancy in the same year, a beneficiary may be assessed and/or receive MIHP services twice in the same year. In such instances, the provider must indicate "second pregnancy" in the remarks section of the claim.

Assessments must be completed by a MIHP interdisciplinary team/member. All three professionals (i.e., the nurse, nutritionist, social worker) must be involved in the psychosocial/nutritional assessment – either directly or through a review/approval process.

An assessment is required for pregnant women who need transportation to keep medical appointments.

No assessment is required if the beneficiary only needs a childbirth education or a parenting education class.

2.6 Plan of Care

Based on the assessment, the interdisciplinary team develops a comprehensive plan of care (POC) to provide needed services to the beneficiary and/or referrals to community agencies. The POC must indicate the specific risk(s), specific outcomes/objectives and specific intervention(s) to be implemented and the number of visits required for actualizing the plan. The POC must be updated whenever a significant change occurs and must justify the interventions that are occurring. Follow-up services must be provided by the nurse, social worker and/or nutritionist based on the POC. While the provider must determine how best to involve staff in implementing the POC, it is expected that all professional staff will be involved to some extent. It is not expected that one professional discipline will implement all interventions on a solo basis. The beneficiary's exit from the program is expected to occur when the objectives of the POC are completed, or when the team concludes that continued intervention is unnecessary.

2.7 Interventions

In order to assure consistency with smoking cessation intervention among prenatal beneficiaries, MIHP providers must begin integrating the MDCH "Prenatal Smoking Cessation: Smoke-Free for Baby and Me" intervention model into their program. The "Smoke-Free for Baby and Me" curriculum includes the 5As intervention model in addition to other intervention strategies for smoking cessation. More information about this program is available through the MDCH Prenatal Smoking Cessation program. (Refer to the Directory Appendix for contact information.)

2.8 Care Coordination

A Care Coordinator (a member of the interdisciplinary team) must be assigned to monitor and coordinate all the MIHP care, referrals, and follow-up services for the beneficiary. The Care Coordinator must assure the families are appropriately followed and referred for needed services. The name of the Care Coordinator must be documented in the beneficiary's record.

For the infant, MIHP providers are encouraged to participate in local Children's Protective Services (CPS) Interdisciplinary Team meetings, Part C/Early-On Interagency Coordinating Council meetings, and in similar efforts to coordinate the infant's care. This is to ensure the use of and coordination with other community resources and to ensure ongoing support when the MIHP case is closed.

When appropriate, MIHP referrals to CPS workers must be made.

Appropriate family planning counseling and referrals must be made and documented.

2.9 Professional Visits

A professional visit/intervention is a face-to-face encounter with a beneficiary conducted by one or more certified professionals (i.e., social worker, nutritionist, or nurse) for the specific purpose of implementing the beneficiary's plan of care. The following guidelines apply:

- The visit must be at least 30 minutes in duration to be billable.
- The initial assessment and up to nine professional visits per woman, per pregnancy, are billable under MIHP.
- The initial assessment and up to nine professional visits per infant are billable under MIHP. An additional nine infant visits may be provided when requested in writing by the medical care provider. The reason for and purpose of additional visits must be well documented.
- The maximum number of reimbursable visits does not increase if two or more infants in the same family are concurrently at risk.
- Professional visits cannot be billed for services provided to a group of beneficiaries.
- More than one visit may be provided on the same date of service if a different professional provides the second visit. The provider must keep in mind the beneficiary's ability to benefit from extended counseling/education when more than one visit is provided on the same day.
- The beneficiary must not be billed for visits provided beyond the established limit.
- Medicaid reimbursement for a professional visit includes related care coordination and monitoring activities.
- All professional visits, including the place of service, must be documented in the beneficiary's MIHP record.

2.10 Drug Exposed Infant

A drug-exposed infant is an infant born with the presence of an illegal drug(s) and/or alcohol in his circulatory system or living in an environment where substance abuse or alcohol is a danger. Due to the complex condition of these cases, they may require additional visits. A separate procedure code is assigned for additional visits. The beneficiary's record must contain documentation of the infant's drug-alcohol exposed condition.

The initial assessment and up to nine professional visits for a drug-exposed infant are billable under MIHP. Additional infant visits may be provided when requested in writing by the medical care provider. In these cases, reason for and purpose of additional visits must be well documented.

The maximum number of reimbursable visits is 36 in a year. Providers must use the professional visit code for the first 18 visits; for additional visits (subsequent 18), bill the drug exposed procedure code.

MDCH does not reimburse for missed visits/appointments. A beneficiary may not be billed for a missed visit/appointment.

2.11 Place of Service

Maternal Services	Infant Services
Professional visits may be provided in a clinic/office setting, or in the beneficiary's home/place of residence (including homeless shelter). Professional visits may not be provided in the inpatient hospital setting. Reasonable efforts should be made to visit the beneficiary at her home. MDCH recommends that at least two visits be made to the beneficiary's home; one at the time of assessment to better understand the beneficiary's background; another, after the birth of the infant, to observe bonding and proficiency in infant care and nutrition.	Infant services under MIHP is a home-based program. The infant assessment and all professional interventions must be done in the beneficiary's home, unless, due to client circumstances, it is not feasible to do so. In this instance, services may be provided any place other than an inpatient hospital setting. On an average, an agency must provide 90 percent of all infant professional visits in the home. Home visits are reimbursed at a different rate than the visits occurring outside of the home. The infant must be present at all visits.

Typically, all visits are performed at the beneficiary's home or at the MIHP provider's office. On rare occasions when a visit cannot be completed in the beneficiary's home and/or in the provider's office, the provider may work with the beneficiary to identify a mutually agreeable site to conduct a visit. These types of visits are referenced as visits occurring in the community setting.

For a community visit to be reimbursable, the beneficiary record must clearly identify the reason(s) why the beneficiary could not be seen in her home or in the MIHP office setting. This documentation must be completed for each visit occurring in the community setting. Visits occurring in buildings contiguous with the provider's office or in the provider's satellite office are considered to be in an office setting rather than in a community setting.

2.12 TRANSPORTATION

Transportation services are to assure beneficiaries keep their health care appointments. Transportation needs must be assessed and transportation provided only if no other means are available to get to health care services.

MDCH covers beneficiary transportation for medical/health care, substance abuse treatment, WIC visits, or for any MIHP services, including childbirth/parenting education classes. A mother's trip to visit her hospitalized infant is also covered. Transportation is available for an initial medical visit that will likely result in an enrollment in MIHP. Transportation is available for the pregnant woman when she is enrolled in MIHP. Transportation is available for the infant and the primary caregiver to attend the infant's appointments when the infant is enrolled in MIHP.

Medicaid covers transportation services for all beneficiaries for obtaining medical care through the local Department of Human Services (DHS). MIHP providers should coordinate transportation services with the local DHS office, which may have transportation resources available. Beneficiaries enrolled in the MIHP program can obtain transportation from the MIHP provider.

For the FFS Medicaid beneficiary, the MIHP provider is required to offer and arrange for transportation needed. MDCH reimburses the provider an administrative fee equal to six percent of the cost of the transportation. When billing for transportation, the six percent fee should be calculated and included in the amount charged. The agency may also contract for transportation services. Transportation service should be billed for each date of service it was provided.

The MIHP provider's contract with MHPs should specify responsibility for meeting the transportation needs of enrolled beneficiaries.

The MIHP provider must determine the most appropriate and cost effective method of transportation. MDCH reimburses transportation costs at the lesser of actual cost or the maximum/upper limit for:

- Bus
- Taxi*
- Mileage (Volunteer/relative/beneficiary/other)

*If other methods of transportation are not available or appropriate, the MIHP provider may make arrangements with local cab companies to provide taxi service for MIHP beneficiaries. Since this is a more expensive service, MDCH reimburses a maximum of 20 trips each per beneficiary under MIHP.

The provider must maintain transportation documentation for each beneficiary provided such services. For each trip billed, the record must specify:

- The name and address of the beneficiary;
- Date of service (DOS);
- The trip's destination (address, city);
- The trip's purpose;
- Number of tokens or miles required for the trip; and
- Amount that the beneficiary or transportation vendor was reimbursed.

The provider must ensure the beneficiary kept the appointments for which transportation funds were provided.

The MIHP provider may give transportation tokens or funds to the beneficiary/caretaker. In situations where funds are provided, it is recommended that the beneficiary sign a receipt, and that the receipt be retained in the case record.

2.13 Education Classes

2.13.A. MIHP Childbirth Education Class

Childbirth education is a series of group classes intended to help the woman:

- Understand the changes in her body during pregnancy.
- Understand the delivery process, including information regarding pre-term labor.
- Understand the postpartum period.
- Care for the infant (classes may include information on developing positive parenting skills).
- Interact with other pregnant women.
- Build a support network.

First time mothers must be encouraged to complete the course.

The medical care provider or the MIHP provider may make a referral for childbirth education classes. An assessment is not required if this is the only service needed. Given appropriate referral, MIHP providers may provide this service directly or have a contract with a local hospital's outpatient clinic. An outpatient hospital clinic that provides this service may bill Medicaid directly for the FFS beneficiaries. The contract must indicate which provider is to bill and receive payment. These services are provided to a group in a classroom situation.

In unusual circumstances (e.g., beneficiary entered prenatal care late or is homebound due to a medical condition) childbirth education may be provided in the beneficiary's home as a separately billable service. Case records must document the need for one-on-one childbirth education and where services were provided.

2.13.B. Suggested Content for Childbirth Education Class

MIHP childbirth education includes, but is not limited to, the following topics:

Pregnancy	▪ Health care during pregnancy ▪ Physical and emotional changes during pregnancy ▪ Nutrition

Labor and Delivery	▪ Signs and symptoms of labor, including information regarding pre-term labor ▪ Breathing and relaxation exercises ▪ Analgesia and anesthesia ▪ Avoiding complications ▪ Coping skills ▪ Types of deliveries ▪ Episiotomy ▪ Support techniques ▪ Hospital tour
Infant Care	▪ Preparation for breast feeding ▪ Infant feeding ▪ Immunizations ▪ Infant car seat use ▪ Parenting
Postpartum	▪ Postpartum physical and emotional changes, including depression ▪ Feelings of partner ▪ Potential stress within the family ▪ Sexual needs ▪ Exercise ▪ The importance of family planning

2.13.C. MIHP PARENTING EDUCATION CLASS

Parenting education is intended to develop positive parenting skills and attitudes, and to provide interaction with the other parents and possibly build a support network. Parenting education may be billed once per infant.

The infant's medical care provider or the MIHP provider may make a referral for parenting education classes. An assessment is not required if this is the only infant service needed. Given an appropriate referral, services may be provided by the MIHP provider or by contract with an outpatient hospital or community based organization. These services are provided to a group in a classroom.

2.13.D. Suggested Content for Parenting Education Class

MIHP parenting education class includes, but is not limited to, the following topics:

Feeding recommendations throughout the first year of life	▪ Nutritional requirements ▪ Developmental issues related to feeding children ▪ Bottle/breast feeding advantages ▪ Formula preparation
Normal and abnormal patterns of elimination	▪ Normal range of elimination patterns and changes throughout childhood ▪ Toilet training issues and developmental readiness
Common signs and symptoms of infant illness	▪ Appropriate care for common illness ▪ Danger signs and when to call the health care provider ▪ Emergency numbers (i.e., poison control, emergency room, etc.)
Common childhood injuries and how to care for them	▪ Signs and symptoms to seek medical care ▪ Basic first aid ▪ Accident prevention and safety
Normal range of sleep, rest, activity and crying patterns	▪ How to assist an infant in settling to sleep ▪ Normal patterns of sleep and activity and developmental changes ▪ Information on Sudden Infant Death Syndrome (SIDS) and appropriate sleeping position ▪ Signs and symptoms of over stimulation and under stimulation ▪ How to quiet a crying baby ▪ How to play with a baby to encourage optimum developmental skills
Hygiene	▪ Hygiene needs of infants ▪ Appropriate care of routine problems (e.g., diaper rash, seborrhea, circumcision etc.)
Normal developmental milestones of infants through the first year	▪ Developmental issues relating to providing care, feeding, and stimulation ▪ Realistic expectations of infants in relationship to their developmental level

Emotional Needs	▪ Parent-infant interactions ▪ Normal changes that occur throughout the first year of life and its impact on the infant-parent interaction ▪ Discussion and modeling of parenting behaviors that positively impact the emotional well-being of the infant
Protection from toxic hazard waste	▪ Paint ▪ Lead ▪ Water
Immunizations and health maintenance	▪ Well baby visits ▪ American Academy of Pediatrics recommended schedule ▪ Care of the infant after immunizations
Day-to-day living with children	▪ Appropriate methods for managing activities and stress when living with infants and children ▪ Second hand smoking ▪ Appropriate ways of discipline

2.13.E. REIMBURSEMENT

Reimbursement for MIHP childbirth education and parenting education are for the complete session, regardless of the number of classes needed to complete the session. At a minimum, the course outlined above must be covered. Additional items may be added at the discretion of the provider. The pregnant woman or mother must attend at least one-half of the session or cover at least one-half of the curriculum for the service to be billed. Dates of attendance must be documented in the beneficiary's record.

- MIHP childbirth education may be billed one time per beneficiary per pregnancy.
- MIHP parenting education may be billed one time per infant.

If the services are available at no charge to the public, neither the Medicaid FFS program nor the beneficiary's MHP can be billed for the service.

2.14 Transfer of Care / Records

During the course of care, the beneficiary may move to another area and require services from a different provider. When an MIHP provider is aware a planned move, information about the MIHP providers at the new location should be provided to the beneficiary. The referring provider must consult with the new provider about the case and transfer necessary information or records in compliance with privacy and security requirements of HIPAA regulations. A copy of the completed assessment and case summary must be shared with the new provider. Close coordination between providers should avoid duplication of services. A release of information from the beneficiary is necessary.

2.15 Immunizations

Providers must determine the status of a child's immunizations from the mother and/or health care provider. Mothers should be encouraged to obtain immunizations and assisted as necessary, such as with transportation where needed.

Before closing an MIHP case, the provider must assess immunization status, take appropriate action and document according in the case record.

2.16 Special Arrangement with Children's Protective Services Program

Because of the serious nature of MIHP cases, some beneficiaries need the assistance of DHS's Child Protective Services (CPS) program. The MIHP provider must work cooperatively and continuously with the local CPS office. Contact persons must be identified. Referral protocol and a working relationship must be developed and maintained. MIHP is a valuable resource for the CPS program. The MIHP provider must seek CPS assistance in a timely manner. MIHP and CPS work concurrently on at least some referred cases. CPS is not to be viewed as recourse of last resort – the agency to call when all else fails.

The Michigan Child Protection Law (Act No. 238, Public Acts of 1975) requires health care professionals and others to report cases of suspected child abuse/neglect to CPS. When and how the MIHP provider must refer can best be determined by discussions with the local CPS agency. MIHP activity does not replace the need for required CPS referrals.

2.17 Communication with Medical Care Provider

When a MIHP case is opened without the medical care providers' involvement, MIHP provider must notify the medical care provider within seven to 14 calendar days. The MIHP provider must keep the medical care provider informed of the services provided as directed by the medical care provider or when a significant change occurs. A discharge summary, including the services provided, outcomes, current status, and ongoing needs of the beneficiary, must be completed and forwarded to the medical care provider when the MIHP case is closed.

SECTION 3 – FORMS

MIHP providers must use standardized forms developed by MDCH. Copies of the forms are located in the Forms Appendix and are also available on the MDCH website. (Refer to the Directory Appendix for website information.) At a minimum, the data elements included in these forms must be maintained. Additional data elements may be incorporated to fit agency/community needs.

The following forms must be used when providing MIHP services:

- MSS/ISS Authorization and Consent to Release Protected Health Information (DCH-1190)
- MSS Risk Screening (DCH-1191) (no longer required)
- MIHP Prenatal Risk Screening (MSA-1200)
- MIHP Prenatal Services Assessment (DCH-1192)
- MIHP Prenatal Plan of Care (DCH-1193)
- ISS Risk Screening (DCH-1194)
- ISS Initial Assessment (DCH-1195)
- ISS Plan of Care (DCH-1196)
- MSS/ISS Professional Visit Progress Report (DCH-1197)
- MSS Discharge Summary (DCH-1198)
- ISS Discharge Summary (DCH-1199)

SECTION 4 – MIHP CASE RATE

For FFS pregnant women, an alternate reimbursement option is available. In counties where there is no MIHP provider, MDCH may consider the MIHP case rate reimbursement plan for the FFS pregnant women. Under this plan, reimbursement is based on the number of Medicaid deliveries in the service area. The provider is responsible for screening all Medicaid FFS pregnant women to determine MIHP eligibility and offering services to those who qualify.

MIHP providers in the case rate program must develop and implement a program to meet performance goals established by MDCH. The performance goals include:

- Screening 90 percent of the Medicaid FFS pregnant women.
- Reducing by 10 percent the incidence of smoking among Medicaid FFS pregnant women.
- Assuring that Medicaid FFS pregnant women receive an appropriate number of prenatal care visits.

Providers are required to provide, at a minimum, the following information for the beneficiaries served each calendar quarter:

- Number of risk assessments (screening) conducted;
- Number of Medicaid FFS pregnant women identified through outreach activities;
- Number referred by physician;
- Number referred by MIHP provider;
- Number of enrolled in MIHP; and
- Number and types of individual MIHP visits provided.

Providers opting for case rate reimbursement program must sign a separate contract with MDCH outlining the policy and procedures for this program.

SECTION 5 – PROVIDER CERTIFICATION

The MDCH certifies MIHP providers.

5.1 CRITERIA

Provider participation criteria are:

- The provider must meet program requirements to qualify to enroll in Medicaid.
- In cases where services are to be provided through a contract with another agency, the contract or letter of agreement must be on file for review by MDCH. It must specify the time period of the agreement, the names of the individuals providing services and where the billing responsibility lies.
- Physical facilities for seeing beneficiaries must be comfortable, safe, clean, and meet legal requirements.
- The provider must have experience in the delivery of services to the target population and a demonstrated understanding of the concept and delivery of maternal and/or infant support services. The provider must demonstrate linkages to relevant services and health care organizations in the area to be served.
- The organization must demonstrate a capacity to conduct outreach activities to the target population and to medical providers in the geographic area to be served.
- Staff for the program must comprise an interdisciplinary team and must include the following disciplines and qualifications:

Nursing	▪ Possession of a MSN or BSN and at least one year of providing community health, pediatric and/or maternal/infant nursing services; or ▪ Possession of a Diploma or ADN and at least two years of providing community health, pediatric and/or maternal/infant nursing services. All nurses must possess current Michigan licensure as a Registered Nurse.
Social work	▪ Registration as a Certified Social Worker (CSW) or ACSW; or ▪ Possession of an MSW; or ▪ Possession of a BSW or RSW. Each of the above-degreed social workers must have at least one year of providing services to families.
Nutrition	▪ MPH with emphasis in nutrition or Master's degree in human nutrition; or ▪ Bachelor of Science and registration as a dietician (RD); or ▪ Bachelor of Science and RD eligible with examination pending in six months or less. Each of the above-degreed nutritionists must have at least one year of providing community health, pediatric, and/or maternal/infant nutrition services.

- An additional member of the multidisciplinary team for the MIHP infant service program may include:

Infant Mental Health Specialist	A person with a bachelor's or a master's degree in psychology, child development, social work, or nursing and possessing either: ▪ Certification in infant mental health from Wayne State University; or ▪ Specialized instruction in parent-infant assessment and intervention. Not less than one year of experience in an infant health program is also required.

Agencies unable to meet staffing requirements may submit written requests for waivers to MDCH, Director of Division of Family & Children's Health, Bureau of Child & Family Programs. (Refer to the Directory Appendix for contact information.) MDCH examines the validity of each waiver request and approves or disapproves accordingly.

Providers must demonstrate its ability to validate the need for, and delivery of, MIHP appropriate to the individual beneficiary's level of need including:

- Respond to referrals promptly to meet the beneficiary's need, within a maximum of 7 calendar days for the infant and 14 calendar days for the pregnant woman.
- Report disposition of the referral (i.e., initiation of services, inability to locate, or denial of services) to the referring source within one week of receipt.
- Notify the medical care provider of beneficiary's enrollment within 14 days.
- Complete an assessment, based on a home visit as required for the infant and, if possible, for the pregnant woman, and develop a plan of care.
- Schedule services to accommodate the beneficiary's situation.
- Provide for weekend and after-hours emergencies.
- Provide directly or arrange for bilingual services, services for the blind or deaf, as indicated.
- Coordinate agency and community services for the beneficiary.
- Arrange for needed beneficiary transportation.
- Be aware of local public health programs such as WIC; EPSDT; CSHCS; and other agencies that may have appropriate services to offer the beneficiaries and agree to work cooperatively with these agencies.
- For infants, collaborate with the hospital staff to assure the transitioning of the infant from hospital to home. Assessments should be conducted within 48 hours of hospital discharge for referrals received prior to the beneficiary's discharge from inpatient setting.
- Have written protocols that comply with the reporting requirements mandated by the Child Protection Law (Act No. 238, Public Acts of 1975).
- Report all new health plan enrollees to the appropriate health plan on a monthly basis.
- Have a referral system to other community agencies.

- Provide ongoing communication with the beneficiary's medical care provider.
- Provide directly the services of at least one of the three disciplines. The other discipline(s) may be provided through a subcontractor.
- Be able to provide services in a clinic, an office, or a home setting, as appropriate.
- Demonstrate a system for handling beneficiary grievances.
- Maintain an adequate and confidential beneficiary records system, including services provided under a subcontract.
- Have written internal protocols to include all aspects of the program.
- Establish protocols with the local DHS's CPS unit to assure participation in or access to the local CPS multidisciplinary team meetings, including referral process and follow-up contacts as appropriate for the infant.
- Be a member of the local Part C/Early-On Interagency Coordinating council, or is otherwise actively linked to it (for the infant).

5.2 Issuance of Certification

Based upon satisfactory application, MDCH provides an interim MIHP certification. After an agency is certified and providing services, MDCH conducts a provider site visit. The site visit must occur within six months of the interim certification. The site visit is to observe how the program is being implemented and assist in resolving any problems that may be experienced in implementation of the program. Based upon the site visit, MDCH grants the agency either a six-month certification, a three-year certification, or discontinues certification. For certified agencies, MDCH makes formal certification visits every three years, with informal site visits at more frequent intervals.

At any time after receiving certification, if the provider becomes deficient in any of the qualifying criteria, including staffing, the provider must notify MDCH immediately. MDCH then determines whether the agency may continue providing services given the deficiency(ies). MDCH's decision evaluates many factors including the number of deficiencies, the specific deficiency(ies) involved, the availability of other providers in the area, impact on caseload, etc.

If at any time the MIHP provider fails to meet the program policies or certification requirements, Medicaid reimbursement received can be jeopardized. Like all Medicaid providers, the MIHP provider is subject to being audited by Medicaid and if at that time any discrepancy(ies) are found, appropriate follow-up actions may be taken, such as recoupment of payments, holding reimbursement on claims, or terminating Medicaid enrollment. If a negative action is imposed, the MIHP provider is given an opportunity for appeal.

Agencies wishing to apply to become a MIHP provider may write to the Medicaid Policy Division. (Refer to the Directory Appendix for contact information.)

MATERNITY OUTPATIENT MEDICAL SERVICES PROGRAM

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SECTION 1 – GENERAL

This chapter applies to providers of maternity related services.

The Maternity Outpatient Medical Services (MOMS) program covers outpatient pregnancy-related services during the prenatal and postpartum period for eligible beneficiaries, as well as inpatient delivery-related services.

1.1 ELIGIBILITY DETERMINATION

Women who are pregnant, and meet the following criteria, may apply for MOMS coverage at a Local Health Department (LHD), Federally Qualified Health Center (FQHC), or local Department of Human Services (DHS):

- Income at or below 185 percent of the federal poverty level.
- Covered by the Medicaid Emergency Services Only (ESO) program.

Women who are incarcerated in any institution where residents are precluded from using their Medicaid coverage are not eligible for this program.

MOMS eligibility does not equate to eligibility for full Medicaid Coverage. However, individuals enrolled in MOMS are frequently determined eligible for Medicaid. MOMS eligibility is terminated on the effective date of full Medicaid coverage.

1.2 PERIOD OF COVERAGE

The MOMS enrollment period is from the date of application, once eligibility is determined, through 60 days after the pregnancy ends. The maximum period of retroactive eligibility for MOMS is 90 days from date of application.

1.3 VERIFYING ELIGIBILITY

MOMS enrollees are given a Guarantee of Payment Letter for Pregnancy Related Services (DCH-1164). The letter is intended to assure providers that MDCH will reimburse for pregnancy-related services provided to the beneficiary. The letter includes information on eligibility, covered services, billing instructions, etc. (A sample of the letter is included in the Forms Appendix.)

Once a woman is determined eligible for the MOMS program, a MOMS Eligibility Letter is issued. The letter contains the beneficiary's identification (ID) number.

MOMS eligibility information is also available through the Medicaid Eligibility Verification System (EVS). (Refer to the Beneficiary Eligibility Chapter of this manual for information on accessing the EVS.)

SECTION 2 – SERVICES

2.1 COVERED SERVICES

The following pregnancy-related services are covered, consistent with current Medicaid policy, during the prenatal period:

- Prenatal care and pregnancy-related care
- Pharmaceuticals and prescription vitamins
- Laboratory services
- Radiology and ultrasound
- Maternal Infant Health Program (MIHP) - for prenatal services only
- Childbirth education
- Outpatient hospital care

Labor and delivery services (including all professional and inpatient hospital services) are covered.

Postpartum care is limited to medically necessary ambulatory postpartum services.

2.2 NONCOVERED SERVICES

Family planning and sterilization services are not covered. MIHP coverage is limited to the prenatal period only.

2.3 PRIOR AUTHORIZATION

If a service does not meet the definition of the pregnancy-related services noted above or if the service normally requires prior authorization (PA) by the Medicaid program, a PA request must be submitted to MDCH. Requests of authorization of pharmaceuticals must be made to the MDCH Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.)

SECTION 3 – BILLING & REIMBURSEMENT

Billing and coordination of benefits policies and procedures, as well as reimbursement rates, parallel Medicaid. (Refer to the Billing & Reimbursement and the Coordination of Benefits Chapters of this manual for additional information.)

3.1 SUBMITTING MEDICAL CLAIMS

Providers should not bill Medicaid without a valid MOMs ID number. MOMS claims should be held until the beneficiary's MOMS ID number can be obtained from the EVS, the MOMS Eligibility Letter, or the beneficiary's **mihealth** card. (Refer to the Beneficiary Eligibility Chapter for instructions on accessing the EVS.) The "M" number that may appear in the upper right-hand corner of the Guarantee of Payment Letter for Pregnancy Related Services (DCH-1164) cannot be used to identify MOMS beneficiaries on claims submitted to MDCH.

If a provider is unable to obtain the MOMS ID number in a reasonable period of time, a copy of the DCH-1164 may be faxed to the MDCH Customer Services Division and a beneficiary ID number requested. (Refer to the Directory Appendix for contact information.) The name and phone number of a contact person should be included with the fax request. MDCH then provides the beneficiary's ID number to the requester.

3.2 SUBMITTING PHARMACY CLAIMS

Pharmacy services provided to MOMS beneficiaries must be billed to the MDCH Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.) Pharmacies have the option of billing the PBM in one of two ways:

- Hold the claim until the beneficiary ID number is available in the EVS and then bill via the PBM's online system; or
- Submit a Universal Claim Form, along with a copy of the DCH-1164, to the PBM per the instructions in the PBM manual.

3.3 REMITTANCE ADVICE

MOMS claim adjudication information is included in the weekly Remittance Advice (RA), merged alphabetically with Medicaid and other MDCH-administered programs. (Refer to the Billing & Reimbursement Chapters for additional information.)

MEDICAID HEALTH PLANS (MHPS)

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SECTION 1 – GENERAL INFORMATION

The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Management and Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.)

MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

1.1 SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

- Ambulance and other emergency medical transportation
- Blood lead services for individuals under age 21
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services for individuals under age 21
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and medical supplies
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids for individuals under age 21
- Home health services
- Hospice services (if requested by enrollee)
- Immunizations

- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility)
- Maternal Infant Health Program (MIHP)
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care (up to 20 outpatient visits per contract year)
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services for individuals under age 21
- Practitioner services (such as those provided by physicians, optometrists, or oral surgeons enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Transplant services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for individuals under age 21

1.2 Services Excluded from MHP Coverage but Covered by Medicaid

The following Medicaid services are not covered by MHPs:

- Custodial care in a licensed nursing facility; restorative or rehabilitative nursing care in a licensed nursing care facility beyond 45 days
- Certain dental services. (Refer to the Dental chapter of this manual for additional information.)
- Specific injectable drugs administered through a PIHP/CMHSP clinic to MHP enrollees are reimbursable by the MDCH on a fee-for-service basis. (Refer to the Injectable Drugs and Biologicals subsection of the Practitioner Chapter of this manual for additional information.)
- Home and Community Based Waiver program services
- Inpatient hospital psychiatric services (MHPs are not responsible for the physician cost related to providing psychiatric admission physical and histories. However, if physician services are required for other than psychiatric care during a psychiatric inpatient admission, the MHP would be responsible for covering the cost, provided the service has been prior authorized and is a covered benefit.)
- Mental health services outside the MHP's contractual responsibility
- Outpatient partial hospitalization psychiatric care
- Personal care or home help services

- Services provided to persons with developmental disabilities and billed through Provider Type 21
- Services provided by a school district and billed through the Intermediate School District
- Substance abuse services through accredited providers, including:
  - Screening and assessment;
  - Detoxification;
  - Intensive outpatient counseling and other outpatient services; and
  - Methadone treatment
- Transportation for services not covered by the MHP.

1.3 Services that MHPs are Prohibited from Covering

- Elective therapeutic abortions and related services. Abortions and related services are covered when medically necessary to save the life of the mother or if the pregnancy is a result of rape or incest;
- Experimental/Investigational drugs, procedures or equipment; and
- Elective cosmetic surgery.

SECTION 2 - SPECIAL COVERAGE PROVISIONS

This section provides general information regarding MHP coverage requirements for certain services. Additional information regarding the MHP requirements related to these services is contained in the MHP contract. A copy of the contract is available on the MDCH website. (Refer to the Directory Appendix for website information.)

2.1 COMMUNICABLE DISEASE SERVICES

MHPs must allow enrollees to receive treatment services for communicable diseases from local health departments without prior authorization. For purposes of this section, communicable diseases are HIV/AIDS, STDs, tuberculosis, and vaccine-preventable communicable diseases.

2.2 EMERGENCY SERVICES

MHPs are responsible for emergency services, including the medical screening exams, consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (41 USCS 1395 dd (a)) and the Federal Balanced Budget Act of 1997. MHPs may not require prior authorization for emergency screening and stabilization services provided to enrollees.

MHPs are not responsible for paying for non-emergency treatment services beyond screening that are not authorized by the MHP. Coverage for emergency services includes emergency transportation, hospital emergency room services, and professional services.

2.3 FAMILY PLANNING SERVICES

MHP enrollees have full freedom of choice of family planning providers, both in-plan and out-of-plan. MHPs may not require prior authorization for family planning services, including the detection and treatment of STDs. MHPs may advise out-of-network family planning providers, including public providers, to communicate with primary care providers (PCPs) once any form of medical treatment is undertaken.

2.4 FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

MHP enrollees may access services provided through a Federally Qualified Health Center (FQHC).

FQHC providers must obtain prior authorization from the MHP. However, the MHP may not refuse to authorize medically necessary services if the MHP does not have a FQHC in the network in the county. The MHP may require FQHC providers to share information and data with the MHP and to provide appropriate referrals to providers in the MHP's network.

2.5 Maternal Infant Health Program (MIHP)

MHPs cover Maternal Infant Health Program (MIHP) services for enrollees who qualify for these services under Medicaid policy. MHPs must utilize the criteria specified in Medicaid policy to determine an enrollee's need for the services and provide the MIHP services specified in Medicaid policy. Only certified providers may deliver MIHP services to MHP enrollees. MHPs work cooperatively with the local Department of Human Services (DHS) office to maintain a referral protocol for those enrollees who need the assistance of the DHS Children's Protective Services. MIHP providers must work with the MHP and DHS Children's Protective Services to ensure appropriate care for MHP enrollees.

2.6 Out-of-Network Services

2.6.A. Professional Services

With the exception of the following services, MHPs may require out-of-network providers to obtain plan authorization prior to providing services to plan enrollees:

- Emergency services (screening and stabilization);
- Family planning services;
- Immunizations;
- Communicable disease detection and treatment at local health departments;
- Child and Adolescent Health Centers and Programs (CAHCP) services; and
- Tuberculosis services.

MHPs reimburse out-of-network (non-contracted) providers at the Medicaid fee-for-service (FFS) rates in effect on the date of service.

2.6.B. Hospital Services

MHPs reimburse hospitals according to the terms of the contract between the MHP and the hospital. If a hospital does not have a contract with an MHP but has signed a hospital access agreement with the MDCH, the following conditions apply:

- The hospital agrees to provide emergent services and elective admission services, arranged by a physician who has admitting privileges at the hospital, to Medicaid beneficiaries enrolled in MHPs with which the hospital does not have a contract.
- MHPs agree to continue to use network-contracted providers when available and appropriate.
- The hospital will be entitled to payment by MHPs for all covered and authorized (if required) services provided in accordance with their obligations under the agreement.
- A rapid dispute resolution process will be available for hospitals and MHPs who are unable to achieve reconciliation solutions for outstanding accounts through usual means.
- MHPs reimburse out-of-network (non-contracted) hospital providers at the Medicaid fee-for-service (FFS) rates in effect on the date of service. The payment for inpatient stays includes the relevant DRG and capital costs.

Copies of the Hospital Access Agreement, Health Plan Obligations, and Rapid Dispute Resolution are available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.) Hospitals that have signed the Hospital Access Agreement and the MHPs are required to abide by the terms and conditions of the agreement.

2.7 Mental Health

MHPs are required to provide up to 20 visits per calendar year under the Mental Health Outpatient benefit, consistent with the policies and procedures established by Medicaid. Services may be provided through contracts with Prepaid Inpatient Health Plans (PIHP) and/or Community Mental Health Services Programs (CMHSP) or through contracts with other appropriate providers within the service area. For mental health needs that do not meet Medicaid's established criteria or are beyond the 20-visit limitation, MHPs must coordinate with the appropriate PIHP/CMHSP to ensure that medically necessary mental health services are provided. The Mental Health/Substance Abuse chapter provides coverage policies for the PIHPs/CMHSPs.

2.8 Child and Adolescent Health Centers and Programs (CAHCP)

2.8.A. Requirements

MHPs must allow enrollees to obtain services from a CAHCP without prior authorization from the MHP. In order to receive payment for covered services, CAHCPs must follow the MHP's billing policies and procedures.

If the CAHCP is in the MHP's provider network, the following conditions apply:

- Covered services must be administered or arranged by a designated primary care physician (PCP)
- The CAHCP must meet the MHP's written credentialing and re-credentialing policies and procedures.
- The CAHCP must meet the MHP's criteria for ensuring quality of care and ensuring that all providers are licensed by the State of Michigan and practice within their scope of practice as defined in Michigan's Public Health Code.

2.8.B. Outreach Services

MHPs contract with CAHCPs to provide outreach services to school-aged children on behalf of the respective plans. The following represent categories of outreach activities that CAHCPs must provide under the contracts:

- Medicaid outreach and public awareness
- Facilitating Medicaid eligibility determination
- Program planning, policy development, and interagency coordination related to Medicaid services

- Referral, coordination, and monitoring of Medicaid services.
- Medicaid-specific training on outreach eligibility and services.

2.9 Substance Abuse, Inpatient and Outpatient

MHPs are not responsible for either inpatient or outpatient substance abuse services. Acute medical detoxification services for Medicaid beneficiaries are reimbursed directly by MDCH. (Refer to the Mental Health/Substance Abuse chapter for information on substance abuse services provided through the PIHPs/CMHSPs.)

2.10 Tuberculosis Services

MHP enrollees may obtain testing for tuberculosis from Local Health Departments (LHDs) without MHP prior authorization. Treatment may also be provided by the LHD without prior MHP authorization and regardless of whether a contractual or coordinating relationship exists between the MHP and the LHD. In the absence of a contract or other coordinating agreement, MHPs will reimburse the LHD at Medicaid fee-for-service (FFS) rates in effect on the date of service.

SECTION 3 – CLAIMS, COPAYMENTS AND REIMBURSEMENT

MHP claim completion requirements must be consistent with MDCH claim completion requirements as detailed in the Billing and Reimbursement chapters.

3.1 BLOOD LEAD TESTING

MHPs are encouraged to establish contractual or other coordinating relationships with local health departments (LHDs) that provide blood lead testing services. LHDs must conduct blood lead testing consistent with Medicaid policy. Similarly, MHPs must reimburse LHDs for blood lead testing as directed by Medicaid policy.

3.2 COPAYMENTS

MHPs may require that members pay copayments for certain services consistent with the requirements of the MHP Contract and Medicaid policy.

3.3 PAYMENT RESPONSIBILITY WHEN ENROLLMENT STATUS CHANGES

MHPs should refer providers to the Billing and Reimbursement chapters of this manual for clarification of payment responsibility if a Medicaid or CSHCS beneficiary changes enrollment status during a course of treatment.

3.4 REIMBURSEMENT FOR NONCONTRACTED PROVIDERS

Reimbursement for providers who are contracted with the MHP is governed by the terms of the contract. MHPs are required to pay noncontracted providers at Medicaid FFS rates for all properly authorized, medically necessary services for which a clean claim is submitted. Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements.

MEDICAL SUPPLIER

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SECTION 1 – PROGRAM OVERVIEW

This chapter applies to Medical Suppliers/Durable Medical Equipment, Orthotists/Prosthetists (Provider Types 85, 87).

The primary objective of the Medicaid Program is to ensure that medically necessary services are made available to those who would not otherwise have the financial resources to purchase them.

The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services that relate to the CSHCS qualifying diagnosis.

This chapter describes policy coverage for the Medicaid Fee-for-Service (FFS) population and the CSHCS population. Throughout the chapter, use of the terms Medicaid and MDCH includes both the Medicaid and CSHCS Programs unless otherwise noted.

Medicaid covers the least costly alternative that meets the beneficiary's medical need.

Below are common terms used throughout this chapter:

Medical Supplies	Medical supplies are those items that are required for medical management of the beneficiary, are disposable or have a limited life expectancy, and can be used in the beneficiary's home. Examples are: hypodermic syringes/needles, ostomy supplies, and dressings necessary for the medical management of the beneficiary. Medical supplies are items covered to: ▪ Treat a medical condition. ▪ Prevent unnecessary hospitalization or institutionalization. ▪ Support Durable Medical Equipment (DME) used by the beneficiary in the home.
Durable Medical Equipment (DME)	DME are those items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and can be used in the beneficiary's home. Examples are: hospital beds, wheelchairs, and ventilators. DME is a benefit for beneficiaries when: ▪ It is medically and functionally necessary to meet the needs of the beneficiary. ▪ It may prevent frequent hospitalization or institutionalization. ▪ It is life sustaining.
Orthotics	Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly, or malfunctioning portion of the body. Orthotics are a benefit to: ▪ Improve and/or restore the beneficiary's functional level. ▪ Prevent or reduce contractures. ▪ Facilitate healing or prevent further injury.

Prosthetics	Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body. Prosthetics are a benefit to: ▪ Improve and/or restore the beneficiary's functional level. ▪ Enable a beneficiary to ambulate or transfer.

1.1 Provider Types

Services provided must be appropriate for the specified provider types according to the Medical Assistance Provider Enrollment & Trading Partner Agreement (DCH-1625). The provider types and the services they may provide are as follows:

Provider Type 85: Orthotist and Prosthetist	▪ Prefabricated, custom-fitted and custom fabricated orthoses and prostheses ▪ Medical supplies related to orthotics and prosthetics (e.g., stump sox, etc.) ▪ Shoes
Provider Type 87: Medical Supplier	▪ Durable medical equipment (including oxygen) ▪ Medical supplies ▪ Prefabricated and specific custom-fitted orthoses (custom-fitting may only include simple or minor intervention) ▪ Shoes
Provider Type 88: Shoe Store	▪ Shoes, selected shoe inserts and additions

1.2 MDCH Medical Supplier/DME/Prosthetics and Orthotics Database

For specifics regarding the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes used to denote covered services, refer to the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database on the MDCH website, hereafter referred to as the MDCH Medical Supplier Database. (Refer to the Directory Appendix for contact information.) The database includes the HCPCS codes, short description, designated modifiers, quantity limits, prior authorization (PA) indicator, fee screens, International Classification of Diseases, Clinical Modification (ICD-9-CM) codes, and whether the item may be billed by a medical supplier if the beneficiary resides in a nursing facility. If there is no established procedure code that adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code.

1.3 Place of Service

Medicaid covers medical supplies, durable medical equipment (DME), orthotics, and prosthetics for use in the beneficiary's place of residence except for skilled nursing or nursing facility.

For residents in a skilled nursing or nursing facility, most medical supplies and/or DME are considered as part of the facility's per diem rate. The following items are exempt from the per diem rate and may be billed by the Medical Supplier:

- Air-fluidized beds.
- Bariatric beds.
- Custom-made wheelchairs may be covered when standard DME does not meet the functional needs of the beneficiary, is required for independence, if it can only be used by the specific beneficiary. (If purchased by Medicaid, the equipment becomes the property of the beneficiary.)
- Gaseous oxygen and equipment if required by the beneficiary for frequent or prolonged use (eight or more hours of use on a daily basis).
- Orthotics and Prosthetics.
- Parenteral nutrition, including all supplies, equipment, and solutions.
- Powered air flotation bed (low air loss therapy).
- Selected surgical dressings. (Refer to the MDCH Medical Supplier Database for specific procedure codes.)
- Shoes and Additional Components.

To determine the acceptable place of service (POS) codes allowed for billing purposes, refer to the Billing & Reimbursement for Professionals Chapter of this manual.

In an outpatient facility, all equipment and services required for treatment during an emergency room or clinic visit are included in the reimbursement to the hospital (e.g., cervical collar, air cast).

In an inpatient hospital setting, services provided as part of the hospital care and treatment would be part of the DRG payment to the hospital (e.g., cervical collar or cast). Services provided to be used after discharge and delivered to the hospital to facilitate discharge, may be reimbursed to the medical supplier (e.g., oxygen, walker, wheelchair).

1.4 Age Limitations

Coverage may be different based on the beneficiary's age. For specifics of HCPCS codes and age parameters, refer to the Coverage Conditions and Requirements Section of this chapter and the MDCH Medical Supplier Database.

1.5 Medical Necessity

Services are covered if they are the most cost-effective treatment available and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter.

A service is determined to be medically necessary if prescribed by a physician and it is:

- Within applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
- Medically appropriate and necessary to treat a specific medical diagnosis or medical condition, or functional need.

- Within accepted medical standards; practice guidelines related to type, frequency, and duration of treatment; and within scope of current medical practice.
- Inappropriate to use a nonmedical item.
- The most cost effective treatment available.

1.5.A. Prescription Requirements

A prescription must contain all of the following:

- Beneficiary's name;
- Date of birth (DOB);
- Beneficiary ID number, or Social Security Number (SSN) (if known);
- Prescribing physician's name, address, and telephone number;
- Prescribing physician's signature (a stamped or co-signature will not be accepted);
- The date the prescription was written;
- The specific item prescribed;
- The amount and length of time that the service is needed; and
- State date of order if different from the physician's signature date.

The prescription must meet the following timeframes:

- For medical supplies, refills may be allowed up to one year from the original physician's signature date on the prescription.
- For oxygen, ventilators, and other long-term use, up to one year from the original physician signature date.
- For purchase of DME, the original physician signature date must be within the last 180 days.
- For orthotics and prosthetics, the original physician signature date for an initial service must be within the last 60 days. For replacement of an orthosis or prosthesis, the physician signature date must be within the last 180 days.

A new prescription will be required when there is a change in the beneficiary's condition causing a change in the item or the frequency of its use.

The provider may complete a detailed description of the item with applicable HCPCS procedure codes but the treating physician must review this description and personally sign and date the order to indicate agreement. The provider may not change or modify a prescription, certificate of medical necessity (CMN), or any other physician or healthcare practitioner's signed documentation.

For beneficiaries eligible for CSHCS coverage only, the following additional requirements apply:

- The prescription must be related to the CSHCS qualifying diagnosis. (Providers must verify this information by referring to the beneficiary's eligibility letter received from CSHCS.)
- A physician subspecialist must sign the prescription if it is stated as required by the CSHCS Program in the Coverage Conditions and Requirements Section of this chapter.

MDCH reserves the right to request additional documentation from a specialist for any beneficiary and related service on a case-by-case basis if necessary to determine coverage of the service.

1.5.B. Documentation

The Coverage Conditions and Requirements Section of this chapter specifies the documentation requirements for individual service areas. Additional information other than what is required on the prescription may be required. To provide this information, Medicaid accepts a certificate of medical necessity (CMNs will be mandatory for electronic PA), a letter or a copy of applicable medical record. The prescribing physician must sign all documentation and the documentation (if a letter or applicable medical records) must state the beneficiary's name, DOB and ID number (if known) or SSN (if known).

1.5.C. Certificate of Medical Necessity Requirements

A CMN must contain all of the following:

- Beneficiary's name and address;
- Date of Birth (DOB);
- Beneficiary ID number (if initiated by the Provider) or SSN;
- Prescribing physician's signature, date of signature, telephone number;
- The suppliers' name and address;
- The expected start date of the service (if different from the prescription date);
- A complete description of the item;
- The amount and length of time the item is needed;
- Beneficiary's diagnosis; and
- The medical necessity of the item.

For specifics, refer to the Coverage Conditions and Requirements Section of this chapter.

MDCH will accept a CMN initiated by a medical supplier, orthotist or prosthetist. However, only the beneficiary identifier fields and the areas detailing the description of the item with applicable HCPCS procedure codes are to be completed by the provider. The physician must complete the CMN by writing the medical reason or necessity for the specific item being requested. A medical supplier, orthotist, or prosthetist may not alter or write the medical reason or necessity for the item requested.

Additional documentation (including the CMN) must be current and within the timeframe stated in the Coverage Conditions and Requirements Section of this chapter, under Documentation for each item.

1.6 Documentation in Beneficiary File

The supplier must maintain all required documentation for the specific service in the beneficiary's file for six years. For audit purposes, the supplier's records or beneficiary's medical record must contain the prescription and required documentation that substantiates the medical necessity of the item supplied. In addition to the prescription and any applicable documentation required, the provider must maintain on file:

- Equipment use logs or other provider required documentation as stated in the Coverage Conditions and Requirements Section of this chapter under Documentation for the item.
- For items purchased, proof of purchase (e.g., delivery slips, sales slips, vouchers).
- For items rented, set-up slips and pick-up slips with signature of beneficiary or legal representative, and maintenance records.
- For items shipped directly to beneficiary, date of delivery must be maintained in the records with delivery slip. Please note that it is the provider's responsibility to replace a service for which the beneficiary states was not received without additional cost to MDCH or beneficiary.
- Proof of education and instruction to beneficiary and/or caregiver regarding the proper usage of equipment and/or supplies when applicable (e.g., delivery slip signed by beneficiary).

1.7 Prior Authorization

Prior authorization (PA) is required for certain items before the item is provided to the beneficiary or in the case of custom-made DME or prosthetic/orthotic appliances, before the item is ordered. To determine if a specific service requires PA, refer to the Coverage Conditions and Requirements Section of this chapter and/or the MDCH Medical Supplier Database on the MDCH website.

PA will be required in the following situations:

- Services that exceed quantity/frequency limits or established fee screen.
- Medical need for an item beyond MDCH's Standards of Coverage.
- Use of a Not Otherwise Classified (NOC) code.
- More costly service for which a less costly alternative may exist.
- Procedures indicating PA is required on the MDCH Medical Supplier Database.

1.7.A. Prior Authorization Form

Requests for PA must be submitted on the Special Services Prior Approval-Request/Authorization form (MSA-1653-B). (Refer to the Forms Appendix for a copy of the PA form and completion instructions.) In addition, medical documentation (e.g., prescription, CMN, letter or other) must accompany the form. The information on the PA request form must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Complete – The provider must provide the specific HCPCS code and the HCPCS code description. If the service falls under a NOC code, a complete description of the service and/or specific materials and labor time, if applicable. The prescription must be submitted with the request. (Refer to the Coverage Conditions and Requirements Section of this chapter for additional information.)

PA request forms and attached documentation may be mailed or faxed to the MDCH Prior Authorization Division. (Refer to Directory Appendix for contact information.)

Instructions for the electronic submission of PA requests and the HIPAA 278 transaction code set are available on the MDCH website.

1.7.B. Emergency Prior Authorization

A provider may contact MDCH to obtain a verbal PA when the prescribing physician has indicated that it is medically necessary to provide the service within a 24-hour time period.

To obtain a verbal PA, the provider may call the Prior Authorization Division or fax a request. If the provider chooses to use a PA form to request a verbal authorization, "verbal PA request" must be in box 37 and the physician's name and phone number. (Refer to the Directory Appendix for contact information.)

If an emergency service is required during nonworking hours (i.e., after 4:00 p.m., weekends, and State of Michigan holidays), the provider must contact the Prior Authorization Division on the next available working day.

The following steps must still be completed before an actual PA number is issued for billing purposes:

- Submission of the PA request (MSA-1653-B) to MDCH within 30 days of the verbal authorization. (Include the date of the verbal authorization in Box 37.)
- Submission of the supporting documentation (e.g., prescription and CMN, physician letter, or applicable medical record).

The PA number will not be given for billing MDCH and the provider will not be reimbursed if:

- The beneficiary was not eligible when the service was provided.
- A completed PA request (MSA-1653-B) is not received within 30 days of the verbal authorization.
- Required prescription and documentation is not received.
- The prescription and/or documentation are not signed within 30 days of the effective date.
- The prescription and/or documentation are not received within 30 days of the date of service (DOS).
- The medical need for the service is different than what was verbally given and does not fall within the Standards of Coverage.

Verbal authorization does not guarantee payment or eligibility.

1.7.C. Retroactive Prior Authorization

Services provided before PA is requested will not be covered unless the beneficiary was not eligible on the DOS and the eligibility was made retroactive. If MDCH's record does not show that retroactive eligibility was provided, then the request for retroactive PA will be denied.

1.7.D. Beneficiary Eligibility

Approval of a service on the MSA-1653-B confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the DOS, or is enrolled in a Medicaid Health Plan (MHP) and the provider orders or delivers the service, MDCH will not reimburse the provider. To assure payment, the provider must verify eligibility prior to ordering or delivering the service. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

When equipment is prior authorized (if required) and ordered, but not delivered before the loss of eligibility, MDCH will pay for the service if the product is delivered within 30 days after the loss of eligibility.

1.7.E. Changes in Enrollment (FFS/MHP)

When beneficiaries change enrollment status (e.g., from managed care to FFS or FFS to managed care) the following applies:

- When custom-made equipment, prosthetic or orthotic, is ordered for a beneficiary during a hospital stay but not delivered until discharge and enrollment changes, the payment must be made by the party responsible for the hospital stay.
- When a custom-made, fit, or modified service is prior authorized and ordered by the provider before a change of enrollment, the party that authorized the service is responsible for payment. This responsibility only applies if the service is delivered within 30 days of the change of eligibility.

This policy does not apply to prefabricated, mass-produced, or ready-made items that can be used by a person other than for whom it is ordered. It also excludes rental items, all expendable/disposable medical supplies, or any item that does not require a length of time (days or weeks) to special order for a specific person.

1.7.F. Age Parameters

Some services are only covered if the beneficiary is under the age of 21. For specifics regarding PA requirements and coverage, refer to the MDCH Medical Supplier Database on the MDCH website or the Coverage Conditions and Requirements Section of this chapter.

1.7.G. Reimbursement Amounts

Most items have established fee screens that are published in the MDCH Medical Supplier Database. The approved reimbursement amount of the fees for NOC codes, and all codes without established fee screens, will be indicated on the authorized PA request. The provider must provide a manufacturer's invoice or other documentation that states the acquisition cost for the service on the PA request form. If the provider is requesting reimbursement for labor, the specific time must be stated on the request form.

Medicaid payment rates may not exceed those paid by Medicare. MDCH will adjust its Medicaid fee schedule when Medicare rate changes result in noncompliance with that requirement. The changes will be reflected in the MDCH Medical Supplier Database. No notice will be issued directly to providers.

1.7.H. Billing Authorized Services

After an authorization is issued, the information (e.g., PA number, procedure code, modifier, and quantity) that was approved on the authorization must match the information on the invoice. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for complete billing instructions.)

1.7.I. Hospital Discharge Waiver Services [Change Made 4/1/06]

Hospital Discharge Waiver Services are DME items rented for the beneficiary in which the PA requirement is waived for up to the first three months after hospital discharge. If the beneficiary still requires these items after three months from hospital discharge, the PA requirement would still apply.

These items are as follows: HCPCS codes E0163, EO165, E0176, E0180, E0255, E0256, E0260, E0292, E0293, E0565, E0619, E0910, E0940, E0961, E0973, E0990, E1226, K0001, K0002, K0003, and K0004. **(list corrected 4/1/06)**

1.8 Durable Medical Equipment

1.8.A. Standard and Custom-Modified versus Custom-Made Equipment

Standard, custom-modified, or custom-made equipment must be medically necessary and meet the medical need and/or functional need of the beneficiary.

- Custom-modified or custom-fitted refers to modifications to a standard item to meet functional needs of a beneficiary by using prefabricated parts (e.g., addition of a strap to a standard item) based on the measurement of the specific beneficiary.
- Custom-made equipment is fabricated to meet the beneficiary's specific medical and/or functional need. The item cannot be used by another beneficiary and conforms to individual measurements, body castings and/or moldings. It incorporates minimal use of prefabricated components, with the majority of the device being fabricated specifically for the beneficiary.

MDCH will consider coverage of custom-made equipment when a standard or custom-modified item (commercially available) will not meet the medical and/or functional needs of the user. All custom-made equipment requires PA. Once the custom-made equipment is purchased, it becomes the property of the beneficiary.

1.8.B. Payment Rules: Rental and/or Purchase

Generally, equipment will be purchased when a beneficiary requires the equipment for an extended period of time. For prior authorized services, the PA consultant may change the authorization request from a rental to a purchase or a purchase to a rental based on the documentation submitted. If DME items are purchased, the provider must indicate whether the DME item provided is new or used as appropriate. The provider should refer to the Payment Rules described in the Coverage Conditions and Requirements Section of this chapter for MDCH's policy on specific services.

Purchase (New or Used) - Items may be purchased if they are inexpensive accessories for other DME equipment or the equipment itself will be used for an extended period of time.	To be reimbursed for **new** equipment, the provider must: ▪ Adhere to all aspects of the manufacturer's warranty, including all routine servicing, ▪ Deliver, set-up and install the equipment in the home, if applicable, ▪ Instruct the beneficiary or caregiver in the use and general care of the item, and ▪ Complete all adjustments and/or modifications needed to make the item functional.
	To be reimbursed for **used** equipment, the provider must: ▪ Ensure that the used equipment is fully serviced and in good operating condition, ▪ Include all routine servicing for the equipment into the purchase price of the item for a minimum of one year, ▪ Instruct the beneficiary or caregiver in the use and general care of the item, and ▪ Not allow the cost of its maintenance to exceed the cost of new equipment.
Rental - The rental payment includes routine servicing and all necessary repairs or replacements to make the rented item functional.	**Rental Only** – Items that require regular and ongoing servicing/maintenance would be rented for the duration indicated by the physician's order. Examples are oxygen, apnea monitors, and volume ventilators.
	Capped Rental – Items rented until purchase price is reached. For Medicaid, items may be rented for a maximum period of 10 months. If the provider has been reimbursed for 10 months of rental, the item is considered purchased. (If used equipment is issued to the beneficiary, the usual and customary charge reported to Medicaid must accurately reflect that the item is used.)
	Converting Rental to Purchase – The majority of DME items can be rented as a capped rental for up to a maximum of 10 months. If the purchase of an item is requested after an initial rental period has occurred, the provider must subtract the amount already paid for the rental item from the total purchase price.

1.8.C. Repairs and Replacement Parts

Repairs and the replacement of component parts for DME owned by the beneficiary are reimbursable if MDCH purchased the item. If MDCH did not reimburse for the original item, it must be medically necessary, meet the Standards of Coverage detailed in this chapter and prescription and documentation requirements must be met as if MDCH were being asked to purchase.

For purchased items, all conditions of the warranty must be followed prior to requesting any repairs or replacement parts. Routine periodic servicing, such as cleaning, testing, regulating, and checking of equipment is also included in the cost of the equipment. If equipment is found to be defective or not operating properly, it must be removed from service and cannot be placed into use again until it is brought up to manufacturer's operating standards and specifications. It is the responsibility of the provider to supply

loaner equipment while the beneficiary-owned item is being serviced at no charge to MDCH. For audit purposes, all suppliers must maintain protocols and records defining how the maintenance of equipment is to be achieved.

MDCH will consider reimbursement for a replacement when it is more costly to repair than replace. When submitting a PA request for a replacement, the provider must provide a statement regarding the cost to repair the service versus replacement.

Repairs and the replacement of component parts for DME do not apply to an item that is currently being reimbursed by MDCH as a rental.

Repair of DME involving the replacement of a component part includes the cost of the part and the labor associated with its removal, replacement and finishing. The RP modifier is required.

For a repair in which no specific HCPCS code is appropriate, report HCPCS code E1340 (for the labor charge) and HCPCS code E1399 (for the replacement part). For wheelchairs, HCPCS code K0108 is to be used in place of HCPCS code E1399. RP modifier is reported for these codes. PA is required. The provider must provide a manufacturer's invoice or other documentation that states the acquisition cost for the service with the PA request form. If the provider is requesting reimbursement for labor, the specific time must be stated on the request form.

The replacement of a DME item will be considered when a significant change in the patient's condition has occurred or the cost of the equipment repair is greater than replacement. If the DME item cannot be restored to a serviceable condition and there has been no change in the medical condition of the beneficiary, MDCH will consider replacement if the existing equipment meets coverage criteria or was purchased by the program. In these cases, a current prescription will meet documentation requirements for the equipment. If there has been a change in the medical condition that would reflect a change in equipment need, then all documentation requirements in the Coverage Conditions and Requirements Section of this chapter apply. Replacement of DME for youth will be evaluated on an individual basis due to the expected growth pattern.

MDCH will not replace an item due to damage to the item as a result of misuse or abuse by the beneficiary or the caregiver. If damage to an item is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable. A copy of the police or fire report must be submitted with the PA request form.

The provider may not provide or substitute a service of lesser quality or provide a different brand or type than what was authorized through PA or would fall under the HCPCS code description to accommodate Medicaid fee screens.

The provider may not add additional component HCPCS codes or bill for a more complex code (e.g., custom versus prefabricated) to increase the amount of reimbursement. The provider may not bill for a HCPCS code describing a custom-made service in lieu of the availability of a code to cover a prefabricated item.

1.9 Prosthetics and Orthotics

For custom-made prosthetics and orthotics (P&O), MDCH reserves the right to request a recommendation from an appropriate physician subspecialist, physical therapist (PT) or occupational therapist's (OT) evaluation, when necessary to determine the functional and/or medical need for the item requested.

1.9.A. Noncustom versus Custom-made

Noncustom orthotics are prefabricated, available off the shelf for use, require basic measurements, and could include simple or minor custom fitting if necessary. Any delivery or service charges, fitting and preparatory procedures are considered part of the total purchase charge. Custom-made P&O require measurements, fitting, casting or recasting, or molding to allow the appliance to meet the specific functional needs of the beneficiary. It may involve the incorporation of some prefabricated components. Adding prefabricated components to a prefabricated item is not considered custom-made. Selection of the procedure code should be based on the service provided. Custom codes should not be used for prefabricated services.

All orthotist and prosthetist providers (Type 85) must have facility accreditation through the American Board for Certification in Orthotics and Prosthetics, Inc. (ABC) in order to furnish and bill for custom-made P&O appliances. Providers must maintain their ABC accreditation and be able to provide proof upon request. Any provider currently enrolled as a Type 87 with proof of ABC facility accreditation must re-enroll as a Type 85 in order to furnish custom-made P&O items. Provider Type 87 providers must only bill specific prefabricated and custom-fitted orthotics that may include simple or minor intervention.

Medicaid will continue to consider coverage of these services when provided by other types of practitioners in which the service is within their scope of current medical practice.

1.9.B. HCPCS Modifiers - Left and Right Side of the Body

The LT or RT modifiers must be reported for orthoses and prostheses to designate either the left or right side of the body if applicable. The frequency limits are based on the individual item being replaced. If the same code is used bilaterally on the same date of service, the items LT and RT must be entered on the same line of the claim listing the appropriate combined quantities. To determine whether a procedure code requires the LT or RT modifier, refer to the MDCH Medical Supplier Database on the MDCH website. (Refer to the Directory Appendix for contact information.)

The provider may not provide or substitute a service of lesser quality or provide a different brand or type than what was authorized through PA or items that would fall under the HCPCS code description to accommodate the Medicaid fee screens.

The provider may not add additional component HCPCS codes or bill for a more complex code (e.g., custom versus prefabricated) to increase the amount of reimbursement. The provider may not bill for a HCPCS code describing a custom-made service in lieu of the availability of a code to cover a prefabricated item.

1.9.C. Adjustments, Replacements and Repairs

Adjustments related to the delivery of orthoses are considered as part of the purchase price and are not separately reimbursable up to 90 days following placement. Providers are still responsible for the replacement, modification, and adjustment of any orthotic or prosthetic item that they placed but was not fitted properly. It is expected that the provider will adjust the device if possible before billing the program for modifications or replacements when there is unexpected growth spurt, substantial weight loss or gain, or post surgery.

Replacement of a component part of an orthosis includes the cost of the part and the labor associated with its removal, replacement and finishing. The RP modifier is required.

For a **repair** in which no specific HCPCS code is appropriate, bill for the actual time it takes to repair or adjust the device and for the minor materials used. Report the labor charge by using HCPCS code L4205 (for orthoses) or HCPCS code L7520 (for prostheses). For minor materials used in repairing the item, report HCPCS code L4210 (for orthoses) or HCPCS code L7510 (for prostheses). No "RP" modifier should be reported with these procedure codes. MDCH will cover the acquisition cost of material, not the provider's charge.

1.10 Noncovered Services

Services that are not covered by Medicaid include, but are not limited to:

- Adaptive equipment (e.g., rocker knife, swivel spoon, etc.)
- Air conditioner
- Air purifier
- Enteral formulae to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or noncompliance with a specialized diet
- Environmental Control Units
- Equipment not used or not used properly by the beneficiary
- Exam tables/massage tables
- Exercise equipment (e.g., tricycles, exercise bikes, weights, mat/mat tables, etc.)
- Generators
- Heating pads
- Home modifications
- Hot tubs

- House/room humidifier
- Items for a beneficiary who is non-compliant with a physician's plan of care (or) items ordered for the purpose of solving problems related to noncompliance (e.g. insulin pump)
- Items used solely for the purpose of restraining the beneficiary for behavioral or other reasons
- Lift chairs, reclining chairs, vibrating chairs
- More than one pair of shoes on the same date of service
- New equipment when current equipment can be modified to accommodate growth
- Nutritional formulae representing only a liquid form of food
- Nutritional puddings/bars
- Over-the-counter shoe inserts
- Portable oxygen, when oxygen is ordered to be used at night only
- Power tilt-in-space or reclining wheelchairs for a long-term care resident because there is limited staffing
- Pressure gradient garments for maternity-related edema
- Prosthetic appliances for a beneficiary with a potential functional level of K0
- Regular or dietetic foods (e.g., Slimfast, Carnation instant breakfast, etc.)
- School Items (e.g., computers, writing aids, book holder, mouse emulator, etc.)
- Second wheelchairs for beneficiary preference or convenience
- Sensory Devices (e.g., games, toys, etc.)
- Sports drinks/juices
- Stair lifts
- Standard infant/toddler formulae
- Therapy modalities (bolsters, physio-rolls, therapy balls, jett mobile)
- Thickeners for foods or liquids (e.g., Thick – it)
- Toothettes
- Transcutaneous Nerve Stimulator when prescribed for headaches, visceral abdominal pain, pelvic pain, or temporal mandibular joint (TMJ) pain
- Ultrasonic osteogenesis stimulators
- Weight loss or "light" products
- Wheelchair lifts or ramps for home or vehicle (all types)
- Wheelchair accessories (e.g., horns, lights, bags, special colors, etc.)
- Wigs for hair loss

For specific procedure codes that are not covered, refer to the MDCH Medical Supplier Database on the MDCH website or the Coverage Conditions and Requirements Section of this chapter.

1.11 Charging the Beneficiary

The provider may not charge the beneficiary for failure to provide sufficient documentation to support coverage or failure to obtain PA. The provider may charge the beneficiary if the beneficiary waives his right to PA. The provider must maintain on file a document that demonstrates that the beneficiary knew and understood that the waiver of PA would result in the beneficiary's responsibility for payment. In addition, the provider may not charge the beneficiary any co-payments (unless permitted by Medicaid) or charges above the Medicaid allowable amount.

SECTION 2 – COVERAGE CONDITIONS AND REQUIREMENTS

2.1 APNEA MONITOR

Definition	An apnea monitor measures both heart rate and respirations and meets all of the Equipment Control Regulatory Industry (ECRI) Standards for home monitors.
Standards of Coverage	**A Newborn Infant Following Hospital Discharge –** Units are covered for a newborn infant up to three months following hospital discharge if one of the following diagnoses or medical conditions applies: ▪ Apnea of newborn ▪ Apnea of prematurity ▪ Apparent life threatening event (ALTE) ▪ Sibling of Sudden Infant Death Syndrome (SIDS) ▪ Bronchopulmonary Dysplasia
	A Sibling of Sudden Infant Death Syndrome (SIDS) Following Hospital Discharge – ▪ Units are covered for up to one month past the age of the sibling who died from SIDS; or ▪ Up to three months past the age of the sibling who died if the child was a twin of the beneficiary being monitored.
	An Acute Respiratory Illness - Short-term coverage of a unit (up to two months) is a benefit when the beneficiary has a respiratory illness/diagnosis such as Pertussis, Respiratory Syncytial Virus (RSV), or Pneumonia.
	As a Diagnostic Tool - Short-term coverage of a unit (up to three months) used as a diagnostic tool is a benefit if the infant is under three months of age at set up, and the parent and/or guardian reports suspected events.
	Beneficiaries with Tracheostomy – Units are generally not covered for beneficiaries who have a tracheostomy. Units may be considered for coverage only if, after careful evaluation of current treatment plan and equipment already in the home, the beneficiary's medical needs are still not met. Documentation explaining the medical need must be submitted with a detailed plan of management.
	Beneficiaries who are Ventilator Dependent - Units are considered to be included in the ventilator reimbursement to function as a back up alarm for the ventilator low-pressure alarm.

Noncovered Conditions	Units are not covered for the following diagnoses/medical conditions unless documentation justifies medical necessity and usage meets the established Standards of Coverage above: ▪ Chromosomal abnormalities ▪ Congenital heart defects with or without arrythymias ▪ Cerebral palsy ▪ Asymptomatic prematurity ▪ Developmental delay/mental retardation ▪ Seizure disorder ▪ Hydrocephaly with or without Arnold-Chiari Syndrome ▪ Irreversible terminal conditions ▪ Distant family history of SIDS (other than immediate sibling)
Documentation	The documentation must be less than 30 days old and include all of the following: ▪ A statement from an appropriate subspecialist trained in the treatment of apnea (i.e., apnea clinic, neonatalogist, pediatric intensivist, pediatric pulmonologist, or neurologist) medically substantiating the continued need for the unit. ▪ Download interpretation of the monitor data documenting continued apnea or bradycardia events. ▪ For a sibling of SIDS, the age of the sibling at death.
PA Requirements	PA is not required for any of the following if the Standards of Coverage are met: ▪ Up to three months usage for newborn infants following a hospital discharge. ▪ Up to three months usage for siblings of SIDS following a hospital discharge. ▪ Used up to two months due to a respiratory illness (e.g., Pertussis, Respiratory Syncytial Virus (RSV), or Pneumonia). ▪ Used up to three months as a diagnostic tool for the following diagnoses or medical conditions: ➢ Apnea of newborn ➢ Apnea of prematurity ➢ Apparent life threatening event (ALTE) ➢ Sibling of Sudden Infant Death Syndrome (SIDS) ➢ Bronchopulmonary Dysplasia
	PA is required for either of the following: ▪ Continuation of the monitor beyond the initial two or three months. ▪ For other diagnosis/medical conditions or applications not indicated in the Standards of Coverage.

Payment Rules	An Apnea Monitor is considered a **rental only** item and includes all of the following: ▪ All accessories needed to use the unit (e.g., electrodes, lead wires, belts, cables, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. ▪ Periodic downloading/interpretation of recorded data.

2.2 Bi-Level Positive Airway Pressure Device

Definition	The bi-level positive airway pressure (BIPAP) device delivers a noninvasive positive air pressure into the upper airway to assist spontaneous respiratory efforts. The device has two pressure levels (one for breathing in and one for breathing out).
Standards of Coverage	A BIPAP device **without the backup rate feature** may be covered for the following conditions for up to four months: ▪ For Obstructive Sleep Apnea (OSA), if the sleep study (polysomnogram) performed in an accredited Sleep Center or Sleep Laboratory documents the following: ➢ Continuous airway pressure of 13-15 cm water does not adequately control/eliminate obstructive/hypopnic events; or ➢ The beneficiary cannot tolerate continuous positive airway pressures of greater than or equal to 12 cm water, in addition to evidence that the sleep lab has worked with the beneficiary to try different application devices, ramp times, relaxation techniques, etc. ▪ For respiratory failure if there are lab values (i.e., arterial blood gas [ABG], venous blood gas [VBG] or capillary blood gas) indicating respiratory failure and follow-up lab values documenting improvement with the use of a BIPAP. ▪ For a diagnosis/medical condition for which a CPAP is inappropriate for use (e.g., cardiomyopathy, corpulmonale, primary pulmonary hypertension, left ventricular hypertrophy, etc.).
	A BIPAP device **with the backup rate feature** may be covered if the beneficiary requires the backup feature due to insufficient spontaneous respiratory efforts (e.g., inadequate negative respiratory force due to central apnea, neuromuscular diseases such as muscular dystrophy, etc.).
Documentation	Documentation must be less than 90 days old and include: ▪ Diagnosis related to the need for BIPAP. ▪ BIPAP settings and number of hours per day used. ▪ Other medical conditions ruling out the appropriate use of a CPAP if present (e.g., cardiomegaly, left ventricular hypertrophy, primary pulmonary hypertension, etc.).

	▪ For diagnosis of OSA, results of a sleep study (polysomnogram) including CPAP/BIPAP titration. ▪ For diagnosis of respiratory failure, test results substantiating the condition (e.g., ABG, VBG, or capillary gas values) as well as test results showing improvement on BIPAP. ▪ Negative inspiratory force measurement, if appropriate. For continued coverage beyond the initial four months, the following additional information must be provided: ▪ Medical statement indicating beneficiary is stable and the BIPAP device settings are adequate. Documentation of beneficiary compliance through the review of equipment use logs.
PA Requirements	PA is required for all BIPAP requests.
Payment Rules	BIPAP units are considered a **capped rental** item and are inclusive of all of the following: ▪ All accessories needed to use the unit (e.g., tubing, application devices, chinstrap, headgear, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.3 BLOOD GLUCOSE MONITORING EQUIPMENT AND SUPPLIES

Definition	Blood glucose monitoring supplies and equipment are defined as those items necessary to monitor blood glucose levels. The equipment and supplies include, but are not limited to, blood glucose monitors, testing strips, lancets, and calibrator solution/chips.
Standards of Coverage	A home blood glucose monitor and related supplies are covered when a beneficiary has been diagnosed with diabetes and it is medically necessary to monitor fluctuations of blood glucose levels on a daily basis. Diabetes includes: ▪ Gestational diabetes ▪ Insulin-dependent diabetes ▪ Non-insulin dependent diabetes
Documentation	Documentation must be less than 90 days old and include all of the following: ▪ Diagnosis/condition related to the need for the blood glucose monitoring. ▪ Items to be dispensed. ▪ Quantity of items to be dispensed for one month's usage. ▪ Frequency of testing.

	▪ For beneficiaries under 21, treatment plan for treating abnormal blood glucose levels (if pediatric endocrinologist did not order the monitor/supplies). **For CSHCS beneficiaries**, a prescription from a Pediatric Endocrinologist is required.
PA Requirements	PA is not required when the Standards of Coverage are met and the beneficiary has one of following diagnoses: ▪ Diabetes Mellitus Without Mention of Complications ▪ Diabetes With Ketoacidosis ▪ Diabetes With Hyperosmolarity ▪ Diabetes With Other Coma ▪ Diabetes With Renal Manifestations ▪ Diabetes With Opthalmic Manifestations ▪ Diabetes With Neurological Manifestations ▪ Diabetes With Peripheral Circulatory Disorders ▪ Diabetes With Other Specified Manifestations ▪ Diabetes With Unspecified Complication ▪ Diabetes Mellitus Complicating Pregnancy ▪ Abnormal Glucose Tolerance (Gestational Diabetes Only)
	PA is required for: ▪ Home glucose monitors with special features such as voice synthesis. ▪ Medical need not within the Standards of Coverage and/or a diagnosis that has not been removed from PA. ▪ Replacement within three years.
Payment Rules	All items (including the monitor) are considered **purchase only** items. To report date of service (DOS) for blood glucose test or reagent strips, lancets, and normal, low and high calibrator solution, use a span date in the "From" and "To" fields, not to exceed one month.

2.4 Blood Pressure Monitoring

Definition	Blood pressure monitoring includes manual and automatic blood pressure units.
Standards of Coverage	A manual blood pressure unit may be covered for a beneficiary under the age of 21 when: ▪ Daily titration of medications is required for renal disease. ▪ A cardiovascular condition is present that affects blood pressure (e.g., congenital heart disease). ▪ A brain lesion or cancer tumor is present that affects blood pressure. ▪ A medication regimen is present that affects blood pressure.
	Coverage for beneficiaries age 21 and over with uncontrolled blood pressures when one of the following is present: ▪ Fluctuation in blood pressure as a result of renal disease. ▪ Medications are titrated based on blood pressure readings.
	Automatic Blood Pressure Monitor is covered when: ▪ Standards of coverage for a manual unit have been met. ▪ Beneficiary is age 11 or over. ▪ Economic alternatives such as a manual blood pressure unit has been either tried or ruled out prior to requesting authorization of an automatic blood pressure monitor.
Documentation	The documentation must be less than 30 days old and include: ▪ Diagnosis/medical condition pertaining to the need for the blood pressure monitor. ▪ Complete physician's treatment plan, including current blood pressure medications, frequency of checks, and specific patient protocol in case of an abnormal reading. ▪ The medical reason a manual blood pressure unit cannot be used for beneficiaries over the age of ten years. ▪ Prescription from a pediatric nephrologist when daily titration of medications is required for renal disease (**required for coverage under CSHCS**).
PA Requirements	PA is required for all blood pressure units.
Payment Rules	A blood pressure monitor is considered a **purchase only** item**.**

2.5 BREAST PUMP

Definition	A hospital grade electric breast pump is heavy duty, piston-operated, and is capable of being used frequently on a daily basis.
Standards of Coverage	A hospital grade electric breast pump may only be covered for a beneficiary with a Neonatal Intensive Care Unit (NICU) infant, up to three months of age, when one of the following applies: ▪ The infant has a severe feeding problem secondary to cleft lip and/or palate. ▪ The infant has a severe feeding problem due to oral motor dysfunction, secondary to pre-maturity. ▪ The infant is hospitalized resulting in a physical separation of the mother and infant. For continued coverage beyond the initial three months, additional documentation must be provided.
Documentation	Documentation must be less than 30 days old and include: ▪ Diagnosis/medical condition of the infant relating to the need for a breast pump. ▪ Infant's age (gestational age, if premature). ▪ Mother's discharge date. ▪ Anticipated duration of need.
PA Requirements	PA is not required when the Standards of Coverage are met.
	PA is required for coverage beyond three months.
Payment Rules	A breast pump is considered a **rental only** item and is inclusive of the following: ▪ All related accessories necessary to use the equipment (To obtain additional reimbursement for the initial breast pump kit, report the "KH" modifier with HCPCS code E0604 for the first month of rental only). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. The rental pump may be billed using the infant's Medicaid ID number if the need for the hospital grade pump meets the standards of coverage and the mother loses Medicaid eligibility.

2.6 CANES AND CRUTCHES

Definition	Canes or crutches include, but are not limited to, adjustable or fixed canes, quad or three prong canes, forearm crutches and under arm crutches.
Standards of Coverage	Canes or crutches are covered if: ▪ The diagnosis/medical condition results in instability in ambulation or inability to ambulate. ▪ The beneficiary requires the stability of a cane or crutch to ambulate.
Documentation	Documentation must be less than 180 days old and include the following: ▪ Diagnosis/medical condition related to instability or inability to ambulate. ▪ Type of item requested. ▪ Medical reason for replacement (when appropriate).
PA Requirements	PA is not required when Standards of Coverage are met.
	PA is required when: ▪ The beneficiary is over the age of 21, and replacement is required within five years. ▪ The beneficiary is under the age of 21, and replacement is required within one year. For replacement of pads, handgrips or tips, the provider may call for a verbal authorization. The provider must provide acquisition cost supported by a manufacturer's invoice. A prescription is not required if the program has covered the cane and/or crutch. The original prescription for the item must be kept on file.
Payment Rules	Canes and crutches are considered **purchase only** items.

2.7 CHILDREN'S PRODUCTS

Definition	Children's products that may be considered for coverage include, but are not limited to, equipment that is used in the home or vehicle by children under age 21 for the purposes of positioning, safety during activities of daily living, or assisted mobility. Examples of these items include: bath supports, specialized car seats, corner chairs, dynamic standers, feeder seats, gait trainers, pediatric walkers, positioning commodes, side lyers, standers, and toileting supports.

Standards of Coverage	Children's products are covered if one or more of the following applies: ▪ Beneficiary is unable to independently maintain a seated position. ▪ Beneficiary cannot stand and/or ambulate without the aid of an assistive device. ▪ Beneficiary has physical anomalies that require support to allow a functional position or prevent further disability.
Documentation	Documentation must be less than 180 days old and include all of the following: ▪ Diagnosis appropriate for the equipment requested. ▪ Any adaptive or assistive devices currently used in the home. ▪ Reason economic alternatives cannot be used, if applicable. ▪ Statement of functional need from an appropriate pediatric subspecialist, occupational, or physical therapist.
PA Requirements	PA is required for all requests.
Payment Rules	All children's products are considered **purchase only** items**.**

2.8 COMMODES

Definition	A commode is a chair with an enclosed pan or pail that may be stationary or mobile, with fixed or removable arms, a seat lift, and footrest.
Standards of Coverage	A **standard commode** may be covered if the beneficiary is unable to safely use home toileting facilities, is confined to a single room, or is confined to one level of the home in which no toileting facilities are available.
	A **heavy-duty commode** may be covered for a beneficiary weighing 300 pounds or greater and the beneficiary is unable to safely use home toileting facilities, is confined to a single room, or is confined to one level of the home in which no toileting facilities are available.
	A **shower commode chair** may be covered if required to enable the beneficiary to shower independently or with assistance in the home setting and there are no economic alternatives available.
Documentation	Documentation must be less than 180 days old and include: ▪ Diagnosis appropriate for the equipment requested ▪ Functional limitations requiring the equipment.

	▪ Weight (if a heavy-duty commode is required). ▪ Discharge date from hospital, if applicable.
PA Requirements	PA is not required for any of the following, if the Standards of Coverage are met: ▪ Up to Three Months Following Hospital Discharge **-** rental of a stationary commode chair with fixed arms (or) stationary commode chair with detachable arms for a diagnosis not already removed from PA. ▪ For the purchase or rental of a stationary, mobile, extra wide, or heavy duty commode chair with fixed or detachable arms for the following diagnoses: ➢ Amyotrophic Lateral Sclerosis ➢ Multiple Sclerosis ➢ Cerebral Palsy, Unspecified ➢ Congenital and Progressive Hereditary Muscular Dystrophy ➢ Fracture of Vertebral Column With Spinal Cord Injury (cervical and dorsal) ▪ Replacement of pail or pan for use with commode chair.
	PA is required for the following: ▪ Medical need beyond the Standards of Coverage. ▪ Commodes with footrests and/or seat mechanisms. ▪ Continued coverage after the three-month rental following hospital discharge for a diagnosis not removed from PA. ▪ Replacement is required within five years, if the beneficiary is over 21. ▪ Replacement is required within two years if the beneficiary is under 21.
Payment Rules	A commode may be considered a **capped rental** or **purchase** item. Reimbursement for all commodes includes pail/pan and accessories (except footrest). If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacement to make the unit functional.

2.9 Compressor (Large Volume)

Definition	A compressor is an electrical device that provides humidity to a tracheostomy and is capable of continuous operation.
Standards of Coverage	A compressor is covered to provide humidity for a tracheostomy.
Documentation	Documentation must be less than 90 days old and include all of the following: ▪ Diagnosis/medical condition related to the need for the equipment. ▪ Specific unit requested.
PA Requirements	PA is not required for rental of a large volume compressor if the Standards of Coverage are met and documentation details one of the following diagnoses: ▪ Artificial Opening Status – Tracheostomy. ▪ Attention to Artificial Openings – Tracheostomy.
	PA is required for: ▪ Purchase of a large volume compressor (if not rented for 10 months). ▪ Medical need beyond the Standards of Coverage. ▪ Replacement within five years.
Payment Rules	A unit may be considered a **capped rental** item or **purchased** item. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.10 Continuous Positive Airway Pressure Device

Definition	The continuous positive airway pressure (CPAP) device delivers a noninvasive positive air pressure into the upper airway to assist spontaneous respiratory efforts.
Standards of Coverage	A CPAP device may be covered for Obstructive Sleep Apnea (OSA) if a sleep study (polysomnogram) performed in an accredited Sleep Center or Sleep Laboratory documents the following: ▪ Apnea-Hypopnea Index (AHI) documents a minimum of 15 events per hour, or ▪ AHI documents five to 14 events per hour with related symptoms such as:

	➢ Excessive daytime sleepiness, impaired cognition, mood disorders; and/or ➢ Hypertension, ischemic heart disease, or history of stroke, or morbid obesity. For beneficiaries under the age of 21 only, tracheomalacia, tracheostomy complications or other anomalies of larynx, trachea, and bronchus may be covered when a particular CPAP setting improved and maintained airway patency and oxygenation.
Documentation	Documentation must be less than 90 days old and include: ▪ Diagnosis and/or medical condition related to the need for the CPAP device. ▪ A copy of the sleep study (polysomnogram) for a diagnosis of OSA. The recorded sleep study must contain at least two hours of recorded sleep and the AHI must be calculated using actual recorded hours of sleep. ▪ For continued coverage beyond the initial four months, documentation must substantiate that the beneficiary has been compliant with the use of the CPAP and the device continues to be effective in treating the condition. If a unit log is maintained, the information must be submitted. ▪ Prescription from an appropriate pediatric subspecialist is required **for coverage under CSHCS Program.**
PA Requirements	PA is not required if the Standards of Coverage are met and: ▪ The beneficiary is over the age of 21 and has one of the following diagnoses: ➢ Obstructive Sleep Apnea (Adults) ➢ Tracheostomy Complications ➢ Tracheomalacia ➢ Other Anomalies of Larynx, Traches, and Bronchus ➢ Insomnia With Sleep Apnea ➢ Hypersomnia With Sleep Apnea ➢ Other and Unspecified Sleep Apnea ▪ For unobstructive sleep apnea, use diagnosis description of other and unspecified sleep apnea. ▪ The beneficiary is under the age of 21, has one of the above diagnoses, and the device is prescribed by the appropriate pediatric subspecialist.
	PA is required for: ▪ Medical need beyond the Standards of Coverage. ▪ Replacement within five years. PA is given for the initial four months and then for the final six months.

Payment Rules	A CPAP device is considered a **capped rental** item and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., tubing, application devices, filters, chinstrap, headgear, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. After the first 10 months of use, necessary repairs and/or replacements of accessories are separately reimbursable. (Replacement parts for the full CPCP mask should be considered prior to replacement of the entire mask.)

2.11 DIABETIC SHOES AND INSERTS

Definition	Diabetic shoes, inserts and related modifications include, but are not limited to, depth inlay shoes, multi-density inserts, roller or rocker bottoms, wedges, metatarsal bar, and off-set heel.
Standards of Coverage	Diabetic Shoes, inserts, and/or modifications may be covered for individuals who have, due to complications with diabetes mellitus, one of the following conditions: ▪ History of previous foot ulcerations or pre-ulcerative calluses. ▪ Established peripheral neuropathy or sensory impairment. ▪ Peripheral Vascular Disease with an ankle brachial index at rest of 0.5 or less following exercise. ▪ Loss of a toe or portion of the foot due to amputation arising from diabetes. A **custom-molded diabetic shoe** is covered only if the depth shoe cannot accommodate a foot anomaly. **Inserts** are covered if the beneficiary requires a depth shoe or custom-molded diabetic shoe. For a depth shoe, three inserts would be separately reimbursable in addition to the noncustomized one included with the shoe. For a custom-molded shoe, two inserts would be separately reimbursable. Modifications to custom-molded or depth shoe may be covered instead of an additional insert.
Documentation	Documentation must be less than 30 days old and include all of the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for specific shoe type and/or modification.

PA Requirements	PA is not required for the following inserts if the Standards of Coverage are met: ▪ Multiple density insert, direct formed, molded to foot with external heat source. ▪ Multiple density insert, direct formed, compression molded to patient's foot without external heat source. ▪ Multiple density insert, custom fabricated and custom-molded from model of patient's foot. ▪ Depth inlay shoes. ▪ Modifications if an additional insert is not provided.
	PA is required for: ▪ Medical need beyond the Standards of Coverage. ▪ Replacement within one year. ▪ Quantity beyond established limits. ▪ Custom-made shoes and other inserts not included above.
Payment Rules	All items are considered **purchase only**.

2.12 Enclosed Bed Systems

Definition	An Enclosed Bed System includes the mattress, bed frame, and enclosure as one unit.
Standards of Coverage	An Enclosed Bed System may be covered if the following applies: ▪ There is a diagnosis/medical condition (e.g., seizure activity) which could result in injury in a standard bed, crib, or hospital bed; and ▪ There are no economic alternatives to adequately meet the beneficiary's needs.
Documentation	The documentation must be less than six months old and include: ▪ Diagnosis/medical condition requiring use of the bed and any special features (if applicable). ▪ Safety issues resulting from the medical condition and related to the need for an Enclosed Bed System. ▪ Other products or safety methods already tried without success, (e.g., bumper pads/rails). ▪ Type of bed requested. ▪ Type of special features requested, if applicable.
Noncovered Conditions	Enclosed Bed Systems are not covered when the purpose is to restrain the beneficiary due to behavioral conditions, caregiver need or convenience, etc.

PA Requirements	PA is required for all Enclosed Bed Systems.
Payment Rules	The Enclosed Bed System is considered a **purchase only** item. For Youth Beds, refer to the Hospital Beds subsection of this chapter.

2.13 Enteral Nutrition

Enteral nutrition is the nutrition administered by tube or orally into the gastrointestinal tract. Seven enteral formulae HCPCS categories have been defined for oral and tube feeding use and the formulae in each main category possess similar characteristics. Each list is not all-inclusive nor are all the enteral formulae generally equivalent within a specific category. The categories are provided as a guideline for medical suppliers when the prescriber has ordered an enteral formula using the brand name. For products not listed, the provider may contact the Statistical Analysis DME Regional Carrier (SADMERC) for a coding determination or refer to the Enteral Product Classification List on the SADMERC web site. (Refer to the Directory Appendix for contact information.) If none of the classifications are appropriate, the NOC code should be used. For more information regarding specific enteral formulae products listed under each main category, refer to the MDCH Medical Supplier Database on the MDCH website.

2.13.A. Enteral Nutrition (Administered Orally)

Standards of Coverage	Enteral nutrition (administered orally) may be covered for beneficiaries under the age of 21 when: ▪ A chronic medical condition exists resulting in nutritional deficiencies and a three-month trial is required to prevent gastric tube placement. ▪ Supplementation to regular diet or meal replacement is required, and the beneficiary's weight to height ratio has fallen below the fifth percentile on standard growth grids. ▪ Physician documentation details low percentage increase in growth pattern or trend directly related to the nutritional intake and associated diagnosis/medical condition. **For CSHCS coverage**, a nutritionist or appropriate subspecialist must indicate that long-term enteral supplementation is required to eliminate serious impact on growth and development.
	For beneficiaries age 21 and over: ▪ The beneficiary must have a medical condition that requires the unique composition of the formulae nutrients that the beneficiary is unable to obtain from food. ▪ The nutritional composition of the formulae represents an integral part of treatment of the specified diagnosis/medical condition. ▪ The beneficiary has experienced significant weight loss.

Documentation	Documentation must be less than 30 days old and include: ▪ Specific diagnosis/medical condition related to the beneficiary's inability to take or eat food. ▪ Duration of need. ▪ Amount of calories needed per day. ▪ Current height and weight, as well as change over time. (For beneficiaries under 21, weight to height ratio.) ▪ Specific prescription identifying levels of individual nutrient(s) that is required in increased or restricted amounts. ▪ List of economic alternatives that have been tried. ▪ Current laboratory values for albumin or total protein (for beneficiaries age 21 and over only). For continued use beyond 3-6 months, **the CSHCS Program requires** a report from a nutritionist or appropriate pediatric subspecialist.
PA Requirements	PA is required for all enteral formulae for oral administration.

2.13.B. ENTERAL NUTRITION (ADMINISTERED BY TUBE)

Standards of Coverage	Enteral formulae are covered when the diagnosis/medical condition requires placement of a gastric tube and nutrition is administered by syringe, gravity, or pump.
Documentation	Documentation must be less than 30 days old and include: ▪ Specific diagnosis/medical condition requiring tube feeding. ▪ Duration of treatment. ▪ Amount needed per day. ▪ If a pump is required, the medical reason why syringe or gravity method could not be used.
PA Requirements	PA is not required for standard formulae for enteral tube feedings provided up to the program's established quantity limits per month. (Applies only to specific enteral formulae and related supplies and equipment. Refer to the MDCH Medical Supplier Database on the MDCH website for additional information.)
	PA is required for the following: ▪ All specialized enteral formulae requests for tube feedings. ▪ Over-quantity requests for standard formulae enteral tube feedings. ▪ Medical need beyond Standards of Coverage.

2.13.C. Enteral Nutrition Payment Rules

When billing for enteral formulae (administered orally or by tube), the appropriate formulae HCPCS code should be billed on a monthly basis with total calories used (divided by 100) as the unit amount. (To calculate the appropriate number of caloric units, combine total calories of all cans to be used and divide by 100.) Medicaid will reimburse for a maximum quantity of up to 900 units for any combination of approved formulae.

Providers should refer to the following chart for additional assistance:

Formulae	100 calories = 1 unit (u)	6 (8 oz) cans a day	1 month = 30 days	6 months = 180 days	$5.00 cost/8 oz liquid or packet or can
Standard @ 250 calories/8 oz	250 cals/100 =2.5 units	2.5 u x 6 = 15 units a day	15 u x 30 = 450 units a month	15 x 180=2700 units for 6 months	$5.00 ÷ 2.5 u = $2.00 per unit
Caloric Dense @ 355 calories/8 oz	355 cals/100 =3.55 units	3.55 u x 6= 21 units a day	21 u x 30 = 630 units a month	21 u x 180 = 3780 units for 6 months	$5.00 ÷ 3.55 u = $1.41 per unit
Powder, 1 package = 150 calories	150 cals/ 100 = 1.5 units	1.5 x 6 = 9 units a day	9 u x 30 = 270 units a month	9 u x 180 =1620 units for 6 months	$5.00 ÷ 1.5 u = $3.33 per unit
Powder, 1# can = 112 oz when mixed @ 20 calories/oz* = 2240 calories for the entire can (* can vary with physician orders)	2240 cals/100 = 22.4 units		6 cans per month = 22.4 x 6 = 134 units a month	134 u x 6 months = 804 units for 6 months	$5.00 ÷ 22.4 u = $0.30 per unit

The necessary equipment and supply code for enteral tube feedings should be billed up to specified quantity limits. Feeding bags, anchoring devices, syringes, drain sponges, cotton tip applicators, tape, adaptors, and connectors used in conjunction with a gastrostomy or enterostomy tube are included in the supply kit codes and should not be billed separately.

Dietary formulae for oral feedings may be obtained from either a medical supplier or a pharmacy.

Dietary formulae for tube feedings are covered only through the medical supplier.

2.14 External Infusion (Insulin) Pump and Related Supplies

Definition	Insulin pumps deliver a constant and continuous infusion of insulin, driven by mechanical force, into the subcutaneous space via a needle or soft cannula.
Standards of Coverage	Insulin pumps are covered when other methods to control blood glucose levels have been ineffective and one of the following applies: ▪ Blood glucose levels demonstrate poor glycemic control despite monitoring at least four times per day and multiple daily insulin injections with a persistently elevated glycosylated hemoglobin level greater than seven percent. ▪ There is a history of severe glycemic excursions, brittle diabetes, hypoglycemic/hyperglycemic reaction, nocturnal hypoglycemia, any extreme insulin sensitivity, and/or very low insulin requirements. ▪ There is evidence of the "dawn" phenomenon where fasting blood glucose level often exceeds 200 mg/dl.
Documentation	Documentation must be less than 90 days old and include: ▪ Diagnoses/medical condition pertaining to the need for the pump. ▪ Lab values of blood glucose levels. ▪ Medical history documenting the need for the pump. ▪ Any medical complications experienced by the beneficiary related to the need for blood glucose monitoring. **CSHCS requires** a prescription from an appropriate pediatric subspecialist.
PA Requirements	PA is not required if the Standards of Coverage are met, and: ▪ The beneficiary is over the age of 16 and has one of the diagnosis indicated below: ➢ Diabetes Mellitus Without Complication ➢ Diabetes With Ketoacidosis ➢ Diabetes With Hyperosmolarity ➢ Diabetes With Other Coma ➢ Diabetes With Renal Manifestations ➢ Diabetes With Ophthalmic Manifestations ➢ Diabetes With Neurological Manifestations ➢ Diabetes With Peripheral Circulatory Disorders ➢ Diabetes With Other Specified Manifestations

	➢ Diabetes With Unspecified Complication ➢ Diabetes Mellitus Complicating Pregnancy ▪ The beneficiary is under the age of 16, has one of the diagnoses above, and the pump is ordered by a pediatric endocrinologist.
	PA is required for the following: ▪ Medical need beyond the Standards of Coverage. ▪ Diagnoses/conditions other than those listed above. ▪ Replacement of pump within five years.
Payment Rules	Insulin pumps are considered a **purchase only** item**.** The purchase payment is inclusive and includes of all of the following: ▪ A 30-day trial period at no cost to Medicaid or the beneficiary prior to purchase of device. ▪ Comprehensive care coordination, including a plan for follow-up monitoring by the physician after installation of the pump.

2.15 HIGH FREQUENCY CHEST WALL OSCILLATION DEVICE

Definition	A high frequency chest wall oscillation (HFCWO) system is an airway clearance device consisting of an inflatable vest connected by two tubes to a small air-pulse generator that is easy to transport. The air-pulse generator rapidly inflates and deflates the vest, gently compressing and releasing the chest wall to create mini-coughs that dislodge mucus from the bronchial walls, increase mobilization, and move it along toward central airways.
Standards of Coverage	A HFCWO system may be covered up to 4 months if both of the following apply: ▪ Diagnosis of Cystic Fibrosis, and ▪ All other treatment modalities have not been effective.
Documentation	Documentation must be less than 180 days old and include: ▪ Diagnosis pertaining to the need for this unit. ▪ Severity of condition (e.g., frequency of hospitalizations, pulmonary function tests, etc.). ▪ Current treatment modalities and others already tried. ▪ Plan of care by the attending Cystic Fibrosis (CF) Center specialist substantiating need for the device is **required under the CSHCS Program**.

	▪ For continuation beyond the initial four months, the following information must be provided: ➢ Documentation of client compliance through the review of equipment use logs; and ➢ Medical statement from a CF Center Specialist substantiating the continued effectiveness of the vest is **required under the CSHCS program.**
PA Requirements	PA is required for all requests.
Payment Rules	The HFCWO system chest compression generator system is considered a **capped rental** item and is inclusive of the following: ▪ All accessories necessary to use the equipment except for the vest itself. This may be separately reimbursed during the initial rental period. ▪ Education on the proper use and care of the equipment ▪ Routine servicing and all necessary repairs and replacements to make the equipment functional.

2.16 HOME INTRAVENOUS INFUSION THERAPY

Definition	Intravenous infusion therapy, administered in the home, is medicine injected directly into a vein.
Standards of Coverage	Coverage of home infusion therapy, its expected course, and duration of treatment is based on the plan of care prescribed by the physician. Only the days involving active infusion will be considered for payment. The medical supplier facilitating the administration of home infusion therapy must: ▪ Be accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other appropriate accrediting body. ▪ Maintain logs detailing proper equipment maintenance consistent with manufacturer's requirements. ▪ Provide education and training to the beneficiary or caregiver related to proper care techniques. ▪ Provide comprehensive care coordination involving the pharmacist, nurses, physician or any other infusion therapy professional.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Diagnosis appropriate for specified therapy ▪ Dosage, frequency, route and duration of medication/medications being infused

	Documentation for **antibiotic, antiviral and/or antifungal therapies** must include at least one of the following tests results to support the diagnosis: ▪ Positive culture from appropriate site (e.g., a blood culture for diagnosis of sepsis, wound culture for diagnosis osteomyelitis, etc.) ▪ Bone scan showing osteomyelitis ▪ X-ray showing osteomyelitis or abscess ▪ ECHO/ultrasound showing endocarditis ▪ Vegetations or abscess ▪ CT or MRI scan showing osteomyelitis or abscess ▪ Minimum of three of the following: ➢ Fever of 101° F or more, pain, warmth, redness, edema in affected area ➢ Elevated C-reactive protein ➢ Elevated white blood cell count ➢ Erythrocyte sedimentation rate (ESR) ➢ A trial course of oral antibiotic therapy with no improvement or worsening of symptoms For the diagnoses of cellulitis, pneumonia, urinary tract infection, and otitis media, documentation must indicate a failure of oral antibiotic therapy, unless a culture shows bacteria that is not sensitive to oral antibiotic medications available. This does not apply to cystic fibrosis pneumonia; PA is not needed with a positive sputum culture or a history of positive sputum cultures.
	Documentation for **electrolyte replacement therapy (condition unrelated to hydration status)** must include a copy of the appropriate abnormal laboratory level (e.g., low potassium level for diagnosis hypokalemia, etc.).
	Documentation for **steroid therapy** must indicate exacerbation of multiple sclerosis or diagnosis related to transplant rejections.
	Documentation for **chemotherapy and pain management therapy** must include a cancer diagnosis and a copy of the treatment protocol to which the beneficiary has been assigned.
	Documentation for **hydration therapy for hyperemesis gravidarium** must include laboratory results indicating current dehydration level, estimated delivery date, and must address a trial of anti-emetics.
	Documentation for **gammaglobulin therapy** must include abnormal IGG, IGM, IGA or IGE levels prior to the beneficiary receiving an IVIG. If beneficiary has been receiving IVIG infusion therapy in an outpatient or physician office setting, these laboratory tests may not be current.

	Documentation for **iron overload therapy** must indicate a diagnosis of Sickle Cell Anemia and support the need for the requested therapy.
	Documentation for **factor products** must indicate a clotting disorder diagnosis and support the need for requested therapy.
	Documentation for **anti-emetic infusion** must indicate a diagnosis of cancer or hyperemesis gravidarium and include a trial of oral anti-emetics.
	The provider must keep **verification of equipment maintenance** on file that includes: ▪ Name of the manufacturer. ▪ Dates the equipment was checked for proper use, care and function according to the manufacturer's requirements.
PA Requirements	PA is not required for specific HCPCS "S" codes if all of the following apply: ▪ Standards of Coverage are met ▪ Beneficiary is age five or older (for factor products, beneficiaries of all ages) ▪ Medical need for the therapy is related to one of the diagnoses/conditions that do not require PA. (For details regarding covered HCPCS "S" codes, PA requirements and related ICD-9-CM diagnosis exception codes ranges, and quantity limits, refer to the MDCH Medical Supplier Database on the MDCH website.)
	PA is required for the following: ▪ Medical need beyond the Standards of Coverage. ▪ The beneficiary is under the age of five. ▪ Infusion days exceed the established Medicaid limits.
Payment Rules	Reimbursement for the HCPCS "S" codes related to home intravenous infusion therapy is calculated on a per diem basis as defined by the code descriptions. Costs included within the per diem rate: ▪ All infusion related supplies and equipment, such as the infusion pump, needles, syringes, gauze, sterile tubing, catheters, etc. (For pump-related infusion, the per diem rate payment includes routine servicing and all necessary repairs or replacements to make the rented DME functional.)

	▪ The compounding of medications compliant with standards of pharmaceutical practice, including a medication profile set-up with recommendations of dosage or medication changes if needed. ▪ Patient educational activities related to receiving home infusion therapy and the coordination of care with physicians, nurses and other caregivers. Costs not associated with the per diem rate: ▪ Medications (drugs) must be billed as pharmacy services. ▪ Nursing visits are covered through a Home Health Agency. ▪ PICC and Midline insertion procedures and associated supplies may be billed separately.
	HCPCS "S" codes must be reported as a daily rate by reporting the total number of days used as units unless otherwise noted. Routine catheter care is included within the daily rate for the active infusion. For interim maintenance of an infusion line not currently in use, report the appropriate catheter care code and bill as a daily rate by reporting the total number of days used as units. For catheter maintenance of an implanted port, bill the appropriate HCPCS code with modifier "22". Details regarding the type and frequency of catheter maintenance completed must be reported in the Remarks area of the claim. If multiple drugs are being administered concurrently for the same therapy, report modifier "SH" for two drugs or "SJ" for three or more drugs. If multiple therapies are needed, more than one therapy code may be reported. For chemotherapy and pain management, the specific HCPCS code will designate either continuous or intermittent administration. If the therapy is provided without interruption for 24 hours or more, report the continuous therapy code. For less than 24 hours of therapy, use the intermittent code. For antibiotic, antiviral, or antifungal therapy, report the code that best describes the frequency of administration. Only one therapy code of this series may be reported on the same date of service. If multiple drugs are administered, report modifier "SH" or "SJ".
	Heparin lock flush syringes and normal saline flush syringes will be reimbursed to a medical supplier by reporting the appropriate HCPCS "J" code. Only medical suppliers designated as licensed pharmacies will be able to bill MDCH for these pre-filled syringes.

2.17 Home Uterine Activity Monitor

Definition	A home uterine activity monitor (HUAM) is used to record the frequency of uterine contractions for the purpose of predicting pre-term delivery. The monitor is worn on a belt, records the uterine contractions that are transmitted across modem lines to a central monitoring office that contacts the physician's office for interpretation.

Standards of Coverage	A HUAM may be covered for up to 90 days in the home setting for a beneficiary at high risk for preterm delivery during the 24th through the 36th gestational week, and one of the following medical conditions applies: ▪ Pre-term labor on tocolytics. ▪ History of pre-term labor or delivery in previous pregnancies. ▪ Incompetent cervix (cerclage).
Documentation	Documentation must be less than 90 days old and include: ▪ Diagnosis and/or medical condition pertaining to the need for the monitor. ▪ Expected date of birth. ▪ Last day of the 36th week of gestation. ▪ Involvement with a regional perinatal center.
PA Requirements	PA is required for all monitors.
Payment Rules	A HUAM is a **rental only** item and is inclusive of the following: ▪ The monitor and other related supplies required to use the equipment properly. ▪ Education on proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. ▪ Periodic downloading and interpretation of the data. ▪ Perinatal nursing services related to oversight of the use of the monitor. To provide a HUAM, the medical supplier must complete a special enrollment process by completing the Medical Assistance Provider Enrollment & Trading Partner Agreement (DCH-1625) and the Ambulatory Uterine Activity Monitor Agreement (DCH-1152) and sending them to the Medicaid Payments Division, Provider Enrollment Unit. (Refer to Directory Appendix for contact information.)

2.18 HOSPITAL BEDS

Definition	A hospital bed has a special construction, consisting of a frame and an innerspring mattress, with a head and/or leg elevation adjustment mechanism for the purpose of repositioning.
Standards of Coverage	A standard hospital bed may be covered if: ▪ The diagnosis/medical condition requires a specific elevation or positioning of the body not possible with a standard bed (elevation of 30 degrees or greater). ▪ The body requires positioning in a hospital bed to alleviate pain. For other beds, the above Standards of Coverage must be met, and one of the following applies: ▪ **Variable height hospital bed** may be covered if different heights are medically necessary for assisting beneficiary transfers from the chair, wheelchair or standing position. ▪ **Heavy-duty extra wide hospital bed** may be covered if a beneficiary weighs more than 350 pounds but does not exceed 600 pounds. ▪ **Extra heavy-duty bed** may be covered if a beneficiary weighs more than 600 pounds. ▪ A **fully electric hospital bed** may be covered when frequent and/or immediate changes in body position are required and there is no caregiver. ▪ A **Youth bed** may be covered if the beneficiary is under the age of 21 and the bed is required to have crib style side rails.
	Hospital Bed Accessories ▪ The **trapeze bar** may be covered when required by the beneficiary to assist with transfers or frequent changes in body position. ▪ **Side rails** are covered when required for safety. ▪ A **replacement innerspring** mattress or foam rubber mattress may be covered for replacement when the beneficiary owns the bed.
Noncovered Condition	Youth beds are not covered for the sole purpose of age appropriateness.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical and/or functional reasons for the specific type of hospital bed and/or accessory. ▪ Any alternatives tried or ruled out.

PA Requirements	PA is not required if the Standards of Coverage are met and the following applies: ▪ For fixed height, variable height, semi-electric beds, side rail, and trapeze for one of the following diagnoses/medical conditions: ➢ Multiple Sclerosis ➢ Infantile Cerebral Palsy ➢ Congenital or Hereditary Progressive Muscular Dystrophy ➢ Fracture of the Cervical or Dorsal Areas (open or closed) ▪ For up to three months, for hospital discharge, for procedure codes E0255, E0256, E0260, E0292, E0293, E0910, E0940 when required for diagnoses not removed from PA.
	PA is required for: ▪ Medical need beyond the Standards of Coverage. ▪ Full electric beds or any other hospital beds and/or accessories requiring PA as specified in the MDCH Medical Supplier Database. ▪ Replacement of a fixed height, variable height, or semi-electric bed and/or accessory within eight years
Payment Rules	A bed may be a **capped rental** or **purchase** item. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment except for trapezes, side rails, and mattresses where appropriate. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.19 INCONTINENT SUPPLIES [CHANGE MADE 4/1/06]

Definition	Incontinent supplies are items used to assist individuals with the inability to control excretory functions. The type of coverage for incontinent supplies may be dependent on the success or failure of a bowel/bladder training program. A bowel/bladder training program is defined as instruction offered to the beneficiary to facilitate: ▪ Independent care of bodily functions through proper toilet training. ▪ Appropriate self-catheter care to decrease risk of urinary infections and/or avoid bladder distention. ▪ Proper techniques related to routine bowel evacuation.

Standards of Coverage	**Diapers, incontinent pants, liners, and belted/unbelted undergarments without sides** are covered for individuals age three or older if both of the following applies: ▪ A medical condition resulting in incontinence and there is no response to a bowel/bladder training program. ▪ The medical condition being treated results in incontinence, and beneficiary would not benefit from or has failed a bowel/bladder training program. **Pull-on briefs** are covered for beneficiaries age 3 through 20 when there is the presence of a medical condition causing bowel/bladder incontinence, and one of the following applies: ▪ The beneficiary would not benefit from a bowel/bladder program but has the cognitive ability to independently care for his/her toileting needs, **or** ▪ The beneficiary is actively participating and demonstrating definitive progress in a bowel/bladder program. **Pull-on briefs** are covered for beneficiaries age 21 and over when there is the presence of a medical condition causing bowel/bladder incontinence and the beneficiary is able to care for his/her toileting needs independently or with minimal assistance from a caregiver. Pull-on briefs are considered a short-term transitional product that requires a reassessment every six months. The assessment must detail definitive progress being made in the bowel/bladder training. Pull-on briefs covered as a long-term item require a reassessment once a year or less frequently as determined by MDCH. Documentation of the reassessment must be kept in the beneficiary's file. **Incontinent wipes** are covered when necessary to maintain cleanliness outside of the home. **Intermittent catheters** are covered when catheterization is required due to severe bladder dysfunction. **Hydrophilic-coated intermittent catheters** are considered for individuals that have Mitrofanoff stomas, partial stricture or small, tortuous urethras. **Intermittent catheters with insertion supplies** are covered for beneficiaries who have a chronic urinary dysfunction for which sterile technique is clinically required. **Disposable underpads** are covered for beneficiaries of all ages with a medical condition resulting in incontinence.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Diagnosis of condition causing incontinence (primary & secondary diagnosis). ▪ Item to be dispensed. ▪ Duration of need. ▪ Quantity of item and anticipated frequency the item requires replacement. ▪ For pull-up briefs, a six-month reassessment is required.

PA Requirements	PA is required for: ▪ Hydrophilic type urinary catheters. (Use HCPCS A4649 and describe type of catheter requested on the PA request for additional reimbursement to be considered) ▪ For usage over the established quantities
	PA is not required for all other incontinent items unless usage exceeds established quantity limitations.
Payment Rules	**Volume Purchase Agreement** - Through a competitive bid process, the State of Michigan has contracted with a volume purchase contractor for selected incontinent supplies for beneficiaries enrolled in the Medicaid FFS, the CSHCS FFS Basic Health Plan, and the Adult Benefits Waiver (ABW). **Beneficiaries Exempt from the MDCH Volume Purchase Contract -** Based on dual eligibility, specific beneficiaries may be exempt from obtaining services from the MDCH Volume Purchase Contractor as described below: ▪ Beneficiaries dually enrolled in Medicaid and Medicare are not required to obtain Medicare-covered incontinence items from the contractor but may choose to if preferred. ▪ Beneficiaries enrolled in a MHP will receive coverage of these products through the medical supplier contracted by the health plan. This medical supplier could be the Contractor if negotiated by the MHP. ▪ Beneficiaries enrolled in either a commercial FFS plan or HMO if its coverage includes incontinence supplies are expected to follow the primary payer's rules first. If these products are not covered by the plan, the beneficiary must obtain these items through the MDCH Volume Purchase Contractor.

Services Covered Through the Contract

The following list details the selected incontinent supply items that must be obtained from the MDCH Volume Purchase Contractor for Medicaid and CSHCS Programs. Beneficiaries dually eligible for Medicaid and Medicare are required to obtain the contracted incontinent items (designated with an X) from the MDCH Volume Purchase Contractor. **[table corrected per MSA 06-23 issued 4/1/06]**

HCPCS Code	Nomenclature	Mandatory for Medicaid/ Medicare	HCPCS Code	Nomenclature	Mandatory for Medicaid/ Medicare
A4310	Insert Tray W/O Bag/Cath		A4357	Bedside Drainage Bag	
A4311	Catheter W/O Bag 2-Way Latex		A4358	Urinary Leg Bag Or Abdomen Bag	
A4312	Cath W/O Bag 2-Way Silicone		**A4520	Incontinence Garment Any Type	X
A4314	Cath W/Drainage 2-Way Latex		A5112	Urinary Leg Bag; Latex	
A4315	Cath W/Drainage 2-Way Silicone		T4521	Adult Size Brief/Diaper SM	X
A4320	Irrigation Tray		T4522	Adult Size Brief/Diaper MED	X
A4322	Irrigation Syringe		T4523	Adult Size Brief/Diaper LG	X
A4326	Male External Catheter		T4524	Adult Size Brief/Diaper XL	X
A4328	Female Urinary Collection Pouch		T4525	Adult Size Pull-On SM	X
A4330	Perianal Fecal Collection Pouch		T4526	Adult Size Pull-On MED	X
A4331	Extension Drainage Tubing		T4527	Adult Sized Pull-On LG	X
A4333	Urinary Cath Anchor Device		T4528	Adult Size Pull-On XL	X
A4334	Urinary Cath Leg Strap		T4529	Ped Size Brief/Diaper SM/MED	X
*A4335	Incontinence Supply		T4530	Ped Size Brief/Diaper LG	X
A4338	Indwelling Catheter Latex		T4531	Ped Size Pull-On SM/MED	X
A4340	Indwelling Catheter, Specialty Type		T4532	Ped Size Pull-On LG	X
A4344	Cath Indw Foley 2-Way Silicone		T4533	Youth Size Brief/Diaper	X
A4349	Disposable Male External Cat		T4534	Youth Size Pull-On	X
A4351	Straight Tip Urine Catheter		T4535	Disposable Liner/Shield/ Pad	X
A4352	Coude Tip Urinary Catheter		T4536	Reusable Pull-On Any Size	X
A4353	Intermittent Catheter w/insertion supplies		T4541	Large Disposable Underpad	X
A4354	Insertion Tray w/Drainage Bag w/o Cath		T4542	Small Disposable Underpad	X

*Use HCPCS code A4335 only to report belted/unbelted undergarments w/o sides. PA is not required up to the established quantity limit of 150 per month
**Use HCPCS code A4520 only for moisture resistant reusable incontinence pants.

Quantity Limitations Based on Combination of Items Used

Diapers and Pull-on Briefs - For a beneficiary using both diapers and pull-on briefs, the combined total quantity of these items cannot exceed 300 per month. (The maximum amount of pull-on briefs is 150 per month even if the beneficiary is not using diapers.)

Diapers of Different Sizes - For a beneficiary using a combination of different sized diapers, the total quantity must not exceed 300 per month.

2.20 LIFTS (HYDRAULIC AND ELECTRIC)

Definition	Lifts include, but are not limited to, hydraulic and electric, and accessories include slings and/or seats.
Standards of Coverage	A standard **hydraulic lift** may be covered when the beneficiary requires assistance in transfers, provision of the lift will allow the beneficiary to be transferred safely, and one of the two conditions stated below are met: ▪ The beneficiary requires a one-person assist but the weight or size of the beneficiary prohibits safe transfers or could cause harm to the caregiver. ▪ The beneficiary requires a two-person assist and there are not two caregivers in the home. An **electric lift** may be covered when the above Standards of Coverage are met and the hydraulic lift cannot be used safely or when the beneficiary's medical condition results in increased tone (e.g., spasticity).
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/condition requiring use of the lift. ▪ Functional level of assistance required to complete activities of daily living (ADLs). ▪ Type of transfer required. ▪ Weight and height of the beneficiary. ▪ Type of lift requested. ▪ An occupational or physical therapy evaluation and recommendation. ▪ Number of caregivers in the home and number of hours during the 24-hour period that each caregiver is present.
PA Requirements	PA is not required if Standards of Coverage are met for**:** ▪ Hydraulic lifts ▪ Replacement slings or seats
	PA is required for: ▪ Electric lifts ▪ Replacement within ten years

Payment Rules	A lift may be a **capped rental** or **purchase** item. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.21 MECHANICAL IN-EXSUFFLATION DEVICE

Definition	A mechanical in-exsufflation device is a portable electric device that utilizes a blower and a valve to alternately apply a positive and then a rapid negative pressure to an individual's airway to assist the person to cough more effectively.
Standards of Coverage	A mechanical in-exsufflation device may be covered for up to four months if the following applies: ▪ Diagnosis of respiratory failure due to neuromuscular deficits. ▪ Beneficiary is unable to cough or clear secretions effectively due to reduced peak expiratory force. ▪ Other treatment modalities have not been effective (e.g., inhalers, PEP mask therapy, or flutter devices). For coverage beyond four months, continued use of a mechanical in-exsufflation device may be covered when there is continued effectiveness.
Documentation	Documentation must be less than 180 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Current treatment modalities and any others already tried. ▪ Documentation of beneficiary's ability to use. ▪ Plan of care from a pulmonologist substantiating need for this device is **required under the CSHCS program.** For coverage beyond the first four months, medical statement substantiating continued effectiveness
PA Requirements	PA is required for all requests.

Payment Rules	A mechanical in-exsufflation device is a **capped rental** item and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., circuits, filters etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.22 NEBULIZER

Definition	A nebulizer is a powered device that allows a medication to be changed from a liquid to a mist so it may be effectively inhaled into the lungs. Types of nebulizers include, but are not limited to, standard and ultrasonic.
Standards of Coverage	A **standard nebulizer** device may be covered if: ▪ The beneficiary has a diagnosis related to an obstructive airway disease (e.g., asthma, bronchopulmonary dysplasia, chronic obstructive pulmonary disease [COPD], etc.). ▪ The physician has already considered use of a metered dose inhaler and it was insufficient to meet the needs of the beneficiary. An **ultrasonic nebulizer** is covered when a standard nebulizer is ineffective.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/condition requiring use of the nebulizer. ▪ Medications prescribed. ▪ Frequency of administration. ▪ Medical reason economic alternatives are ineffective. ▪ For an ultrasonic nebulizer, pulmonary function testing done after use of a standard nebulizer and after use of an ultrasonic nebulizer showing the ultrasonic is more efficacious.
PA Requirements	PA is not required if Standards of Coverage are met for standard nebulizer and associated accessories up to established quantity limits
	PA is required for: ▪ Ultrasonic nebulizer. ▪ Replacement of standard nebulizer within five years. ▪ When the Standards of Coverage are not met.

Payment Rules	A nebulizer is considered either a **capped rental** or **purchase** item. Accessories are separately reimbursable. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ Education on the proper use and care of the equipment ▪ Routine servicing and all necessary repairs or replacements to make the unit functional

2.23 NEGATIVE PRESSURE WOUND THERAPY (PUMP AND ACCESSORIES)

Definition	Negative pressure wound therapy (NPWT) utilizes a sub-atmospheric (negative) pressure technique to reduce edema, increase localized blood flow and granulation tissue formation, and remove exudates from the wound. The NPWT pump must be able to apply pressure intermittently or continuously in a range from 25 - 125 mm HG and accommodate multiple wounds.
Standards of Coverage	Negative pressure wound therapy is covered for short-term therapy (7 to 14 days) if one of the following conditions applies and failure of several less expensive treatment modalities has occurred: ▪ Stage III or IV pressure ulcer(s) - ➢ Beneficiary has been part of a comprehensive ulcer management program (e.g., appropriately turned and positioned, appropriately managed for either moisture or incontinence, received adequate nutritional support, etc.) for at least the last 30 days. ➢ Beneficiary has used either a Group 2 or 3 Support Surface for at least the last 30 days. ▪ Diabetic Ulcers - Beneficiary has been on a comprehensive diabetic management program. ▪ Venous stasis ulcers - ➢ Compression bandages have been applied consistently. ➢ Mobility and leg elevation have been encouraged. ▪ Dehisced incisions, or traumatic wounds - Wound care clinical protocols have been ineffective.

Documentation	All documentation, except wound measurements, must be less than 30 days old. Documentation of wound measurements must be less than seven days old and include the following: ▪ Evaluation, care and wound measurements by a licensed medical professional. ▪ All previous dressings tried. ▪ Debridement of necrotic tissue, if applicable. ▪ Evaluation and provision of adequate nutritional status. ▪ Appropriate turning/repositioning schedule. ▪ Incontinence management, if applicable. ▪ Appropriate pressure reduction addressed if wound is pressure related.
Continued Coverage	For continued coverage beyond the initial 7 to 14 days, documentation must be submitted detailing updated wound measurements and substantiate continued effectiveness.
PA Requirements	PA is required for all requests.
Payment Rules	A negative pressure wound therapy pump is a **rental only** service. Payment for the pump is considered as a daily rental rate by reporting total number of days used as units. The canister and dressing set are considered **purchase** items and may be separately reimbursed from the pump code.

2.24 ORTHOPEDIC FOOTWEAR

Definition	Orthopedic Footwear may include, but are not limited to, orthopedic shoes, surgical boots, removable inserts, Thomas heels, and lifts.
Standards of Coverage	**Orthopedic shoes and inserts** may be covered if any of the following applies: ▪ Required to accommodate a leg length discrepancy of ¼ inch or greater or a size discrepancy between both feet of one size or greater. ▪ Required to accommodate needs related to a partial foot prosthesis, clubfoot, or plantar fascitis. ▪ Required to accommodate a brace (extra depth only are covered). **Surgical Boots or Shoes** may be covered to facilitate healing following foot surgery, trauma or a fracture.

Noncovered Items	Shoes and inserts are noncovered for the conditions of: ▪ Pes Planus or Talipes Planus (flat foot) ▪ Adductus metatarsus ▪ Calcaneus Valgus ▪ Hallux Valgus Standard shoes are also noncovered.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for specific shoe type and/or modification. ▪ Functional need of the beneficiary. ▪ Reason for replacement, such as growth or medical change. **CSHCS requires** a prescription from an appropriate pediatric subspecialist.
PA Requirements	PA is not required for the following items if the Standards of Coverage are met: ▪ Surgical boots or shoes. ▪ Shoe modifications, such as lifts, heel wedges, or metatarsal bar wedges up to established quantity limits. ▪ Orthopedic shoe to accommodate a brace. ▪ Orthopedic shoes and inserts when the following medical conditions are present: ➢ Plantar Fascial Fibromatosis ➢ Unequal Leg Length (Acquired) ➢ Talipes Ezuinovarus (Clubfoot) ➢ Longitudinal Deficiency of Lower Limb, Not Elsewhere Classified ➢ Unilateral, without Mention of Complication (Partial Foot Amputation) ➢ Unilateral, Complicated (Partial Foot Amputation) ➢ Bilateral, without Mention of Complication (Partial Foot Amputation) ➢ Bilateral, Complicated (Partial Foot Amputation)
	PA is required for: ▪ All other medical conditions related to the need for orthopedic shoes and inserts not listed above. ▪ All orthopedic shoes and inserts if established quantity limits are exceeded. ▪ Medical need beyond the Standards of Care. ▪ Beneficiaries under the age of 21, replacement within six months. ▪ Beneficiaries over the age of 21, replacement within one year.

Payment Rules	These are **purchase only** items.

2.25 ORTHOTICS (CERVICAL)

Definition	Cervical orthotics include, but are not limited to, cervical collars and cranial helmets.
Standards of Coverage	**Cervical collars** may be covered to facilitate healing and/or restrict mobility for the following indications: ▪ Pre- and post-surgery ▪ Pre- and post-cervical fusion ▪ Cervical trauma ▪ Post fractures
	Cervical helmets may be covered to prevent head injury for beneficiaries with medical conditions effecting balance that predisposes them to fall. For the medical condition of plagiocephaly, a **custom fabricated cranial remolding orthosis** is covered and must include the following: ▪ Proper measurements including topography, casting, etc. ▪ The use of a FDA approved helmet. ▪ All necessary follow-up visits including fitting and adjustments for 18 months after placement.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance requested. ▪ Functional needs of the beneficiary. ▪ Reason for replacement, such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.** For repairs, a copy of the physician's prescription at the time of original placement and itemization of materials used to repair appliance or rationale for related labor costs must be documented.
PA Requirements	PA is not required when the Standards of Coverage met for: ▪ Cervical collars. ▪ Nonmolded cranial helmets. ▪ Molded cranial helmets for a beneficiary under the age of one year with diagnosis of plagiocephaly when prescribed by an appropriate pediatric subspecialist.

	▪ Repairs as follows: ➢ The total repair cost equals one hour of labor or less ➢ The cost of minor parts equals $50 or less
	PA is required for: ▪ Custom molded cranial helmets for conditions other than plagiocephaly. ▪ Replacement of a cranial nonmolded helmet or cervical collar within one year. ▪ Repair costs exceed the maximum limits as stated above.
Payment Rules	These are covered as **purchase only** items.

2.26 ORTHOTICS (LOWER EXTREMITY)

Definition	Lower extremity orthotics includes, but is not limited to, hip, below knee, above knee, knee, ankle, and foot orthoses, etc.
Standards of Coverage	Lower extremity orthotics are covered to: ▪ Facilitate healing following surgery of a lower extremity. ▪ Support weak muscles due to neurological conditions. ▪ Improve function due to a congenital paralytic syndrome (i.e., Muscular Dystrophy).
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance requested including current functional level. ▪ A physical therapy evaluation may be required on a case-by-case basis when PA is required. ▪ Reason for replacement, such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.** ▪ Medical justification for each additional component required. For repairs, a new prescription is not required if the original orthotic was covered by MDCH. A copy of the original prescription for the orthotic and itemization of materials used to repair appliance and rationale for related labor costs must be documented.

PA Requirements	PA is not required for the following if the Standards of Coverage are met: ▪ Fracture orthosis for fractures. ▪ Hip orthosis for Legg Perthes. ▪ Prefabricated knee appliances. ▪ Custom fabricated knee orthosis for Old Disruption of Anterior Cruciate Ligament. ▪ Prefabricated ankle foot orthosis (AFO) and knee ankle foot orthosis (KAFO). ▪ Custom fabricated plastic AFOs if up to four additional components with the base code as indicated in the MDCH Medical Supplier Database (add-ons include: double action joints, t-strap or malleolar pad, varus/valgus modification and soft interface). ▪ Custom fabricated metal AFOs if up to six additional components with the base code as indicated in the MDCH Medical Supplier Database (add-ons include: double action joints, noncorrosive finish, t-strap or malleolar pad, extended steel shank, long tongue stirrup and growth extensions). Shoes are not considered an add-on and would be considered in addition the other items. ▪ Custom fabricated plastic KAFOs if up to eight additional components with the base code as indicated in the MDCH Medical Supplier Database (add-ons include: double action joints, t-strap or malleolus pad, drop lock, varus/valgus modification, noncorrosive finish, knee cap, soft interface and growth extensions). ▪ Custom fabricated metal KAFOs if up to eight additional components with the base code as indicated in the MDCH Medical Supplier Database (add-ons include: double action joints, t-strap or malleolus pad, drop lock, growth extensions, noncorrosive finish, knee cap, extended steel shank and long tongue stirrup). Shoes are not considered an add-on and would be considered in addition the other items. If other add-on items not listed above, or a greater number of components are medically necessary, PA is required for the entire appliance. Additional components are not covered simply to add reimbursement value to the appliance. For **repairs**, up to two episodes per year, as follows: ▪ The total repair cost equals one hour of labor or less. ▪ The cost of minor parts equals $50 or less.
	PA is required for: ▪ Custom fabricated knee orthoses for all other diagnoses/medical conditions. ▪ Hip Knee Ankle Foot Orthosis (HKAFO) for all other diagnoses/medical conditions. ▪ Fracture orthosis for all other diagnoses/medical conditions. ▪ Other base codes or additional codes indicated as requiring PA in the MDCH Medical Supplier Database. ▪ Repair costs exceed the maximum limits as stated above. ▪ Replacement within six months for a beneficiary under the age of 21. ▪ Replacement within two years for a beneficiary over the age of 21.

Payment Rules	These are covered as **purchase only** items.

2.27 ORTHOTICS (SPINAL)

Definition	Spinal orthotics include, but are not limited to, cervical, thoracic, lumbar, sacral, spinal, thoracic mid belt lumbar sacral, and sacroiliac orthotics.
Standards of Coverage	Spinal orthotics are covered to: ▪ Facilitate healing following a spinal injury. ▪ Arrest or correct the curvature of the spine or spondylolisthesis greater than grade 1. ▪ Support weak spinal muscles due to atrophy and/or a deformed spine. ▪ Facilitate healing following spinal surgery.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance. ▪ Functional needs of the beneficiary. ▪ Reason for replacement, such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.** For **repairs**, a new prescription is not required if the original orthotic was covered by MDCH. A copy of the original prescription for the orthotic and itemization of materials used to repair appliance and rationale for related labor costs must be documented.
PA Requirements	PA is not required for the following if the Standards of Coverage are met: ▪ Prefabricated thoracic-lumbar-sacral orthosis (TLSO) ▪ Prefabricated lumbar sacral orthosis (LSO) ▪ Prefabricated sacroiliac supports ▪ Cervical-Thoracic-Lumbar -Sacral Orthosis (CTLSO) for the treatment of curvature of the spine ▪ Custom fabricated TLSOs, LSOs, and sacroiliac supports for the Base code and up to three additional components indicated on the MDCH Medical Supplier Database and with one of the following diagnoses: ➢ Neurofibromatosis, Type 1 ➢ Scoliosis (and Kyphoscoliosis), Idiopathic ➢ Progressive Infantile Idiopathic Scoliosis ➢ Curvature of Spine (Scoliosis) **

	➢ Certain Congenital Musculoskeletal Deformities of the Spine ➢ Spondylolisthesis **Curvature of the spine (scoliosis) must be listed in conjunction with the other conditions of Charcot-Marie-Tooth Disease or Neurofibromatosis to not require PA. ▪ For **repairs**, up to two episodes per year, as follows: ➢ The total repair cost equals one hour of labor or less. ➢ The cost of minor parts equals $50 or less.
	PA is required for: ▪ Diagnosis/medical conditions not removed from PA. ▪ Repair costs exceed the maximum limits as stated above. ▪ Replacement within one year for a beneficiary under the age of 21, from the original service date. ▪ Replacement within two years for a beneficiary over the age of 21, from the original service date.
Payment Rules	These are covered as **purchase only** items.

2.28 ORTHOTICS (UPPER EXTREMITY)

Definition	Upper extremity orthotics includes, but are not limited to, shoulder, elbow, wrist, and hand orthotics.
Standards of Coverage	Upper extremity orthoses are covered: ▪ Following an acute cerebral vascular accident. ▪ To support weak muscles due to a neuromuscular condition. ▪ Facilitate healing immediately following surgery. ▪ Improve function due to a congenital paralytic syndrome (e.g., Muscular Dystrophy).
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance requested. ▪ Functional needs of the beneficiary. ▪ Reason for replacement such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.**

	For **repairs**, a new prescription is not required if the original orthotic was covered by MDCH. A copy of the original prescription for the orthotic and itemization of materials used to repair appliance and rationale for related labor costs must be documented.
PA Requirements	PA is not required for the following if the Standards of Coverage are met: ▪ Prefabricated shoulder orthosis (SO), elbow orthosis (EO) and shoulder-wrist-hand orthosis (SEWHO). ▪ Custom fabricated SOs, EOs and SEWHOs if the base code and up to two additional components are needed. ▪ Prefabricated upper extremity fracture orthosis if the treatment is related to a fracture related condition. ▪ Custom fabricated upper extremity fracture orthosis if the base code and up to two additional components are needed. ▪ Prefabricated wrist-hand-finger orthosis (WHFO) and hand-finger orthosis (HFO). ▪ For **repairs** as follows: ➢ The total repair cost equals one hour of labor or less. ➢ The cost of minor parts equals $50 or less.
	PA is required for: ▪ Custom fabricated WHFOs and HFOs. ▪ Repair costs that exceed the maximum limits as stated above. ▪ Replacement within one year for a beneficiary under the age of 21, from the original service date. ▪ Replacement within two years for a beneficiary over the age of 21, from the original service date.
Payment Rules	These are covered as **purchase only** items.

2.29 OSTEOGENESIS STIMULATORS

Definition	An Osteogenesis Stimulator is a device that provides electrical stimulation to augment bone repair. A noninvasive electrical stimulator is characterized by an external power source, which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site. The stimulator includes, but is not limited to, the Osteogenesis stimulator, electrical, noninvasive, other than spinal applications and Osteogenesis stimulator, electrical, noninvasive, spinal applications.

Standards of Coverage	A **nonspinal electrical osteogenesis stimulator** may be covered for up to 90 days when other treatment methods have been ineffective and when one of the following applies: ▪ There is a nonunion of a long bone fracture with radiographic evidence indicates that the fracture healing has ceased for three or more months. ▪ If there is failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the surgery. ▪ Congenital Pseudoarthrosis. A **spinal electrical osteogenesis stimulator** may be covered for up to 90 days when other treatment methods have been ineffective and when one of the following applies: ▪ There is a failed spinal fusion where a minimum of nine months has elapsed since the last surgery. ▪ Following multilevel (three or more vertebrae) spinal fusion surgery without internal fixation. ▪ Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same level or levels.
Documentation	Documentation must be less than 90 days old and include all of the following: ▪ Diagnosis/medical condition related to the need for the device. ▪ A minimum of two sets of radiographs, prior to placement of the device, of multiple views and at least 90 days apart. ▪ Alternative treatment methods tried and results. ▪ Other modalities still to be used (include type and location.)
PA Requirements	PA is required.
Payment Rules	Osteogenesis Stimulators are considered a **rental only** item and are inclusive of the following: ▪ All Accessories needed to use the unit (e.g., electrodes, wires, cables, etc.). ▪ Education on the proper use and care if the equipment. ▪ Routine servicing and all necessary repairs or replacement to make the unit functional.

2.30 Ostomy Supplies

Definition	Ostomy supplies are those products necessary to maintain and care for a temporary or permanent stoma and include, but are not limited to, belts, barriers, adhesive remover, filters and pouches.
Standards of Coverage	**Standard wear ostomy products** are changed daily and are covered for specified quantities when the beneficiary has an ostomy. **Extended wear ostomy products** may be covered when change is not required on a daily basis and the quantities must match manufacturers' recommendations for use.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition. ▪ Appliance required. ▪ Quantity of item. ▪ Frequency of change. ▪ Type and location of ostomy. ▪ Condition of the skin surface surrounding the stoma.
PA Requirements	PA is not required for ostomy supplies up to established quantity limits.
	PA is required for quantities above established Program limits.
Payment Rules	These are **purchase only** items.

2.31 Oxygen, Oxygen Equipment and Accessories

Definition	Oxygen therapy includes, but is not limited to, stationary compressed systems, portable gaseous systems, stationary liquid systems, portable liquid systems, and concentrators.
Standards of Coverage	Stationary oxygen equipment and accessories may be covered in the home setting for either short-term (less than six months) or long-term (six months or greater) use. **For beneficiaries under age 21**, oxygen therapy may be covered when oxygen is required during a variety of activities (e.g., sleeping, feeding, resting) and there is an oxygen saturation rate of 93 percent or below or PO2 level of 65 mm HG or below. **For beneficiaries age 21 and older,** when the beneficiary requires oxygen for continuous use (test taken while the beneficiary is at rest, breathing room air), nocturnal use (test taken while sleeping), or exercise use (test taken during exercise) and the oxygen saturation rate is 88 percent or below or the PO2 level is 55 mm HG or below.

	Once the Standards of Coverage are met, the type of equipment covered is determined by the following: ▪ Medical diagnosis/or condition related to the need for oxygen. ▪ Activity level. ▪ Amount of liter flow needed. The three main types of oxygen systems are: ▪ **Compressed Oxygen System** – Used primarily for intermittent use or low liter flow requirements (less than one liter per minute). A portable unit may be authorized if activities cannot be accomplished by the use of a stationary alone. ▪ **Concentrators -** Used for higher liter flows, usually one liter or more. A portable compressed oxygen unit may be authorized if activities cannot be accomplished by the use of a concentrator alone. ▪ **Liquid Oxygen System -** Used for high liter flow requirements. Liter flow must be ordered at more than four liters per minute. In cases where liquid oxygen is inappropriate, a compressed gas or concentrator system could be covered if criteria for that unit are met.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Diagnosis/medical condition appropriate for the need of oxygen. ▪ Required liter flow (e.g., two liters per minute). An order for "Oxygen PRN" or "Oxygen as Needed" does not meet this requirement. ▪ Hours used per day (e.g., eight hours a day). For intermittent use (less than eight hours per day), indicate activity or time of day. An order for "Oxygen PRN" or "Oxygen as Needed" does not meet this requirement. ▪ Duration of need (e.g., three months, six months or lifetime). ▪ Delivery system to be used (e.g., concentrator, compressed gas, liquid). ▪ Current oxygen saturation level or pO2 level. ▪ For liquid oxygen, total number of pounds required per month. ▪ A prescription from a pediatric pulmonologist, a neonatologist, a pediatrician intensivist, and/or pediatric cardiologist is **required under the CSHCS program.** **After the initial prescription for home oxygen**, a six-month follow-up prescription and/or CMN must be obtained. At this time, a new oximetry or ABG test result must be obtained to substantiate the continued need for treatment. Thereafter, a prescription is only required on an annual basis. An updated lab test is required only when there is a change in equipment need or level of oxygen usage.

<table>
<tr><td></td><td>Equipment Maintenance - Verification of the proper use, care and function (e.g., verification that the equipment delivers the proper percentage of liter flow) must be performed according to the manufacturer's requirements.

The following information must also be maintained in the patient's file:

▪ The name of the manufacturer.
▪ The manufacturer's requirements for verification of proper use, care and function of the equipment.
▪ The date that each equipment verification was performed.</td></tr>
<tr><td>PA Requirements</td><td>PA is not required for gaseous stationary, concentrators, and portable oxygen systems if the Standards of Coverage are met and the beneficiary has one of the following diagnoses:

<table>
<tr><th>Diagnosis Description</th></tr>
<tr><td>Pulmonary Tuberculosis</td></tr>
<tr><td>Coccidioidomycosis</td></tr>
<tr><td>Malignant Neoplasm of Trachea, Bronchus, and Lung</td></tr>
<tr><td>Secondary Malignant Neoplasm of Respiratory and Digestive Systems</td></tr>
<tr><td>Other and Unspecified Disorders of Metabolism (Cystic Fibrosis)</td></tr>
<tr><td>Other Diseases of Blood and Blood – Forming Organs (Secondary Polycythemia, Familial Polycythemia)</td></tr>
<tr><td>Myoneural Disorders</td></tr>
<tr><td>Muscular Dystrophies and other Myopathies</td></tr>
<tr><td>Chronic Pulmonary Heart Disease</td></tr>
<tr><td>Heart Failure</td></tr>
<tr><td>Chronic Bronchitis</td></tr>
</table>
<table>
<tr><th>Diagnosis Description</th></tr>
<tr><td>Other Emphysema</td></tr>
<tr><td>Bronchiectasis</td></tr>
<tr><td>Chronic Airway Obstruction</td></tr>
<tr><td>Pneumoconioses and other Lung Diseases due to External Agents</td></tr>
<tr><td>Postinflammatory Pulmonary Fibrosis</td></tr>
<tr><td>Other Alveolar and Parietoalveolar Pneumonopathy</td></tr>
<tr><td>Pulmonary Eosenophilia</td></tr>
<tr><td>Tracheomalacia</td></tr>
<tr><td>Congenital Heart Disease</td></tr>
<tr><td>Bronchopulmonary Disease</td></tr>
<tr><td></td></tr>
</table>

PA is not required for gaseous stationary or concentrators for the condition of obstructive sleep apnea.</td></tr>
<tr><td></td><td>PA is required for:

▪ Oxygen required for short-term use only.
▪ Liquid oxygen systems.
▪ Liquid oxygen contents only.
▪ Medical need for long-term oxygen use does not meet Standards of Coverage.</td></tr>
</table>

Payment Rules	All oxygen equipment is a **rental only** and is inclusive of the following: ▪ All necessary accessories (e.g., regulator, tubing, mask or cannula, contents base, etc.). Stationary gaseous or liquid oxygen contents are separately payable only when the patient owns the equipment and the coverage criteria has been met. ▪ The rental payment includes routine servicing and all necessary repairs or replacements to make the rented DME functional. The equipment should be checked according to manufacturer's specifications.
	Combination of Equipment Covered: ▪ Only one delivery method is covered per month (i.e., gaseous, gaseous/concentrator or liquid). ▪ A portable compressed gaseous system or liquid system will only be provided in addition to an existing stationary system, unless oxygen is needed for ambulation only. ▪ A backup cylinder is considered part of the inclusive reimbursement for the oxygen system.
	Nursing Facility Residents: ▪ For a nursing facility resident, the DME provider may bill for oxygen gas, equipment, and supplies only when used for prolonged daily use. Intermittent or infrequent use of these items is included in the nursing facility per-diem rate. ▪ For a County Medical Care Facility or Hospital Long Term Care Unit, the DME provider cannot bill for oxygen gas, equipment and supplies for any resident. Frequent or prolonged use is defined as: ▪ Long-term daily basis. ▪ At least eight hours duration or more per day.

2.32 PARENTERAL NUTRITION

Definition	Parenteral nutrition is the provision of nutrition intravenously.
Standards of Coverage	Parenteral nutrition may be covered when: ▪ There is an impairment or disease of the gastrointestinal track that impairs the ability of nutrients to be digested and absorbed. ▪ Post-surgical nonabsorption from a recent massive small bowel resection leaving less than five feet of small bowel remaining beyond the ligament of Treitz or short bowel syndrome with severity that involves a net gastrointestinal fluid and electrolyte malabsorption in which the enteral losses exceed 50 percent of oral/enteral intake.

Documentation	Documentation must be less than 30 days old and include the following: ▪ Specific diagnosis related to the beneficiary's inability to take or eat regular food. ▪ Amount of nutrients needed per day. ▪ Duration of treatment. ▪ Current height, weight, and recent weight loss. ▪ Identification of levels of individual nutrient(s) that are required in increased or restricted amounts.
PA Requirements	PA is not required for parenteral equipment, supplies, and solutions when the Standards of Coverage have been met, and one of the following diagnoses exists: ▪ Noninfectious Enteritis of the Small Intestine ▪ Noninfectious Enteritis of the Large Intestine ▪ Unspecified Intestinal Obstruction ▪ Fistula of Intestine, Excluding Rectum and Anus ▪ Acute Pancreatitis ▪ Chronic Pancreatitis ▪ Cyst and Pseudocys of Pancreas ▪ Other and Unspecified Post-Surgical NonAbsorption
Payment Rules	Parenteral nutrition must be billed as a daily rate by reporting total number of days used as units. The parenteral lipids, the parenteral pre-mix solution, the infusion pump, supply kit, and the administration kit, may be billed in combination with each other. If reporting parenteral lipids without one of the parenteral pre-mix solutions, only the pump code is separately reimbursable. The administration kit includes all items necessary for the administration of the solution (e.g., the extension sets, pump cassettes, clamps, containers, and connectors). The supply kit includes all necessary medical supplies such as dressings, tape, alcohol wipes, filters, syringes, needles, and injection caps. For Medicaid beneficiaries residing in a nursing facility, the parenteral solution, equipment and supplies may be billed by the medical supplier.

2.33 Peak Flow Meter

Definition	A peak flow meter is a small device used to measure the airflow out of the lungs.
Standards of Coverage	A peak flow meter may be covered if the beneficiary has a diagnosis related to an obstructive airway disease (e.g., asthma, COPD).

Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/condition related to the need for the meter. ▪ Frequency of use.
PA Requirements	PA is not required if the Standards of Coverage have been met**.**
	PA is required when: ▪ Medical need is beyond Standards of Coverage. ▪ Replacement is required within one year.
Payment Rules	This is a **purchase only** item.

2.34 PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER

Definition	A phototherapy light with photometer is an ultraviolet light source used to reduce bilirubin levels.
Standards of Coverage	A phototherapy light may be covered if: ▪ The beneficiary is being treated for the diagnosis of neonatal jaundice. ▪ The treatment is limited to seven consecutive days and occurs during the first 30 days of life.
Documentation	Documentation must be less than 24 hours old and include: ▪ Diagnosis/condition related to the need for the device. ▪ Duration of need.
PA Requirements	PA is not required if the Standards of Coverage are met and there is one of the following diagnoses: ▪ Optic Papillitis ▪ Hemolytic Disease due to Other and Unspecified Isoimmunization ▪ Perinatal Jaundice from Other Excessive Hemolysis ▪ Neonatal Jaundice Associated with Preterm Delivery ▪ Neonatal Jaundice due to Delayed Conjugation from Other Cases ▪ Unspecified Fetal and Neonatal Jaundice ▪ Kernicterus not due to Isoimmunization

	PA is required for: ▪ Diagnosis/medical condition other than those listed above. ▪ Medical need is beyond the Standards of Coverage.
Payment Rules	A phototherapy light with photometer is a **rental only** item, and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., ultraviolet light source, a fiberoptic system with fiberoptic blanket if needed, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.35 Pneumatic Compressors and Appliances (Lymphedema Pump)

Definition	Pneumatic compressors and appliances may be either nonsegmented or segmented, with or without calibrated gradient pressure. An integral part of treatment, along with the pneumatic compression device, is leg or arm elevation and the use of custom fabricated gradient pressure stockings or sleeves, compression bandaging, etc.
Standards of Coverage	A pneumatic compression device may be covered only as a treatment of last resort (e.g., other less intensive treatment has not been effective). A **nonsegmented device or segmented device without manual control** of the pressure in each chamber may be covered for up to 90 days for any of the following: ▪ Radical surgical procedures with removal of regional groups of lymph nodes (e.g., radical mastectomy) ▪ Post-radiation fibrosis ▪ Metastasis of malignant tumors to regional lymph nodes with lymphatic obstruction ▪ Scarring of lymphatic channels if: ➢ There is significant ulceration of the lower extremity(ies); and ➢ The beneficiary has received repeated, standard treatments from a physician using such methods as a compression bandage system or its equivalent ▪ Treatment of chronic venous insufficiency with edema and/or venous ulcers ▪ Milroy's Disease ▪ Congenital anomalies ▪ Refractory lymphedema related to venous insufficiency complicated by recurrent cellulitis (scarring of the lymphatic channels) A **segmented device with calibrated gradient pressure** may be covered when there is a painful focal lesion (e.g., significant sensitive skin scar or contracture) of the extremity that requires a reduction in pressure over the affected segment.

Documentation	The Documentation must be less than 30 days old and include the following: ▪ Diagnosis/condition appropriate for the equipment requested ▪ Location and size of the painful focal lesion(s), which necessitates the use of the device, if applicable ▪ Length of time each lesion has been continuously present ▪ Plan of treatment including the frequency and duration of each treatment episode and anticipated prognosis ▪ Type of unit to be used, the necessary pressure in each chamber and why the specific features of the equipment are needed ▪ Description of other treatments that have been tried
Continued Use After the Initial 90 Days	For continued coverage beyond the initial 90 days, the following additional information must be provided: ▪ Bilateral limb measurements before and after the approved treatment ▪ Results of the treatment provided
PA Requirements	PA is required for all requests.
Payment Rules	A unit may be a **capped rental** or **purchase** item. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment ▪ Education on the proper use and care of the equipment ▪ Routine servicing and all necessary repairs or replacements to make the unit functional

2.36 PRESSURE GRADIENT PRODUCTS

Definition	Pressure gradient products include, but are not limited to, sleeves, wrist gauntlets, vests, legs, etc.
Standards of Coverage	Pressure gradient products may be covered to reduce edema, promote circulation, reduce scarring or reduce retention of fluid in the extremities due to the following conditions: ▪ Lymphedema ▪ Chronic venous insufficiency ▪ Thrombophlebitis ▪ Burns Up to two garments may be covered when the items must be worn for 24 hours.

	Gradient compression stockings are custom-made or custom-fitted support and are covered when ordered by a physician to treat one of the above conditions and deliver at least 18 mmHG or greater compression. For custom burn garments, refer to HCPCS codes A6501- A6512. Surgical stockings, such as heavy elastic or anti-embolism stockings, are covered when ordered by a physician as a short-term treatment (up to three months) after a surgical event (e.g., prevent blood clots for non-ambulatory individuals after hospital discharge). If required for treatment during an inpatient hospital stay or outpatient hospital visit, the service will not be reimbursed to the medical supplier.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis of condition being treated ▪ Item to be dispensed ▪ Number of hours to be worn ▪ Location and number of extremities involved
PA Requirements	PA is not required for ready-made pressure gradient products up to established quantity limits.
	PA is required for: ▪ All custom-made products and special features such as a zipper, enclosed toe, open pubis, etc. ▪ Replacement within three months
Payment Rules	All pressure gradient products are considered a **purchase only** item.

2.37 PROSTHETICS (LOWER EXTREMITIES)

Definition	Lower extremity prosthetics include, but are not limited to, partial foot, below knee, above knee, hip and hemi-pelvectomy prostheses.
Standards of Coverage	A **lower extremity prosthesis** may be covered to restore mobility for a beneficiary who demonstrates the ability to transfer and/or ambulate, and the beneficiary's potential functional level is between the ranges of K1 through K4.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Current functional "K" level. ▪ An occupational or physical therapy evaluation may be required on a case-by-case basis when PA is required.

PA Requirements	**Below Knee Prosthesis** ▪ Preparatory prosthesis - PA is not required for a BK preparatory prosthesis when the Standards of Coverage are met and it consists of a base procedure code (e.g., L5510, L5520, or L5530) and the following add-ons: ➢ one test socket ➢ insert ➢ suspension system (e.g. L5666, L5670, or L5674) ➢ total contact ➢ distal cushion The SACH foot is included with the BK preparatory base code. If any prosthetic foot other than a SACH foot is placed on a preparatory prosthesis, it will require prior authorization and must be transferred to the definitive prosthesis. ▪ Definitive Exoskeletal BK prosthesis – PA is not required for a BK definitive exoskeletal prosthesis when the Standards of Coverage are met and it consists of a base procedure code (e.g., L5100, L5105, L5050) and the following add-ons: ➢ up to two test sockets ➢ socket material ➢ total contact ➢ distal cushion ➢ foot ➢ suspension locking system ➢ insert ➢ gel liner ▪ Definitive Endoskeletal BK Prosthesis - PA is not required for a BK definitive endoskeletal prosthesis when the Standards of Coverage are met and it consists of a base procedure code (e.g., L5301, L5311) and the following add-ons: ➢ up to two test sockets ➢ socket material ➢ total contact ➢ distal cushion ➢ foot

	➢ suspension locking system ➢ insert ➢ gel liner ➢ cover. Socks and sheaths are not considered as add-ons and would be considered in addition to the other add-on items for either the preparatory or definitive prosthesis. **Above Knee Prosthesis** ▪ PA is not required for an above knee preparatory prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: one test socket, foot, knee, socket design and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other items. ▪ PA is not required for an exoskeletal above knee definitive prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: up to two test sockets, foot, knee, insert, socket material, socket design, and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other items. ▪ PA is not required for an endoskeletal above knee definitive prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: up to two test sockets, foot, insert, socket material, socket design, and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other others. Refer to the MDCH Medical Supplier Database for the specific codes removed from PA. For **repairs**, up to two episodes per year, as follows: ▪ The total repair cost equals one hour of labor or less. ▪ The cost of minor parts equals $50 or less.
	PA is required for either below knee or above knee prosthesis when: ▪ The standards of coverage are not met. ▪ Any component part of the prosthesis requires PA. ▪ The beneficiary is over the age of 21 and replacement is required within five years. ▪ The beneficiary is under the age of 21 and replacement is required within two years.
Payment Rules	These are **purchase only** items.

2.38 PULSE OXIMETER

Definition	A pulse oximeter is a noninvasive device that measures arterial oxygen saturation levels and pulse rate. The device consists of a sensor attached to the patient's finger or ear lobe that is linked to a processing unit that delivers a read-out.
Standards of Coverage	Pulse oximeter may be covered: ▪ **For beneficiaries 21 or over** as a diagnostic tool for short-term rental (one month) if ordered for oxygen or ventilator weaning in the home. ▪ **For beneficiaries under 21**: ➢ As a diagnostic tool for short-term rental (one month) when there are suspected desaturations during sleep, stress, or feeding. ➢ Up to six months with a diagnosis requiring oxygen use. ➢ Up to six months for beneficiaries with a tracheostomy.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition related to the need for the unit. ▪ Treatment plan addressing what is to be done for abnormal readings. ▪ Current oxygen orders, if applicable. ▪ For coverage beyond the initial six-month period, an evaluation by an appropriate subspecialist is required (e.g., pediatric pulmonologist, pediatric cardiologist, neurologist, ENT, or pediatric internist) is **required under the CSHCS program**.
PA Requirements	PA is not required when the Standards of Coverage are met, the beneficiary is under 21, and has one of the following diagnoses: ▪ Tracheostomy (Artificial Opening Status) ▪ Tracheostomy (Attention to Artificial Openings)
	PA is required: ▪ For all beneficiaries over the age of 21. ▪ When the Standards of Coverage is not met.
Payment Rules	A pulse oximeter is a **capped rental** item and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., nondisposable infant or adult oximeter probes, cables, etc). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. ▪ Periodic downloading of recorded data.

	If needed for continuous use beyond the 10 months of rental, the item is considered purchased and necessary repairs and/or replacements of accessories are separately reimbursable if not covered under the manufacturer warranty. Replacement of one non-disposable probe annually is separately reimbursable without prior authorization.

2.39 Speech Generating Devices [Change Made 4/1/06]

Definition	A Speech Generating Device (SGD) is defined as any electric or nonelectric aid or device that replaces or enhances lost communication skills. The device must be an integral part of a treatment plan for a person with a severe communication disability who is otherwise unable to communicate basic functional needs.
Standards of Coverage	SGDs may be covered under the following conditions for beneficiaries who demonstrate the comprehension and physical skills necessary to communicate using the requested device. ▪ **Prosthetic Function -** To replace a missing body part, to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body. ▪ **Rehabilitative Function -** To restore communication skills to the previous functional level by providing a tool to the beneficiary. A speech-language pathologist in conjunction with other disciplines such as occupational therapists, physical therapists, psychologists, and seating specialists as needed must provide a thorough and systematic evaluation of the beneficiary's receptive and expressive communication abilities. Ancillary professionals must possess proper credentials (certification, license, and registration, etc., as appropriate). SGD vendors (manufacturers, distributors) may not submit assessment information or justification for any requested SGD.
	Frequency - The program will purchase new equipment only. Only one SGD will be purchased within a three-year period for beneficiaries under age 21. Only one SGD will be purchased within five years for beneficiaries age 21 and older. Exceptions may be considered in situations where there has been a recent and significant change in the beneficiary's medical or functional status relative to the beneficiary's communication skills.
	Warranty - The warranty period begins at the point when the device is in the beneficiary's home and the beneficiary has received adequate training to use his system for functional communication.

	Repairs - Repairs for augmentative communication devices (SGD) are covered after the warranty expires for no more than one SGD per beneficiary. Additionally, repair of an SGD not purchased by MDCH is covered only if the SGD is determined to be necessary to meet basic functional communication needs in accordance with the criteria for SGD coverage.
Documentation	Documentation must be within 90 days old and include: ▪ Medical diagnosis. (The medical diagnosis must directly relate to the beneficiary's communication deficit.) ▪ Specifications for the SGD. (Refer to the Outpatient Therapy Chapter) **(modified 4/1/06)** ▪ Necessary therapy and training to allow the beneficiary to meet functional needs. All SGD evaluation documentation must be submitted following the established criteria stated within the Evaluations and Follow-up for Speech Generating Devices subsection of the Outpatient Therapy Chapter. **(modified 4/1/06)** Documentation for modifications must indicate the changes in the beneficiary's functional or medical status that necessitate the need for modifications in the system or parts. When a current SGD needs replacement and the replacement is **identical** to the SGD previously purchased by MDCH, the documentation required is: ▪ Clinical confirmation of continued suitability by a speech-language pathologist. ▪ Clinical confirmation of ability to functionally access a SGD by a speech-language pathologist and occupational or physical therapist. ▪ Cost of the repair and the cost of replacement. When a current SGD needs replacement and the replacement is **different** than the SGD previously purchased by the program a new SGD Evaluation must be conducted utilizing MSA-1653-C. Additional documentation required is a statement that indicates how the current system no longer meets the beneficiary's functional communication needs. A current re-evaluation is required for any device that is not identical to the device being replaced. For replacements due to loss or damage, indicate the following additional documentation: ▪ The cause of the loss or damage; and ▪ The plan to prevent recurrence of the loss or damage.

PA Requirements	The speech-language pathologist performs the functional communication assessment and SGD evaluation and initiates the PA request with a medical supplier that has a specialty enrollment with the MDCH to provide SGDs. To improve beneficiary access to low-end devices, a medical supplier without a SGD specialty enrollment with MDCH may provide SGDs with eight minutes or less of speech capability, basic SGD accessories such as switches, buttons, etc., or SGD wheelchair mounting systems. A SGD vendor must enroll with MDCH as a medical supplier with a specialty enrollment in order to provide the full range of SGDs. Providers may contact the Medicaid Payments Division, Provider Enrollment Unit for enrollment information. (Refer to the Directory Appendix for contact information.) PA is required for all SGD systems. Required documentation must accompany the Special Services Prior Approval—Request/Authorization (MSA-1653-B) when requesting authorization for all original and replacement/upgrade SGD requests. **(modified 4/1/06)** A copy of the physician prescription must be submitted with the request for an SGD. The prescription must be based on the evaluation of an individual's communication abilities and medical needs made by a speech-language pathologist and other evaluation team members (as appropriate).
	Modifications - All modifications and upgrades for SGDs require PA. Indicate the procedure code that defines the modifications requesting PA for modifications and upgrades.
	Repairs - For a repair, report HCPCS code E1340 (for the labor charge) and HCPCS code E1399 (for the replacement part). PA is required for all repairs. If repair charges exceed $150, a speech-language pathologist, occupational therapist, or physical therapist must conduct an evaluation. A statement must be included in the evaluation indicating whether the current SGD continues to meet the beneficiary's functional needs. If the beneficiary's needs are being met with the current system, PA may be granted. Each repair must consist of a thorough assessment of the general working condition of the entire system so that frequent repairs may be avoided. If additional repairs to the system are needed, PA for those additional services must be obtained. In some cases, it may be more costly to repair the SGD than to replace it. When requesting PA for a repair, provide the cost of the repair and the cost of the replacement so that determination can be made by MDCH whether to repair or replace the device.
	Replacements - All replacements (identical, upgrades, downgrades) of an SGD require PA.

Payment Rules	**Purchase** - MDCH will purchase new equipment only. The serial number of the device purchased must be maintained on file by the vendor for audit purposes. Shipping and handling fees relating to the SGD equipment are not separately reimbursed. Reimbursement includes the charges for the SGD and all approved components. The provider's charge for an SGD must be based on the usual and customary charge. Reimbursement will be the lesser of the provider's charge and/or the Medicaid fee screen.
	Rental - MDCH will rent equipment or devices when the purchase price of the device, including the component parts, exceeds $9,000. Equipment will not be rented for a period of less than 30 days and may be rented for a maximum period of 90 days. The monthly rental reimbursement rate will be 1/10 of the maximum purchase reimbursement. The amount reimbursed for rental will be deducted from the total purchase price.

2.40 SUPPORT SURFACES – GROUP 1

Definition	Pressure Reducing Support Surfaces – Group 1 includes, but is not limited to, alternating pressure pad and pump; water, air, or dry pressure mattresses; or gel or gel-like pressure pads. A Group 1 support surface must provide both a waterproof cover and adequate support to prevent the beneficiary from "bottoming out" with the use of the item.
Standards of Coverage	A Group 1 mattress overlay or mattress may be covered if one of the following applies: The beneficiary: ▪ Is completely immobile (i.e., cannot make changes is body position without assistance). ▪ Has limited mobility (i.e., cannot independently make changes in body position significant enough to alleviate pressure) with the presence of at least one of the additional conditions: ➢ Impaired nutritional status; ➢ Fecal or urinary incontinence; ➢ Altered sensory perception; or ➢ Compromised circulatory status. ▪ Has any stage pressure ulcer on the trunk or pelvis with the presence of at least one of the additional conditions: ➢ Impaired nutritional status; ➢ Fecal or urinary incontinence; ➢ Altered sensory perception; or ➢ Compromised circulatory status.

<table>
<tr><td>Documentation</td><td>Documentation must be less than 30 days old and include the following:
Education of the beneficiary and/or caregiver on the prevention and/or management of pressure ulcers.
Diagnosis/medical condition related to need for the item.
Regular assessment by a nurse, physician, or other licensed healthcare practitioner.
Appropriate turning and positioning.
Appropriate wound care (for a Stage II, III, or IV ulcer).
Appropriate management of moisture/incontinence.
Wound size, stage and location (for a Stage II, III or IV ulcer).
Nutritional assessment and intervention consistent with the overall plan of care.</td></tr>
<tr><td>PA Requirements</td><td>PA is not required for HCPCS codes A4640, E0180, E0184, E0185, E0186, E0187 or E0197 if the Standards of Coverage are met and one of the following diagnoses is present:<table><tr><th>Diagnosis Description</th></tr><tr><td>Alteration of Consciousness, coma or Transient Alteration of Awareness</td></tr><tr><td>Anoxic Brain Damage</td></tr><tr><td>Anterior Horn Cell Disease</td></tr><tr><td>Cerebral Degenerations Usually Manifest in Childhood</td></tr><tr><td>Cerebral Edema</td></tr><tr><td>Compression of Brain</td></tr><tr><td>Congenital or Hereditary Progressive Muscular Dystrophy, Myotonic Disorders, Familial Periodic Paralysis</td></tr><tr><td>Decubitus Ulcer</td></tr><tr><td>Encephalophy, Unspecified</td></tr><tr><td>Fracture of the Cervical or Dorsal Areas (open or closed)</td></tr><tr><td>Hemiphegia and Hemiparesis</td></tr></table><table><tr><th>Diagnosis Description</th></tr><tr><td>Huntington’s Chorea</td></tr><tr><td>Infantile Cerebral Palsy</td></tr><tr><td>Multiple Sclerosis</td></tr><tr><td>Neurofibromatosis</td></tr><tr><td>Other Congenital Anomalies of Nervous System</td></tr><tr><td>Other Demyelinating Disease of Central Nervous System</td></tr><tr><td>Other Paralytic Syndromes</td></tr><tr><td>Parkinson’s Disease</td></tr><tr><td>Spina Bifida</td></tr><tr><td>Spinocerebellar Disease</td></tr><tr><td></td></tr></table></td></tr>
<tr><td></td><td>PA is required for:
Medical need beyond the Standards of Coverage.
All other diagnoses
Replacement in less than three years.</td></tr>
</table>

Payment Rules	A Group 1 support surface may be a **capped rental** or **purchase** depending on the specific HCPCS code. Only a single Group 1 support surface will be considered for a purchase/rental at any given time. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment (e.g., pump, pad, cards etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacement to make the unit functional.

2.41 SUPPORT SURFACES – GROUP 2

Definition	Pressure Reducing Support Surfaces - Group 2 includes, but is not limited to, powered air flotation beds; powered pressure-reducing air mattresses; powered air overlay for mattress, or nonpowered advance pressure reducing mattress. A Group 2 support surface must provide both a waterproof cover and adequate support to prevent the beneficiary from "bottoming out" with the use of the item.
Standards of Coverage	A Group 2 mattress support may be covered up to three months when one of the following applies: ▪ Multiple Stage II pressure ulcers are located on the trunk or pelvis and the beneficiary has participated with a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate Group 1 support surface, and the wound has worsened or had no change. ▪ Large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis. ▪ Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) and the beneficiary has been on a Group 2 or 3 surface immediately after a recent discharge from a hospital or nursing facility (discharge within the past 30 days).
	Continued Use of a Group 2 support surface **-** Continued use of a Group 2 support surface on a monthly basis may be covered for restorative purposes only when healing continues to progress. Continued use of a Group 2 support surface on a monthly basis will not be reauthorized for coverage if: ▪ The beneficiary is noncompliant with care plan; or ▪ The documentation in the medical record demonstrates that other aspects of the plan of care are not being modified to promote healing
Documentation	Documentation must be less than 14 days old and include the following: ▪ Diagnosis/medical condition related to need for item. ▪ Size, stage and location of the ulcer.

	▪ Other treatment modalities/surfaces already tried. ▪ Education of the beneficiary and caregiver on the prevention and/or management of pressure ulcers. ▪ Regular assessment by a nurse, physician, or other licensed healthcare practitioner. ▪ Appropriate turning and positioning. ▪ Current appropriate wound care (for a Stage II, III, or IV ulcer). ▪ Appropriate management of moisture/incontinence. ▪ Nutritional assessment and intervention consistent with the overall plan of care.
PA Requirements	PA is required for all Group 2 support surfaces.
Payment Rules	A Group 2 support surface may be a **capped rental** or **purchase** depending on the specific HCPCS procedure code. A powered flotation bed is a **rental only** and must be billed as a daily rate by reporting total number of days used as units. If the unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. For a power flotation bed, if use exceeds a ten-month time frame, report the "MS" modifier after six months of continued maintenance and servicing of the item. (MS - six-month maintenance and servicing fee for reasonable and necessary parts and labor that are not covered under any manufacturer or supplier warranty).

2.42 SUPPORT SURFACES – GROUP 3

Definition	Pressure Reducing Support Surfaces – Group 3 are fully integrated air fluidized beds for the purpose of alleviating pressure. The surface uses the circulation of filtered air through silicone coated ceramic beads that creates the characteristics of fluid.
Standards of Coverage	A Group 3 air-fluidized bed is covered for up to 90 days if all of the following applies: ▪ The beneficiary has a Stage III (full thickness tissue loss) or Stage IV (deep tissue destruction) pressure ulcer. ▪ The beneficiary is bedridden or chair bound as a result of severely limited mobility. ▪ The beneficiary's attending physician orders in writing an air-fluidized bed based on a comprehensive assessment and evaluation of the beneficiary after conservative treatment has been tried without success.

	▪ A trained adult caregiver is available to assist the beneficiary with ADLs, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments and management of the air-fluidized bed ▪ A physician directs the home treatment regimen, and re-evaluates the need for the air-fluidized bed on a monthly basis. ▪ All other conservative treatment methods have been tried without success (e.g., Group 1 or Group 2 support surfaces) **Continued Use** of a Group 3 support surface - Continued use of a Group 3 support surface may be covered for restorative purposes only when healing continues to progress. Continued use of a Group 3 support surface will not be reauthorized for coverage if: ▪ Beneficiary is noncompliant with care plan; or ▪ Documentation in the medical record demonstrates that other aspects of the plan of care are not being modified to promote healing
Noncovered	Group 3 support surfaces are noncovered if: ▪ Beneficiary requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material. ▪ Caregiver is unwilling or unable to provide the type of care required by the beneficiary on a air-fluidized bed. ▪ Structural support is inadequate to support the weight of the air-fluidized bed system. ▪ Electrical system is insufficient for the anticipated increase in energy consumption. ▪ Other known contraindications exist.
Documentation	Documentation must be less than 14 days old and include the following: ▪ Diagnosis/medical condition related to the need for the bed. ▪ Size, stage and location of the ulcer. ▪ Other treatment modalities already tried. ▪ Education of the beneficiary and/or caregiver on the prevention and/or management of pressure ulcers. ▪ Monthly assessment by a nurse, physician, or other licensed healthcare practitioner. ▪ Appropriate turning and positioning. ▪ Current appropriate wound care (for a Stage II, III, or IV ulcer). ▪ Appropriate management of moisture/incontinence. ▪ Nutritional assessment and intervention consistent with the overall plan of care.

PA Requirements	PA is required for all Group 3 support surface requests.
Payment Rules	A Group 3 support surface or air fluidized bed is a **rental only** item and must be billed as a daily rate by reporting total number of days used as units. The rental payment is considered to include the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. If use exceeds a 10-month timeframe, report the "MS" modifier after six months of continued maintenance and servicing of the item.

2.43 SURGICAL DRESSINGS

Definition	Surgical dressings include a primary dressing (used as a protective covering applied directly to the wound or lesion) and/or a secondary dressing (used to secure a primary dressing in place). Many of the primary dressings covered by MDCH are self-adhesive and would not require a secondary dressing to be placed as well. Examples of surgical dressing are adhesive tape, roll gauze, and elastic bandages.
Standards of Coverage	Surgical dressings are covered for one or more of the following: ▪ To treat a wound or opening in the skin. ▪ To debride a wound or lesion. ▪ To treat pressure ulcers. Coverage of the quantity or type of dressing is based on: ▪ Size, stage, location and current status of the wound/lesions being treated. ▪ Number of wounds/lesions. ▪ Number of body locations involved. ▪ Frequency of dressing change.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Diagnosis/medical condition related to the need for the items(s). ▪ Item to be dispensed. ▪ Quantity of item. ▪ Anticipated frequency of dressing change. ▪ Size, stage, location, and number of wounds/lesions.

	For dressing requests of quantities over established limits, documentation to substantiate medical need is required.
PA Requirements	PA is required for: ▪ Collagen dressings or wound fillers. ▪ Silicone gel sheets. ▪ Composite dressings. ▪ Quantities beyond Medicaid's established limits.
	PA is not required for all other types of surgical dressings unless usage exceeds established quantity limitations.
Payment Rules	All items are considered a **purchase** up to the allowable quantities. Modifiers A1 through A9 must be reported in addition to the HCPCS code to report the appropriate number of wounds being treated. The modifiers are as follows: ▪ A1 - Dressing for one wound ▪ A2 – Dressing for two wounds ▪ A3 – Dressing for three wounds ▪ A4 – Dressing for four wounds ▪ A5 – Dressing for five wounds ▪ A6 – Dressing for six wounds ▪ A7 – Dressing for seven wounds ▪ A8 – Dressing for eight wounds ▪ A9 – Dressing for nine or more wounds Dressings related to infusion pumps, or parenteral/enteral nutrition, tracheostomy, or gastrostomy are included in either the daily rate or in established all-inclusive kit codes and are not separately reimbursable.

2.44 TRACHEOSTOMY CARE SUPPLIES

Definition	Tracheostomy care supplies include, but are not limited to, tracheostomy filters, tubes, masks, care kits, cleaning brushes, shower protectors and suction catheters.
Standards of Coverage	Tracheostomy care supplies are covered to support the care of a beneficiary with a tracheostomy. A tracheostomy starter kit may be covered for the four weeks following the initial tracheostomy surgery. The kit code includes the following items: Plastic tray, basin, sterile gloves, tube brush, pipe cleaners, a pre-cut tracheostomy dressing, a roll of gauze, drain sponges, cotton tip applicators, tracheostomy tube ties or twill tape.

	After the initial four weeks, the established tracheostomy kit may be covered. The kit code includes the following items: Tube brush, pipe cleaners, cotton tip applicators, tracheostomy tube ties or twill tape, and drain sponges.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition. ▪ Specific items required.
PA Requirements	PA is not required when the Standards of Coverage are met and established quantity limits are not exceeded.
	PA is required when: ▪ Standards of Coverage are not met. ▪ Quantities requested exceed the established limits. ▪ Other items not part of one of the kit codes may be considered for separate reimbursement. (Refer to the MDCH Medical Supplier Database on the MDCH website for additional information.)
Payment Rules	Payment is **purchase only**. All quantities reported should reflect a 30-day supply.

2.45 TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR

Definition	A Transcutaneous Electrical Nerve Stimulator (TENS) is a device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the beneficiary's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins.
Standards of Coverage	A TENS unit is covered for reduction of pain for beneficiaries with either chronic, intractable pain of at least three months duration, or acute post-operative pain limited to 30 days from the date of surgery, or pain related to cancer, when: ▪ The beneficiary is able to use the TENS device. ▪ There is effective control of pain. ▪ Other treatment modalities have been ineffective.
Documentation	Documentation must be less than 30 days old and must include all of the following: ▪ Diagnosis/medical condition related to the need for a TENS (including type and location of pain). ▪ Alternative treatments for pain tried and the results. ▪ Other modalities of treatment still being used, (type and duration must be detailed).

	For coverage beyond 90 days, include documentation addressing continued effective pain control.
	Continued Use after the initial 90 days - The documentation must be included with the PA request to describe the effectiveness of the treatment received. For continued coverage for chronic intractable pain, the documentation must be within 30 days old and include the following: ▪ Medication regimen, before and after use. ▪ Functional level (affected by pain) before and after.
PA Requirements	PA is required for all requests.
Payment Rules	A TENS unit may be considered as a **capped rental**. The rental payment is inclusive of the following: ▪ All accessories needed to use the equipment (e.g., electrodes, lead wires, cables etc). ▪ Education on the proper use and care of the equipment. ▪ Routine Servicing and all necessary repairs or replacements to make the unit functional.

2.46 WALKERS

Definition	Walkers include, but are not limited to, rigid, wheeled, heavy duty, and folding.
Standards of Coverage	Walkers may be covered when the beneficiary has impaired ambulation and requires a walker for safe and independent ambulation.
Documentation	Documentation must be less than six months old and include: ▪ Diagnosis/medical condition related to the need for the service. ▪ Functional level possible with use of walker. ▪ Medical reason for type of attachment or modification, if applicable. ▪ Medical reason for heavy-duty walker (e.g., obesity, severe neurological disorder or restricted use of hands).
PA Requirements	PA is not required for standard walkers when the Standards of Coverage are met.

	PA is required for: ▪ An enclosed, framed folding walker. ▪ Heavy-duty walker. ▪ Replacement within five years. ▪ Additional attachments (e.g., arm troughs).
Payment Rules	Walkers may be a **capped rental** or **purchase** item. After the first ten months of rental, necessary repairs and/or replacements of accessories are separately reimbursable.

2.47 WHEELCHAIRS, PEDIATRIC MOBILITY ITEMS AND SEATING SYSTEMS

Definition	**A wheelchair** has special construction, consisting of a frame and wheels, with many different options, and includes, but is not limited to, standard, lightweight high strength, powered, etc. A pediatric mobility item or stroller has special lightweight construction, consisting of a frame and wheels, with many different options and includes, but not limited to, transport chairs. Seating systems are systems to facilitate positioning in a wheelchair. These include, but are not limited to: ▪ Standard or planar prefabricated components or components assembled by a supplier or ordered from a manufacturer who makes available special features, modifications or components. ▪ Contoured seating is shaped to fit a person's body to provide support to facilitate proper posture and /or pressure relief. Contoured seating is not considered custom-made. ▪ Custom seating is uniquely constructed or substantially modified to meet the specific needs of an individual beneficiary. A standing wheelchair is a wheelchair that incorporates a standing mechanism that may be self-propelled by the user for mobility. It allows an individual to go from a seated position to a standing position with either a manual level or power switch.
Standards of Coverage Wheelchairs	**Manual wheelchairs** will be covered if the beneficiary demonstrates all of the following: ▪ Has a diagnosis/condition that indicates a lack of functional ambulatory status. ▪ Must be able to regularly use the wheelchair throughout the day. ▪ Must be able to be positioned in the chair safely and without aggravating any medical condition or causing injury.

	▪ Must have a method to propel wheelchair, which may include: ➢ Ability to self-propel for at least 60 feet over hard, smooth, and carpeted surfaces. ➢ Willing, able, and reasonable caregiver to push the chair if needed. A **standard hemi-wheelchair** may be covered when a lower seat to the floor is required. A **lightweight wheelchair** may be covered when the beneficiary is unable to propel a standard wheelchair due to decreased upper extremity strength or secondary to a medical condition that affects endurance. A **heavy-duty wheelchair** may be covered if the beneficiary's weight is more than 250 pounds but does not exceed 300 pounds. An **extra heavy-duty wheelchair** is covered if the beneficiary's weight exceeds 300 pounds. A **high strength lightweight, ultra-light or an extra heavy-duty wheelchair** may be covered when required for a specific functional need.
	Back Up or Secondary Manual Wheelchair may be considered when the: ▪ Beneficiary is primarily a power wheelchair user but needs a manual wheelchair to have access to the community or independent living. ▪ Beneficiary's medical condition requires a power wheelchair that cannot accommodate public transportation and, therefore requires another transport device.
	Power Wheelchairs or Power Operated Vehicles (POV) may be covered if the beneficiary demonstrates all of the following: ▪ Lacks ability to propel a manual wheelchair or has a medical condition that would be compromised by propelling a manual one for at least 60 feet over hard, smooth, or carpeted surfaces. ▪ Requires the use of a wheelchair for at least four hours throughout the day. ▪ Able to safely control a wheelchair through doorways and over thresholds up to 1½ inches. MDCH may consider coverage of a POV, including custom or modified seating, rather than a more expensive power wheelchair if the beneficiary has sufficient trunk control and balance necessary to safely operate the device.
	Wheelchair Accessory may be covered if medically necessary to meet the functional needs of the beneficiary. Specific accessories are part of the initial purchase of a wheelchair and should not be billed separately. Other accessories/modifications are considered as upgrades and would require medical justification from physician, occupational or physical therapist. Specific wheelchair accessories requested solely to facilitate transport of a beneficiary within a vehicle are not covered. Physician, occupational or physical therapist must address the status/condition of the current chair and include the brand, model, serial number and age of current chair.

	Standard and Custom-Modified Versus Custom-Made - Standard, custom-modified, or custom-made wheelchairs must be medically necessary and meet the intended purpose. ▪ **Custom-modified** refers to modifications to a standard wheelchair item to meet specialized needs of a beneficiary by using prefabricated parts (e.g., addition of a strap to a standard item). ▪ A **custom-made wheelchair** is fabricated to meet the functional needs of one specific person. The item is specifically made to fit one user based on direct measurements or body castings. It may involve the incorporation of some prefabricated components but the majority of the device is fabricated specifically for the user. Structural modification beyond the initial fabrication may be required to ensure the desired fit and functionality. MDCH will consider coverage of custom-made equipment when a standard or custom-modified item will not meet the medical and/or functional needs of the user.
	For beneficiaries under 21, **stand-up wheel chairs** may be covered if: ▪ Medical documentation supports the need for standing daily and it is ordered by a pediatric specialist. ▪ Other economic alternatives have been ineffective.
	A **pediatric mobility item (wheelchair/stroller)** may be covered for children ages three and over when: ▪ The requested item will be the primary mobility device for a child who cannot self propel a manual wheelchair or operate a power wheelchair. ▪ Diagnosis or medical condition effects resulting in the ability to ambulate. ▪ It is required as a transport device when primary wheelchair is not portable and cannot be transported.
	Standard or planar seating systems are covered when necessary to assure appropriate positioning in a wheelchair, other economic alternatives have been ineffective, and beneficiary has one of the following conditions: ▪ Postural deformities ▪ Contractures ▪ Tonal abnormalities ▪ Functional impairment ▪ Muscle weakness ▪ Pressure points ▪ Difficulties with seating balance Payment for a seating system includes all repairs and modifications for a two-year period for beneficiaries of all ages.

	Custom fabricated seating systems are covered when both of the following apply: ▪ The criteria for standard seating system has been met. ▪ A comprehensive written medical evaluation substantiates that a prefabricated seating system is, or would be, inadequate to meet the beneficiary's needs. Payment for a seating system will be based on the least costly alternative that meets the beneficiary's medical needs. Payment for the seating system includes all repairs and modifications for a two-year period for beneficiaries of all ages.
Standards of Coverage – Wheelchair Modifications	**Manual or Power Recline** may be covered when needed for relief of pressure on the seat and/or back and one of the following applies: ▪ History of skin breakdown or current indication of imminent skin breakdown that cannot be controlled (or has not in the past) by less costly modalities such as pressure relief cushions or manual pressure relief techniques. ▪ Has ability to tolerate a 90 – 135 degree of range of motion at the hip needed for reclining without triggering excessive abnormal tone. ▪ Is unable to tolerate an upright position in a wheelchair for the long periods of time to fatigue, shortness of breath, increased tone, or discomfort related to pressure that cannot be manually relieved. A low shear recline back is covered when the beneficiary does not have the ability to reposition himself in the chair following reclining and the shearing would result in skin breakdown.
	Tilt-in-Space function allows the seat and back of the wheelchair to move as a unit such that the angle of the back to the floor changes from approximately 90 degrees to 45 degrees or less. This change in position does not affect the hip-to-knee angle. The seat may be tilted manually or by power. The tilt-in-space modification to a wheelchair may be covered if one or more of the following apply: ▪ History of skin breakdown or current indication of skin breakdown that cannot be controlled (or has not in the past) by less costly modalities such as pressure relief cushions or manual pressure relief techniques. ▪ Excessive extensor or flexor muscle tone that is exacerbated by change in hip ankle and makes positioning in any upright chair ineffective and a reason why changing angles of position is medically necessary. ▪ Very low muscle tone that cannot maintain upright positioning against gravity, causing spinal anomalies. ▪ Beneficiary has knee contractures and has a custom molded seating system.
	Coverage of a joint **tilt-in-space and recline modification** to a wheelchair requires medical need such as high probability of the development of hip contractures if only a tilt-in-space without recline is used. There also needs to be a medical contraindication to recline only without tilt-in-space.

	A **power driven recline mechanism or tilt-in-space** may be covered if: ▪ Beneficiary requires assistance to use a manual tilt-in-space or recline system and there are regular periods of time that the beneficiary is without assistance. ▪ Beneficiary requires assistance to use a manual tilt-in-space or recline system and is able to independently care for himself when provided a power recline or tilt-in-space modification. ▪ Beneficiary resides in a nursing facility and use of a power tilt-in-space will permit movement to a less restrictive setting
Noncovered Items	▪ Secondary wheelchairs for beneficiary preference or convenience. ▪ Standing wheelchairs for beneficiaries over 21 years old. ▪ Coverage of power tilt-in-space or recline for a long-term care resident because there is limited staffing. ▪ Nonmedical wheelchair accessories such as horns, lights, bags, etc. ▪ New equipment when current equipment can be modified to accommodate growth.
Documentation	The documentation must be within 180 days old, and include the following: ▪ Diagnosis appropriate for the equipment requested. ▪ Occupational therapy or physical therapy evaluation and recommendation. ▪ Brand and model of requested wheelchair. ▪ If a replacement wheelchair is requested, list brand, model, serial number and age of current chair. ▪ Medical reason for add-on components or modifications if applicable. ▪ Specific medical condition (e.g., contractures, muscle strength) if seating system requested. ▪ Current ambulatory status of beneficiary (e.g., distance the individual can walk, the level of assistance required). ▪ Any adaptive or assistive devices currently used (if replacement chair is requested, list brand, model, serial number and age of current chair). ▪ Other cost-effective alternatives that have been ruled out. ▪ A pediatric subspecialist is **required under the CSHCS Program**.

PA Requirements	PA is not required for the following if Standards of Coverage are met: ▪ The rental of specific wheelchairs up to the first three months after hospital discharge. ▪ The rental of standard wheelchairs, for up to three months following outpatient surgery or discharge from a rehabilitation/nursing facility, if standards of coverage are met. ▪ Specific accessory codes. ▪ Specific pediatric mobility items if the related diagnosis/condition is one of the following: ➢ Spinal Muscular Atrophy ➢ Motor Neuron Disease ➢ Other Anterior Horn Cell Disease ➢ Anterior Horn Cell Disease, Unspecified ➢ Hemiplegia And Hemiparesis ➢ Infantile Cerebral Palsy ➢ Other Specified Myoneural Disorders ➢ Myoneural Disorders, Unspecified ➢ Spina Bifida With Hydrocephalus ➢ Spina Bifida Without Mention Of Hydrocephalus ➢ Spina Bifida (Other Congenital Anomalies of Nervous System ➢ Microcephalus ➢ Reduction Deformities of Brain ➢ Congenital Hydrocephalus ➢ Muscular Dystrophies and Other Myopathies To verify if a specific accessory item (or) pediatric mobility item does not require PA, refer to the Medical Supplier Database on the MDCH website. (Refer to the Directory Appendix for website information.)
	PA is required for: ▪ Rental of a standard wheelchair beyond three months for hospital discharge waiver. ▪ Replacement of standard chairs beyond established timeframes. ▪ Medical need of a standard chair not defined by Standards of Coverage. ▪ Custom wheelchairs.

	▪ Wheelchair modifications of tilt-in-space and/or recline (power or manual). ▪ Seating systems. ▪ Diagnosis/medical conditions not listed to bypass PA for pediatric mobility items. ▪ Medical need not within the Standards of Coverage.
Payment Rules	A wheelchair can be considered a **capped rental** or **purchase** item.
	Repairs for beneficiary owned wheelchairs are covered only after manufacturer warranty has been exhausted. It is the responsibility of the provider to supply loaner equipment while the original item is being serviced. If repair of a wheelchair not purchased by MDCH is requested, the item must be medically necessary and meet the basic Standards of Coverage. The repair of a second (older) manual or power wheelchair used as a backup chair is not covered. Repair of a wheelchair involving the replacement of a component part includes the cost of the part and the labor associated with its removal, replacement and finishing.
	Replacement of a wheelchair is subject to manufacturer warranty and/or cost of repairs. The replacement may also be considered when a significant change in the patient's condition has occurred or the item cannot be restored to a serviceable condition. Replacement of wheelchairs for youth will be evaluated on an individual basis due to the expected growth pattern. Based on these conditions, a wheelchair may be considered for replacement every five years for adults and every two years for children.
	For **beneficiaries residing in a nursing facility**, ▪ Standard DME is included in the facility's per diem rate. ▪ Custom fabricated DME required for the beneficiary's full time use is billable by a medical supplier. The custom made DME must offer physical/restorative function to the beneficiary and allow for independence in the nursing facility setting that is not possible with standard DME. Once the custom made equipment is purchased, it becomes the property of the beneficiary.
	Details regarding whether or not separate reimbursement may be considered for specific **wheelchair accessory codes** when provided in conjunction with the purchase of a manual wheelchair, power wheelchair, or modification of an existing wheelchair may be found in the MDCH Medical Supplier Database on the MDCH website.

2.48 VENTILATORS

Definition	A ventilator is a device designed to intermittently or continuously assist or control pulmonary ventilation. ▪ A negative pressure ventilator exerts negative (sub-atmospheric) pressure on the exterior chest wall. ▪ A positive pressure ventilator ventilates the lungs as the result of a positive pressure applied to the airway.
Standards of Coverage	Negative and positive pressure ventilators may be covered when there is a respiratory related diagnosis (e.g., neuromuscular disease, thoracic restrictive disease, chronic respiratory failure) and the beneficiary requires ventilatory assistance.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Respiratory diagnosis/medical condition related to the need for the ventilator. ▪ Type of ventilator ordered. ▪ Ventilator settings. ▪ Number of hours beneficiary is required to use the ventilator.
PA Requirements	PA is required for all ventilators.
Payment Rules	All ventilators are a **rental only** item and are inclusive of the following: ▪ All accessories needed to use the unit (e.g., circuits, water feed sets, adaptors, temperature probes, filters, heated or nonheated humidifier, oxygen analyzer, water or saline for humidifier, etc). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. An additional ventilator may only be covered to allow a beneficiary access to the community. When billing more than one vent, the additional vent must be reported using a NOC code. A back up ventilator in case of a power failure is not separately reimbursable.

MENTAL HEALTH / SUBSTANCE ABUSE

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Mental Health providers (Provider Types 77, 21). Information contained in this chapter is to be used in conjunction with other chapters of this manual including the Billing & Reimbursement chapters and the Practitioner Chapter, as well as the related procedure code databases located on the Michigan Department of Community Health (MDCH) website. (Refer to the Directory Appendix for contact information).

1.1 MDCH APPROVAL

Pursuant to Michigan's Medicaid State Plan and federally approved 1915(b) waiver and 1915(c) Habilitation Supports Waivers (HSW), community-based mental health, substance abuse and developmental disability specialty services and supports are covered by Medicaid when delivered under the auspices of an approved Prepaid Inpatient Health Plan (PIHP). To be an approved Medicaid provider, a PIHP must be certified as a Community Mental Health Services Program (CMHSP) by MDCH in accordance with Section 232a of the Michigan Mental Health Code. A PIHP may be either a single CMHSP, or the lead agency in an affiliation of CMHSPs approved by the Specialty Services Selection Panel. Service providers may contract with the PIHP or an affiliate of the PIHP. PIHPs must be enrolled with MDCH as Medicaid providers. (Refer to the General Information for Providers Chapter of this manual for additional information.) The PIHP must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, being Public Act 258 of 1974, as amended, and those specialty services/supports included in this manual.

For the Specialty Services and Supports Program, Centers for Medicare and Medicaid Services gave Michigan permission to use Section 1915(b)(3) of the Social Security Act which allows a state to use Medicaid funds to provide services that are in addition to the state plan services. Those services are described in the Additional Mental Health Services (B3s) section of this chapter. Services selected during the person-centered planning process may be a mix of state plan, HSW, and additional/B3 services, or state plan or HSW or additional/B3 services only, depending on what services best meet a beneficiary's needs and will assist in achieving his goals.

The 1915(c) Children's Waiver services are delivered under the auspices of a CMHSP that has been enrolled as a Children's Waiver provider. Children's Waiver services are reimbursed by MDCH through a fee-for-service (FFS) payment system. The Children's Waiver program is described in the Children's Home and Community-Based Services Waiver Section of this chapter.

1.2 STANDARDS

The PIHP shall comply with the standards for organizational structure, fiscal management, administrative record keeping, and clinical record keeping specified in this section. In order for a state plan or HSW service to be reported as a Medicaid cost, it must meet the criteria in this chapter.

1.3 ADMINISTRATIVE ORGANIZATION

The administrative organization shall assure effective and efficient operation of the various programs and agencies in a manner consistent with all applicable federal and state laws, regulations, and policies. Effective and efficient operation includes value purchasing. As applied to services and supports, value purchasing assures appropriate access, quality, and the efficient and economic provision of supports and services. Quality is measured by meeting or exceeding the sets of outcome specifications in the

beneficiary's individual plan of service, developed through the person-centered planning process or, for substance abuse services, the individualized treatment plan. Efficient and economic is the lowest cost of the available alternatives that has documented capacity to meet or exceed the outcome quality specifications identified in the beneficiary's plan. There shall be clear policy guidelines for decision-making and program operations and provision for monitoring same. The PIHP must offer direct assistance to explore and secure all applicable first- and third-party reimbursements, and assist the beneficiary to make use of other community resources for non-Medicaid services, or Medicaid services administered by other agencies.

1.4 Provider Registry

The PIHPs must register with MDCH any Medicaid state plan, HSW, or additional/B3 service they provide directly or through one of their contracted providers, or an affiliate as applicable, as specified in the MDCH/PIHP contract. The PIHPs should contact the Division of Quality Management and Planning for more information about the provider registry, and the Bureau of Community Mental Health Services for MDCH approval of special programs. (Refer to the Directory Appendix for contact information.) PIHPs must update the registry whenever changes (address, scope of program, additions, deletions) occur, according to the format and schedule specified by MDCH.

Children's Waiver providers must be registered by the CMHSPs.

1.5 Programs Requiring Special Approval

Certain programs and sites require the PIHP to request specific approval by MDCH prior to service delivery. Programs must be approved by MDCH prior to service provision in order to be reported as a Medicaid cost. (Refer to the Directory Appendix for contact information.) Programs previously approved by MDCH and delivered by CMHSPs that are now affiliates do not need to be approved again. Programs requiring specific approval are:

Assertive Community Treatment Programs	Drop-in Programs
Clubhouse Psychosocial Rehabilitation Programs	Extended Observation Beds
Crisis Residential Programs	Home-Based Services
Day Program Sites	Intensive Crisis Stabilization

The PIHP shall notify MDCH of changes in providers of these programs or sites, including change of address or discontinuation.

Children's Waiver services remain the responsibility of CMHSPs. CMHSPs must submit requests for approvals and changes to MDCH, Division of Mental Health Services to Children and Families.

1.6 Beneficiary Eligibility

A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual's clinical record.

The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**
▪ The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. ▪ The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.	▪ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills). ▪ The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse. ▪ The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.

The "mental health conditions" listed in the table above are descriptions and are intended only as a general guide for PIHPs and MHPs in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require

collaboration and negotiated understanding between the medical directors from the MHP and the PIHP. The critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary.

Medicaid beneficiaries who are not enrolled in a MHP, and whose needs do not render them eligible for specialty services and supports, receive their outpatient mental health services through the fee-for-service (FFS) Medicaid Program when experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. Refer to the Practitioner Chapter of this manual for coverages and limitations of the FFS mental health benefit.

Medicaid beneficiaries are eligible for substance abuse services if they meet the medical eligibility criteria for one or more services listed in the Substance Abuse Services Section of this chapter.

Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria (for mental illness [MI]) or services selection guidelines (for developmental disabilities [DD]) attached to the MDCH/PIHP contract, be appropriate to the individual's needs, and meet the standards herein. A person-centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDCH/PIHP contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities.

1.7 Definition of Terms

This list of terms is not exhaustive, but rather the most commonly used terms, listed alphabetically:

Amount	The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.
Certificate of Medical Necessity (CMN)	A document written by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under Michigan law that contains all of the following: ▪ Beneficiary's name and address; ▪ Practitioner's signature, date of signature, and telephone number; ▪ The supplier's name and address; ▪ The expected start date of the order (if different from the date of signature); ▪ A complete description of the item or service; ▪ The amount and length of time the item or service is needed;

	▪ Beneficiary's diagnosis; and ▪ The medical necessity of the item or service. (If required by Medicare or other insurer, a CMN may replace a prescription as an order for an item or service. If a CMN is completed, a separate prescription is not required.)
Child Mental Health Professional	▪ A person who is trained and has one year of experience in the examination, evaluation, and treatment of minors and their families and who is either a physician, psychologist, licensed masters social worker, certified social worker or social worker, or registered professional nurse; or ▪ A person with at least a bachelor's degree in a mental health-related field from an accredited school who is trained, and has three years of supervised experience in the examination, evaluation, and treatment of minors and their families; or ▪ A person with at least a master's degree in a mental health-related field from an accredited school who is trained, and has one year of experience in the examination, evaluation, and treatment of minors and their families.
Covered Service or Medicaid Covered Services	For the purposes of this manual, Medicaid State Plan Services.
Duration	The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.
Health Care Professional	A physician, registered nurse, physician's assistant, nurse practitioner, or dietitian. Services provided must be relevant to the health care professional's scope of practice. Refer to the Staff Provider Qualifications in the Program Requirements Section of this chapter.
Individual Plan of Services (also referred to as the "plan" or "plan of services and supports" or "treatment plan" for beneficiaries receiving substance abuse treatment)	The document that identifies the needs and goals of the individual beneficiary and the amount, duration, and scope of the services and supports to be provided. For beneficiaries receiving mental health or developmental disabilities services, the individual plan of services must be developed through a person-centered planning process. In the case of minors with developmental disabilities, serious emotional disturbance or mental illness, the child and his family are the focus of service planning, and family members are an integral part of the planning process.
Medical Necessity	Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care.

Mental Health Professional	A physician, psychologist, licensed masters social worker, certified or registered social worker, social work technician under the supervision of a professional, professional counselor, psychiatric nurse, or registered nurse under the supervision of a professional. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter.)
Prescription	A written order for a service or item by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under Michigan law that contains all of the following: ▪ Beneficiary's name; ▪ Prescribing practitioner's name, address and telephone number; ▪ Prescribing practitioner's signature (a stamped signature is not acceptable); ▪ The date the prescription was written; ▪ The specific service or item being prescribed; ▪ The expected start date of the order (if different from the prescription date); and ▪ The amount and length of time that the service or item is needed.
Qualified Mental Health Professional (QMHP)	An individual who has specialized training or one year of experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, or rehabilitation counselor. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter for specific requirements of the professionals.)
Qualified Mental Retardation Professional (QMRP)	An individual who meets the qualifications under 42 CFR 483.430. A QMRP is a person who has specialized training or one year of experience in treating or working with a person who has mental retardation; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, or rehabilitation counselor. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter for specific requirements of the professionals.)
Scope of Service	The parameters within which the service will be provided, including ▪ Who (e.g., professional, paraprofessional, aide supervised by a professional); ▪ How (e.g., face-to-face, telephone, taxi or bus, group or individual); and ▪ Where (e.g., community setting, office, beneficiary's home).

SECTION 2 – PROGRAM REQUIREMENTS

2.1 MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES

Mental health and developmental disabilities services (state plan, HSW, and additional/B3) must be:

- Provided under the supervision of a physician, or other licensed health professional whose profession is relevant to the services being provided. This includes professionals who are licensed or certified in Michigan in a human services field typically associated with mental health or developmental disabilities services. (Refer to Staff Provider Qualifications later in this section.)
- Provided to the beneficiary as part of a comprehensive array of specialized mental health or developmental disabilities services.
- Coordinated with other community agencies (including, but not limited to, Medicaid Health Plans [MHPs], family courts, local health departments [LHDs], MIChoice waiver providers, school-based services providers, and the county Department of Human Services [DHS] offices).
- Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the Balanced Budget Act of 1997, Section 438.10 (f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which he is entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of his plan of services within 15 business days of completion of the plan.

2.2 SUBSTANCE ABUSE SERVICES

Substance abuse services must be furnished by service providers licensed by the State of Michigan to provide each type of substance abuse services for which they contract. Substance abuse service providers also must be accredited as an alcohol and/or drug abuse program by one of the following national accreditation bodies:

- Joint Commission on Accreditation of Health Care Organizations (JCAHO);
- Commission of Accreditation of Rehabilitation Facilities (CARF);
- American Osteopathic Association (AOA);
- Council on Accreditation of Services for Families and Children (COA); or
- National Committee on Quality Assurance (NCQA).

Substance abuse services must be coordinated with other community services as appropriate to an individual's needs and circumstances. Services must also be provided according to an individualized treatment plan. All standard requirements of the Michigan Public Health Code, Article 6 - Substance Abuse, apply.

2.3 Location of Service

Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in other locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.

Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home.

For beneficiaries residing in nursing facilities, only the following clinic services may be provided:

- Nursing facility mental health monitoring;
- Psychiatric evaluation;
- Psychological testing, and other assessments;
- Treatment planning;
- Individual therapy, including behavioral services;
- Crisis intervention; and
- Services provided at enrolled day program sites.

Refer to the Nursing Facility Chapter of this manual for PASAAR information as well as mental health services provided by Nursing Facilities.

Medicaid does not cover services delivered in Institutions of Mental Disease (IMDs) for individuals between ages 22 and 64, as specified in §1905(a)(B) of the Social Security Act. Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCIs). Medicaid **does** cover services provided to children with developmental disabilities in a CCI that exclusively serves children with developmental disabilities, and has an enforced policy of prohibiting staff use of seclusion and restraint. Medicaid does not cover services provided to persons involuntarily residing in non-medical public facilities (such as jails or prisons). Medically necessary specialty services may be provided in situations when a child is temporarily placed in a non-medical public facility because placement in another facility (e.g., foster care) is not immediately available.

2.3.A. Day Program Sites

The PIHP may organize a set of state plan, HSW or additional/B3 services at a day program site, but the site and the set of services must be approved by MDCH. Some services (e.g., inpatient or respite) may not be provided at a day program site. (Refer to individual program descriptions in this chapter for more information on those limitations.)

Mental health and developmental disabilities day program sites are defined as places other than the beneficiary's/family's home, nursing facility, or a specialized residential setting where an array of mental health or developmental disability services and supports are provided:

- To assist the beneficiary in achieving goals of independence, integrated employment and/or community inclusion, as specified in his individual plan of services.
- Through a predetermined schedule, typically in-group modalities.
- By staff under the supervision of professional staff who are licensed, certified, or registered to provide health-related services.

Medicaid providers wishing to provide mental health and/or developmental disability services and supports at a day program site must obtain approval of the day program site by the MDCH. (Refer to the Directory Appendix for contact information.) MDCH approval will be based upon adherence to the following requirements:

- Existence of a program schedule of services and supports.
- Existence of an individual beneficiary schedule of state plan, HSW, and additional/B3 services and supports with amount, duration and scope identified.
- The beneficiary's services and supports must be based upon the desired outcomes and/or goals of the individual defined through a person-centered planning process.
- Direct therapy services must be delivered by professional staff, or aides under the supervision of professional staff, who are licensed, certified, or registered to provide health-related services within the scope of practice for the discipline.
- If an aide under professional supervision delivers direct therapy services, that supervision must be documented in the beneficiary's clinical record.

Approval of new program sites will be contingent upon submission of acceptable enrollment information to MDCH by the PIHP, and upon a site visit by MDCH.

2.4 Staff Provider Qualifications

Providers of specialty services and supports (including state plan, HSW, and additional/B3) are chosen by the beneficiary and others assisting him/her during the person-centered planning process, and must meet the staffing qualifications contained in program sections in this chapter. In addition, qualifications are noted below for provider staff mentioned throughout this chapter, including the Children's Waiver. The planning team should also identify other competencies that will assure the best possible outcomes for the beneficiary. Credentialing and re-credentialing standards located in the Quality Assessment and Performance Improvement Program in the MDCH/PIHP contract must be followed.

All providers must be:

- At least 18 years of age.
- Able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports.
- Able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed.
- In good standing with the law according to the MDCH/PIHP contract.

Aides	Must be able to perform basic first aid procedures. Children's Waiver aides must also successfully complete training in recipient rights and implementation of the child's individual plan of services.
Dietitian	An individual who is a Registered Dietitian or an individual who meets the qualification of Registered Dietitian established by the American Dietetic Association.
Licensed Practical Nurse (LPN)	An individual who is licensed by the State of Michigan to practice as a licensed practical nurse under the supervision of a registered nurse, physician, or dentist.
Nurse Practitioner (NP)	An individual licensed to practice as a registered nurse and certified in a nursing specialty by the State of Michigan.
Occupational Therapist (OT)	An individual who is registered by the State of Michigan to practice as an occupational therapist.
Occupational Therapy Assistant (OTA)	An individual who is registered by the State of Michigan to practice as an occupational therapy assistant and who is supervised by a qualified occupational therapist.
Physician (MD or DO)	An individual who possesses a permanent license to practice medicine in the State of Michigan, a Michigan Controlled Substances license, and a Drug Enforcement Agency (DEA) registration.
Physician's Assistant	An individual licensed by the State of Michigan as a physician's assistant. Practice as a physician's assistant means the practice of medicine or osteopathic medicine and surgery performed under the supervision of a physician(s) license.
Physical Therapist (PT)	An individual licensed by the State of Michigan as a physical therapist.

Physical Therapy Assistant	An individual who is a graduate of a physical therapy assistant associate degree program accredited by an agency recognized by the Secretary of the Department of Education or the Council on Postsecondary Accreditation. The individual must be supervised by the physical therapist licensed by the State of Michigan and must comply with the policy on Education and Utilization of Physical Therapy Assistant published by the American Physical Therapy Association.
Professional Counselor	An individual who is licensed by the State of Michigan to practice professional counseling. This includes Rehabilitation Counselors.
Psychologist	An individual who possesses a full license by the State of Michigan to independently practice psychology; or a master's degree in psychology (or a closely related field as defined by the state licensing agency) and licensed by the State of Michigan as a limited-licensed psychologist (LLP); or a master's degree in psychology (or a closely related field as defined by the state licensing agency) and licensed by the State of Michigan as a temporary-limited-licensed psychologist.
Registered Nurse (RN)	An individual licensed by the State of Michigan to practice nursing.
Social Worker	An individual who possesses a Michigan licensure as a masters social worker, Michigan Certificate of Registration as a certified social worker; or a Michigan Certificate of Registration as a social worker; or a bachelor's degree with a major in social work and a Michigan Certificate of Registration as a social work technician.
Speech Pathologist or Audiologist	An individual who has a Certificate of Clinical Competence (CCC) from the American Speech and Language Association; the equivalent educational requirements and work experience necessary for the certificate; or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

2.5 Medical Necessity Criteria

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. Medical Necessity Criteria

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. Determination Criteria

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

2.5.C. Supports, Services and Treatment Authorized by the PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP Decisions

Using criteria for medical necessity, a PIHP may:

- Deny services that are:
  - deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
  - experimental or investigational in nature; or
  - for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

SECTION 3 – COVERED SERVICES

The Mental Health Specialty Services and Supports program is limited to the state plan services listed in this section, the services described in the Habilitation/Supports Waiver for Persons with Developmental Disabilities Section of this chapter, and the additional/B3 services described in the Additional Mental Health Services (B3s) section of this chapter. The PIHP is not responsible for providing state plan covered services that MDCH has designated another agency to provide (refer to other chapters in this manual for additional information, including the Chapters on Medicaid Health Plans, Home Health, Hospice, Pharmacy and Ambulance), nor is the PIHP responsible for providing the Children's Waiver Services described in this chapter. However, it is expected that the PIHP will assist beneficiaries in accessing these other Medicaid services. (Refer to the Substance Abuse Section of this chapter for the specific program requirements for substance abuse services.)

3.1 ASSERTIVE COMMUNITY TREATMENT

Refer to the Assertive Community Treatment Program (ACT) Section of this chapter for specific program requirements.

3.2 ASSESSMENTS

Health Assessment	Health assessment includes activities provided by a registered nurse, physician assistant, nurse practitioner, or dietitian to determine the beneficiary's need for medical services and to recommend a course of treatment within the scope of practice of the nurse or dietician.
Psychiatric Evaluation	A comprehensive evaluation, performed face-to-face by a psychiatrist, that investigates a beneficiary's clinical status, including the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination. This examination concludes with a written summary based on a recovery model of positive findings, a biopsychosocial formulation and diagnostic statement, an estimate of risk factors, initial treatment recommendations, estimate of length of stay when indicated, and criteria for discharge.
Psychological Testing	Standardized psychological tests and measures rendered by full, limited-licensed, or temporary-limited-licensed psychologists. The beneficiary's clinical record must indicate the name of the person who administered the tests, the results of the tests, the actual tests administered, and any recommendations. The protocols for testing must be available for review.
All Other Assessments and Testing	Generally accepted professional assessments or tests, other than psychological tests, that are conducted by a mental health care professional for the purposes of determining eligibility for specialty services and supports, and the treatment needs of the beneficiary.

3.3 Behavioral Management Review

A behavior management or treatment plan, where needed, is developed through the person-centered planning process that involves the beneficiary. Any behavior management or treatment plan that proposes aversive, restrictive or intrusive techniques, or psycho-active medications for behavior control purposes and where the target behavior is not due to an active substantiated psychotic process, must be reviewed and approved by a specially constituted body comprised of at least three individuals, one of whom shall be a fully- or limited-licensed psychologist with the formal training or experience in applied behavior analysis; and one of whom shall be a licensed physician/psychiatrist. The approved behavioral plan shall be based on a comprehensive assessment of the behavioral needs of the beneficiary. Review and approval (or disapproval) of such treatment plans shall be done in light of current research and prevailing standards of practice as found in current peer-reviewed psychological/psychiatric literature. Acceptable behavioral treatment plans are designed to reduce maladaptive behaviors, to maximize behavioral self-control, or to restore normalized psychological functioning, reality orientation, and emotional adjustment, thus enabling the beneficiary to function more appropriately in interpersonal and social relationships. Such reviews shall be completed prior to the beneficiary's signing and implementation of the plan and as expeditiously as possible.

3.4 Child Therapy

Treatment activity designed to prevent deterioration, reduce maladaptive behaviors, maximize skills in behavioral self-control, or restore or maintain normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the child to function more appropriately in interpersonal and social relationships. A child mental health professional may provide child therapy on an individual or group basis.

3.5 Clubhouse Psychosocial Rehabilitation Programs

Refer to the Clubhouse Psychosocial Rehabilitation Programs Section of this chapter for specific program requirements.

3.6 Crisis Interventions

Unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy.

The standard for whether or not a crisis exists is a "prudent layperson" standard. That means that a prudent layperson would be able to determine from the beneficiary's symptoms that crisis services are necessary. Crisis situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following applies:

- The individual can reasonably be expected within the near future to physically injure himself, or another individual, either intentionally or unintentionally.
- The individual is unable to provide himself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.

- The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the mental health professional, his continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

If the beneficiary developed a crisis plan, the plan is followed with permission from the beneficiary.

3.7 Crisis Residential Services

Refer to the Crisis Residential Services Section of this chapter for specific program requirements.

3.8 Family Therapy

Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a mental health professional.

3.9 Health Services

Health Services are provided for purposes of improving the beneficiary's overall health and ability to care for health-related needs. This includes nursing services (on a per-visit basis, not on-going hourly care), dietary/nutritional services, maintenance of health and hygiene, teaching self-administration of medication, care of minor injuries or first aid, recognizing early symptoms of illness and teaching the beneficiary to seek assistance in case of emergencies. Health assessments are covered under Assessments subsection above. A registered nurse, nurse practitioner, or dietician must provide these services, according to their scope of practice. Health services must be carefully coordinated with the beneficiary's health care plan so that the PIHP does not provide services that are the responsibility of the MHP.

3.10 Home-Based Services

Refer to the Home-Based Services Section of this chapter for specific program requirements.

3.11 Individual/Group Therapy

Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Individual/group therapy is performed by a mental health professional.

3.12 Intensive Crisis Stabilization Services

Refer to the Intensive Crisis Stabilization Services Section of this chapter for specific program requirements.

3.13 Intermediate Care Facility For Individuals With Mental Retardation (ICF/MR)

Health and rehabilitative services provided in specially licensed facilities of 16 beds or less to beneficiaries with mental retardation or related conditions who need active treatment.

3.14 Medication Administration

Medication Administration is the process of giving a physician-prescribed oral medication, injection, intravenous (IV) or topical medication treatment to a beneficiary. This should not be used as a separate coverage when other health services are utilized, such as Private Duty Nursing or Health Services, which already include these activities. A physician, psychiatric nurse, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse assisting the physician may perform medication administration.

For injections administered through the CMHSP clinic, refer to the Injectable Drugs and Biologicals subsection of the Practitioner Chapter of this manual.

3.15 Medication Review

Medication Review is evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. A physician, psychiatric nurse, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications.

3.16 Nursing Facility Mental Health Monitoring

This service is the review of the beneficiary's response to mental health treatment, including direct beneficiary contact and, as appropriate, consultation with nursing facility staff to determine whether recommendations from mental health assessments are carried out by the nursing facility. Nursing facility mental health monitoring is intended to allow follow-up for treatment furnished in response to emerging problems or needs of a nursing facility resident. It is not intended to provide ongoing case management, nor is it for monitoring of services unrelated to the mental health needs of the beneficiary. A physician, psychiatric nurse, physician assistant, nurse practitioner, certified social worker, social work technician supervised by a professional, professional counselor, QMRP, QMHP, or registered nurse supervised by a professional, may provide nursing facility mental health monitoring.

3.17 Occupational Therapy

Evaluation	Therapy
Physician-prescribed activities provided by an occupational therapist currently registered by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. An occupational therapy assistant may not complete evaluations.	It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered. Therapy must be skilled (requiring the skills, knowledge, and education of a registered occupational therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage. Services must be prescribed by a physician and may be provided on an individual or group basis by an occupational therapist or occupational therapy assistant, currently registered by the State of Michigan or by an occupational therapy aide who has received on-the-job training. The occupational therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress, but on-site supervision of an assistant is not required. An aide performing an occupational therapy service must be directly supervised by a qualified occupational therapist who is on site. All documentation by an occupational therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising occupational therapist.

3.18 Personal Care in Licensed Specialized Residential Settings

Refer to the Personal Care in Licensed Specialized Residential Settings Section for specific program requirements.

3.19 Physical Therapy

Evaluation	Therapy
Physician-prescribed activities provided by a physical therapist currently licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. A physical therapy assistant may not complete an evaluation.	It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological, developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered. Physical therapy must be skilled (it requires the skills, knowledge, and education of a licensed physical therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, registered occupational therapist, family member or caregiver) would not be considered as a Medicaid cost under this coverage. Services must be prescribed by a physician and may be provided on an individual or group basis by a physical therapist or a physical therapy assistant currently licensed by the State of Michigan, or a physical therapy aide who is receiving on-the-job training. The physical therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress. On-site supervision of an assistant is not required. An aide performing a physical therapy service must be directly supervised by a physical therapist that is on-site. All documentation by a physical therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising physical therapist.

3.20 Speech, Hearing, and Language

Evaluation	Therapy
Activities provided by a speech-language pathologist or audiologist possessing a current Certificate of Clinical Competence (CCC) to determine the beneficiary's need for services and to recommend a course of treatment. A speech-language pathology assistant may not complete evaluations.	Diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO). Therapy must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy is when the treatment is required due to a

Evaluation	Therapy
	recent change in the beneficiary's medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status were the therapy not provided. Speech therapy must be skilled (i.e., requires the skills, knowledge, and education of a certified speech-language pathologist) to assess the beneficiary's speech/language function, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, registered occupational therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage. Services may be provided by a speech-language pathologist or audiologist possessing a current CCC or by a speech pathology or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a CCC). All documentation by the candidate must be reviewed and signed by the appropriately credentialed supervising speech-language pathologist or audiologist.

3.21 Substance Abuse

Refer to the Substance Abuse Services Section of this chapter for specific program requirements relating to substance abuse services.

3.22 Targeted Case Management

Refer to the Targeted Case Management Section of this chapter for specific program requirements.

3.23 Transportation

PIHPs are responsible for transportation to and from the beneficiary's place of residence when provided so a beneficiary may participate in a state plan, HSW or additional/B3 service at an approved day program site or in a psychosocial rehabilitation program. MHPs are responsible for assuring their enrollees' transportation to the primary health care services provided by the MHPs, and to (non-mental health) specialists and out-of-state medical providers. The DHS is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs; and to dental, substance abuse, and mental health services (except those noted above and in the HSW program described in the Habilitation/Supports Waiver for Persons with Developmental Disabilities Section of this chapter) for all Medicaid beneficiaries. (Refer to the local DHS or MHP for additional information, and to the Ambulance Chapter of this manual for information on medical emergency transportation.)

PIHP's payment for transportation should be authorized only after it is determined that it is not otherwise available (e.g., DHS, MHP, volunteer, family member), and for the least expensive available means suitable to the beneficiary's need.

3.24 TREATMENT PLANNING

Activities associated with the development and periodic review of the plan of service, including all aspects of the person-centered planning process, such as pre-meeting activities, and external facilitation of person-centered planning. This includes writing goals, objectives, and outcomes; designing strategies to achieve outcomes (identifying amount, scope, and duration) and ways to measure achievement relative to the outcome methodologies; attending person-centered planning meetings per invitation; and documentation.

Case managers and supports coordinators perform these functions as part of the case management and supports coordination services; therefore they should not report this activity as "Treatment Planning." Other mental health and health professionals who attend the beneficiary's person-centered planning should report the activity as "Treatment Planning."

For the Children's Waiver, the attendance of all clinicians and case managers during treatment planning is included in the monthly case management coverage.

SECTION 4 – ASSERTIVE COMMUNITY TREATMENT PROGRAM

Assertive Community Treatment (ACT) is a set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team. The team also provides basic services and supports essential to maintaining the beneficiary's ability to function in community settings, including assistance with accessing basic needs through available community resources, such as food, housing, and medical care and supports to allow beneficiaries to function in social, educational, and vocational settings. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of the beneficiary. Services are provided in the beneficiary's residence or other community locations by all members of the ACT team.

All team staff must have a basic knowledge of ACT programs and principles acquired through ACT specific training.

4.1 PROGRAM APPROVAL

Medicaid providers wishing to become providers of ACT services must obtain approval from MDCH and meet the program components outlined below. Provider programs with more than one ACT team must be approved and registered separately.

4.2 TARGET POPULATION

ACT services are targeted to beneficiaries with serious mental illness who require intensive services and supports and who, without ACT, would require more restrictive services and/or settings.

- Beneficiaries with serious mental illness with difficulty managing medications without ongoing support, or with psychotic/affective symptoms despite medication compliance.
- Beneficiaries with serious mental illness with a co-occurring substance disorder.
- Beneficiaries with serious mental illness who exhibit socially disruptive behavior that puts them at high risk for arrest and inappropriate incarceration or those exiting a county jail or prison.
- Beneficiaries with serious mental illness who are frequent users of inpatient psychiatric hospital services, crisis services, crisis residential, or homeless shelters.
- Older beneficiaries with serious mental illness with complex medical/medication conditions.

4.3 ESSENTIAL ELEMENTS

Team-Based Service Delivery	ACT is a team-based service that includes shared service delivery responsibility. Case management services are interwoven with treatment and rehabilitative services, and are provided by all members of the team. Substance abuse treatment provided within the context of the ACT team must meet the criteria located in the Substance Abuse Services Section of this chapter. Team meetings occur Monday through Friday and are attended by all members on duty. The status of all beneficiaries is briefly reviewed and documentation of daily team meetings includes all individuals discussed and all staff members present. The daily schedule is organized and contacts scheduled.

Team Composition	The ACT team requires a sufficient number of qualified staff to assure the provision of an intensive array of services on a 24-hour basis. The minimum essential ACT staffing requirements are: ▪ A physician who provides psychiatric coverage for all beneficiaries served by the team. The physician is considered part of the team and meets with the team on a frequent basis. The physician (MD or DO) must possess a valid license to practice medicine in Michigan, a Michigan Controlled Substance License, and a DEA registration. ▪ A registered nurse (RN) is required (in addition to the physician). The nurse oversees medication and provides direct services to the beneficiary in the community. ▪ A team coordinator with a minimum of a master's degree in a relevant discipline with appropriate licensure or certification to provide clinical supervision, plus a minimum of two years clinical experience with adults with serious mental illness. The team coordinator also provides direct services to beneficiaries in the community. The coordinator is assigned full-time to the ACT team. Additional positions should reflect the special conditions, services or supports required by the population or special populations to be served. ▪ Other professional staff licensed, certified, or registered by the State of Michigan or national organizations to provide health care services. ▪ Other staff not licensed, certified, or registered (i.e., paraprofessional staff, possessing at least a bachelor's degree in an unrelated field with one year experience working with adults with mental illness, or a high school diploma with two years experience working with the mentally ill population) are considered a part of staff-to-beneficiary ratio. Peer support staff, a valuable resource to both the recipients and members of the team, is not counted in the staff-to-beneficiary ratio. Under the supervision of the team leader, both may provide documentation in beneficiary records. This supervision is documented in the beneficiary record. Providers of substance abuse treatment must meet criteria in the Substance Abuse Services Section of this chapter.
Staff-to-Beneficiary Ratio	The staff-to-beneficiary ratio shall be no more than 1:10, i.e., a maximum of 10 beneficiaries to each member of the team. The ratio includes the team coordinator and all other team members who provide direct services, and excludes the physician, peers who do not meet paraprofessional or professional criteria, and clerical support staff.
Fixed Point of Responsibility	The ACT team is the fixed point of responsibility for the development of the individual plan of service using the person-centered planning process, and for supporting beneficiaries in all aspects of community living. The process addresses all services and supports to be provided or obtained by the team including consultation with other disciplines and/or referrals to other supportive services as appropriate.

Availability of Services	Availability of services must include: ▪ Twenty-four-hour/seven-day crisis response coverage (including psychiatric availability) that is handled directly by members of the team. ▪ The capacity to provide a rapid response to early signs of relapse, including the capability to provide multiple contacts daily with beneficiaries in acute need or with emergent conditions.
Individual Plan of Services	ACT services and interventions must be consistent and balanced through medical necessity and preferences of the beneficiary while embracing person-centered principles and recovery, with the goal of maximizing independence and progression into less intensive services. Beneficiaries with co-occurring substance use disorders must have both mental health and substance use disorders addressed in their individual plan of service. Treatment in the same program is preferred.

4.4 ELEMENTS OF ACT

"In Vivo" Settings	Services
According to the beneficiary's preference and clinical appropriateness, the majority of services are provided in the beneficiary's home or other community locations rather than the team office.	ACT teams provide a wide array of clinical, medical, or rehabilitative services during face-to-face interactions that are designed to help beneficiaries to live independently or facilitate the movement of beneficiaries from dependent settings to independent living. These services and supports are focused on maximizing independence and the beneficiary's quality of life, such as maintaining employment, social relationships and community inclusion. For beneficiaries with co-occurring substance use disorders, individualized treatment will be integrated by the team as part of the overall treatment approach. Services may include those defined elsewhere in this section, as well as others that are consistent with preferences, professionally accepted standards of care, and are medically necessary. ACT services may be used as an alternative to hospitalization. The following criteria shall be used to determine the appropriateness of these services as an alternative to hospitalization.

4.5 Eligibility Criteria [Changes Made 4/1/06]

Utilization of ACT services in high acuity conditions/situations allows beneficiaries to remain in their community residence and may prevent the use of more restrictive alternatives which may be detrimental to a beneficiary's existing natural supports and occupational roles. This level of care is appropriate for beneficiaries with a history of persistent mental illness who may be at risk for inpatient hospitalization, intensive crisis residential or partial hospitalization services, but can remain safely in their communities with the considerable support and intensive interventions of ACT. In addition to meeting the following criteria, these beneficiaries may also be likely to require or benefit from continuing psychiatric rehabilitation.

The ACT program is an individually tailored combination of services and supports that may vary in intensity over time based on the beneficiary's needs and condition. Services include multiple daily contacts and 24-hour, seven-days-per-week crisis availability provided by a multi-disciplinary team which includes psychiatric and skilled medical staff.

The ACT acute service selection guideline covers criteria in the following domain areas:

Diagnosis	The beneficiary must have a mental illness, as reflected in a primary, validated, current version of DSM or ICD diagnosis (not including V Codes), including personality disorders.
Severity of Illness	Prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) which may manifest as intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc., and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance. ▪ Self-Care/Independent Functioning - Disruptions of self-care, limited ability to attend to basic physical needs (nutrition, shelter, etc.), seriously impaired interpersonal functioning, and/or significantly diminished capacity to meet educational/occupational role performance expectations. ▪ Drug/Medication Conditions - Drug/medication compliance and/or coexisting general medical condition which needs to be simultaneously addressed along with the psychiatric illness and which cannot be carried out at a less intensive level of care. Medication use requires monitoring or evaluation for adherence to achieve stabilization, to identify atypical side effects or concurrent physical symptoms and medical conditions. ▪ Risk to Self or Others - Symptom acuity does not pose an immediate risk of substantial harm to the person or others, or if a risk of substantial harm exists, protective care (with appropriate medical/psychiatric supervision) has been arranged. Harm or danger to self, self-mutilation and/or reckless endangerment or other self-injurious activity is an imminent risk.

Intensity of Service	ACT team services are medically necessary to provide treatment in the least restrictive setting, to allow beneficiaries to remain in vivo, to improve the beneficiary's condition and/or allow the person to function without more restrictive care, and the person requires at least one of the following: ▪ An intensive team-based service is needed to prevent elevation of symptom acuity, to recover functional living skills and maintain or preserve adult role functions, and to strengthen internal coping resources; ongoing monitoring of psychotropic regimen and stabilization necessary for recovery. ▪ The person's acute psychiatric crisis requires intensive, coordinated and sustained treatment services and supports to maintain functioning, arrest regression, and forestall the need for inpatient care or a 24-hour protective environment. ▪ The person has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but requires intensive coordinated services and supports. ▪ Consistent observation and supervision of behavior are needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations. ▪ Frequent monitoring of medication regimen and response is necessary and compliance is doubtful without ongoing monitoring and support. ▪ Routine medical observation and monitoring are required to affect significant regulation of psychotropic medications and/or to minimize serious side effects.
Discharge	Cessation or control of symptoms is not sufficient for discharge from ACT. Recovery must be sufficient to maintain functioning without support of ACT as identified through the person-centered planning process. **(added for clarification 4/1/06)** ▪ The beneficiary no longer meets severity of illness criteria and has demonstrated the ability to meet all major role functions for a period of time sufficient to demonstrate clinical stability. Beneficiaries who meet criteria for ACT services usually require and benefit from long term participation in ACT. If a beneficiary requests transition to other service(s) because he believes he has received maximum benefit, consideration for transition must be reviewed during the person-centered planning process. If clinical evidence supports the beneficiary's desire to transition, this evidence and the transition plan must be detailed in a revised Individual Plan of Services developed through the person-centered planning process. The plan must identify what supports and services will be made available, and contain a provision for reenrollment in ACT services, if needed. **(modified for clarification 4/1/06)** ▪ Engagement of the individual in ACT is not possible as deliberate, persistent and frequent assertive team outreach including face-to-face engagement attempts and legal mechanisms, when necessary, have been consistent, unsuccessful, and documented over many months; and an appropriate alternative plan has been established with the beneficiary. ▪ Beneficiary has moved outside of the geographic service area and contact continues until service has been established in the new location.

SECTION 5 – CLUBHOUSE PSYCHOSOCIAL REHABILITATION PROGRAMS

A clubhouse program is a community-based psychosocial rehabilitation program in which the beneficiary (also called clubhouse "members"), with staff assistance, is engaged in operating all aspects of the clubhouse, including food service, clerical, reception, janitorial and other member supports and services such as employment, housing and education. In addition, members, with staff assistance, participate in the day-to-day decision-making and governance of the program and plan community projects and social activities to engage members in the community. Through the activities of the ordered day, clubhouse decision-making opportunities and social activities, individual members achieve or regain the confidence and skills necessary to lead vocationally productive and socially satisfying lives.

5.1 PROGRAM APPROVAL

PIHPs must seek approval for providers of psychosocial rehabilitation clubhouse services from MDCH. (Refer to the Directory Appendix for contact information.) MDCH approval will be based on adherence to the requirements outlined below.

5.2 TARGET POPULATION

Clubhouse programs are appropriate for adults with a serious mental illness who wish to participate in a structured program with staff and peers and have identified psychosocial rehabilitative goals that can be achieved in a supportive and structured environment. The beneficiary must be able to participate in, and benefit from, the activities necessary to support the program and its members, and must not have behavioral/safety or health issues that cannot adequately be addressed in a program with a low staff-to-member ratio.

5.3 ESSENTIAL ELEMENTS [CHANGE MADE 4/1/06]

Member Choice/ Involvement	▪ All members have access to the services/supports and resources with no differentiation based on diagnosis or level of functioning. ▪ Members establish their own schedule of attendance and choose a unit that they will regularly participate in during the ordered day. ▪ Members are actively engaged and supported on a regular basis by clubhouse staff in the activities and tasks that they have chosen. ▪ Membership in the program and access to supportive services reflects the beneficiary's preferences and needs building on the person-centered planning process. ▪ Both formal and informal decision-making opportunities are part of the clubhouse units and program structures so that members can influence and shape program operations.

Informal Setting	▪ Staff and members work side-by-side to generate and accomplish individual/team tasks and activities necessary for the development, support, and maintenance of the program. ▪ Members have access to the clubhouse during times other than the ordered day, including evenings, weekends, and all holidays (including New Year's Day, Memorial Day, Independence Day, Thanksgiving Day, and Christmas Day). **(added for clarification 4/1/06)**
Program Structure and Services	The program's structure and schedule identifies when the various program components occur, e.g., ordered-day, vocational/educational. Other activities, such as self-help groups and social activities shall be scheduled before and after the ordered day.
Ordered Day	The ordered day is a primary component of the program and provides an opportunity for members to regain self-worth, purpose, and confidence. It is made up of those tasks and activities necessary for the operation of the clubhouse and typically occurs during normal work hours. The ordered day is carried out in organizational units defined by the clubhouse that accomplish the work necessary to operate the clubhouse and meet the community living needs of the members, such as housing and transportation. Although participation in the ordered day provides opportunities to develop a variety of interpersonal and vocationally related skills, it is not intended to be job-specific training. Member participation in the ordered day provides experiences that will support members' recovery, and is designed to assist members to acquire personal, community and social competencies and to establish and navigate environmental support systems.
Employment Services and Educational Supports	Services directly related to employment, including transitional employment, supported employment, on-the-job training, community volunteer opportunities, and supports for the completion or initiation of education or training and other vocational assistance must be available.
Member Supports	Opportunities for clubhouse members to provide and receive support in the community in areas of outreach, warm line, self-help groups, housing supports, entitlements, food, clothing and other basic necessities or assistance in locating community resources must be available.
Social Supports	Opportunities for members to develop a sense of a community through planning and organizing clubhouse social activities. This may also include opportunities to explore recreational resources and activities in the community. The interests and desires of the membership determine both spontaneous and planned activities.

5.4 Psychosocial Rehabilitation Components

Following are some of the broad domains of psychosocial rehabilitative goals and objectives. Based on the member's individual plan of service developed through the person-centered planning process, these are carried out during the member's participation in the ordered day and through interactions with other staff and members. Staff may also work informally with members on individual goals while working side-by-side in the clubhouse.

Symptom Identification and Care	▪ Identification and management of situations and prodromal symptoms to reduce the frequency, duration, and severity of psychological relapses. ▪ Gaining competence regarding how to respond to a psychiatric crisis. ▪ Gaining competence in understanding the role psychotropic medication plays in the stabilization of the members' well being. ▪ Working in partnership with members who express a desire to develop a crisis plan.
Competency Building	▪ Community living competencies (e.g., self-care, cooking, money management, personal grooming, maintenance of living environment). ▪ Social and interpersonal abilities (e.g., conversational competency, developing and/or maintaining a positive self-image, regaining the ability to evaluate the motivation and feelings of others to establish and maintain positive relationships). ▪ Personal adjustment abilities (e.g., developing and enhancing personal abilities in handling every day experiences and crisis, such as stress management, leisure time management, coping with symptoms of mental illness). The goal of this is to reduce dependency on professional caregivers and to enhance independence. ▪ Cognitive and adult role competency (e.g., task-oriented activities to develop and maintain cognitive abilities, to maximize adult role functioning such as increased attention, improved concentration, better memory, enhancing the ability to learn and establishing the ability to develop empathy).
Environmental Support	▪ Identification of existing natural supports for addressing personal needs (e.g., families, employers, and friends). ▪ Identification and development of organizational support, including such areas as sustaining personal entitlements, locating and using community resources or other supportive programs.

5.5 STAFF CAPACITY

The number of staff from the PIHP should be sufficient to effectively administer the program, but also allow the members sufficient leeway to participate meaningfully in the program. Clubhouse staff shall include:

- One full-time on-site clubhouse manager who is a qualified professional and has extensive experience with the target population and is licensed, certified, or registered by the State of Michigan or a national organization to provide health care services. The clubhouse manager is responsible for all aspects of clubhouse operations, staff supervision and the coordination of clubhouse services with case management and ACT.
- Other experienced professional staff licensed, certified, or registered by the State of Michigan or a national organization to provide health care services.

Other staff who are not licensed, certified, or registered by the State of Michigan to provide health care services may be part of the program, but shall operate under the supervision of a qualified professional. This supervision must be documented.

SECTION 6 – CRISIS RESIDENTIAL SERVICES

Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert a psychiatric admission, or to shorten the length of an inpatient stay.

6.1 POPULATION

Services are designed for a subset of beneficiaries who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital.

6.2 COVERED SERVICES

Services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiaries to allow them to return to less intensive community living as soon as possible.

The covered crisis residential services include:

- Psychiatric supervision;
- Therapeutic support services;
- Medication management/stabilization and education;
- Behavioral services;
- Milieu therapy; and
- Nursing services.

6.2.A. CHILD CRISIS RESIDENTIAL SERVICES

Nursing services must be available through regular consultation, and must be provided on an individual basis according to the level of need of the child. Child Crisis Residential Services may not be provided to children with serious emotional disturbances in a Child Caring Institution (CCI).

6.2.B. ADULT CRISIS RESIDENTIAL SERVICES

The program must include on-site nursing services (RN or LPN under appropriate supervision).

- For settings of six beds or fewer: on-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call.
- For 7-16 beds: on-site nursing must be provided eight hours per day, seven days per week, with 24-hour availability on-call.

6.3 PROVIDER CRITERIA

Services must be provided under the auspices of an enrolled PIHP. The PIHP must identify the crisis residential program as part of their provider registration process with MDCH.

6.4 Qualified Staff

Treatment services must be provided under the supervision of a psychiatrist. A psychiatrist need not be present when services are delivered, but must be available by telephone at all times. The program must be under the immediate direction of a professional possessing at least a bachelor's degree in a human services field, and who has at least two years work experience providing services to beneficiaries with serious mental illness.

Treatment activities may be carried out by non-degreed staff who have at least one year of satisfactory work experience providing services to beneficiaries with mental illness, or who have successfully completed a PIHP/MDCH-approved training program for working with beneficiaries with mental illness.

6.5 Location of Services

Services must be provided to beneficiaries in licensed crisis residential foster care or group home settings not exceeding 16 beds in size. Homes/settings must have appropriate licensure from the state and must be approved by MDCH to provide specialized crisis residential services. Services must not be provided in a hospital or other institutional setting.

Child caring institutions are permitted and may exceed 16 beds, according to the terms of their license.

6.6 Admission Criteria

Crisis residential services may be provided to adults or children who are assessed by, and admitted through, the authority of the local PIHP. Beneficiaries must meet psychiatric inpatient admission criteria but have symptoms and risk levels that permit them to be treated in such alternative settings. Services are designed for beneficiaries with mental illness or beneficiaries with mental illness and another concomitant disorder, such as substance abuse or developmental disabilities. For beneficiaries with a concomitant disorder, the primary reason for service must be mental illness.

6.7 Duration of Services

Services may be provided for a period up to 14 calendar days per crisis residential episode. Services may be extended and regularly monitored, if justified by clinical need, as determined by the interdisciplinary team.

6.8 Individual Plan of Service

Services must be delivered according to an individual plan based on an assessment of immediate need. The plan must be developed within 48 hours of admission and signed by the beneficiary (if possible), the parent or guardian, the psychiatrist, and any other professionals involved in treatment planning, as determined by the needs of the beneficiary. If the beneficiary has an assigned case manager, the case manager must be involved in the course of treatment as soon as possible, and must also be involved in follow-up services.

The plan must contain:

- Clearly stated goals and measurable objectives, derived from the assessment of immediate need, stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis.
- Identification of the activities designed to assist the beneficiary to attain his/her goals and objectives.
- Discharge plans, the need for aftercare/follow-up services, and the role of, and identification of, the case manager.

If the crisis period exceeds 14 days, an interdisciplinary team must develop a subsequent plan based on comprehensive assessments. The team is comprised of the beneficiary, the parent or guardian, the psychiatrist, the case manager and other professionals whose disciplines are relevant to the needs of the beneficiary, including the individual ACT team, outpatient services provider or home-based services staff, when applicable. If the beneficiary did not have a case manager prior to initiation of the intensive/crisis residential service, and the crisis episode exceeds 14 days, a case manager must be assigned and involved in treatment and follow-up care. (The case manager may be assigned prior to the 14 days, according to need.)

For children's intensive/crisis residential services, the plan must also address the child's needs in context with the family's needs. Educational services must also be considered and the plan must be developed in consultation with the child's school district staff.

SECTION 7 – HOME-BASED SERVICES

Mental health home-based service programs are designed to provide intensive services to children (birth through age 17) and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to promote normal development, promote healthy family functioning, support and preserve families, reunite families who have been separated, and reduce the usage of, or shorten the length of stay in, psychiatric hospitals and other substitute care settings. Treatment is based on the child's need with the focus on the family unit. The service style must support a strength-based approach, emphasizing assertive intervention, parent and professional teamwork, and community involvement with other service providers.

One staff member or a team of staff may provide these services. Home-based services programs are designed to provide intensive services to children and families in their home and community. The degree of intensity will vary to meet the needs of families. The home-based services worker-to-family ratio must be established to accommodate the levels of intensity that may vary from two to twenty hours per week based on individual family needs. The worker-to-family ratio should not exceed 1:15 for a full-time equivalent position.

Medicaid providers seeking to become providers of home-based services must request approval from MDCH. (Refer to the Directory Appendix for contact information.) MDCH approval will be based on adherence to the requirements outlined below.

7.1 PROGRAM APPROVAL

Applications for approval must identify the target population to be served by the program. Providers must assure that staff providing services in this program meet the required qualifications.

Information submitted to MDCH must include the basic program information submitted in a format prescribed by MDCH. For approved providers, MDCH is available to assist the PIHP in securing any necessary training and technical assistance. If necessary during an initial period, the providers may receive provisional approval that will allow them to provide services. However, any necessary additional actions must be completed within the timeframe specified by MDCH or provisional approval will be withdrawn.

Organizational Structure	The PIHP must specify the organizational structure through which the mental health home-based service program shall be delivered. The following requirements must be met: ▪ The structure must be centralized (i.e., the staff with responsibility for operating the home-based services program must be assigned to an identifiable service unit of an organization). ▪ Responsibility for directing, coordinating, and supervising the program must be assigned to a specific staff position. The supervisor of the program must meet the qualifications of a child mental health professional with three years of clinical experience. There must be an internal mechanism for coordinating and integrating the home-based services with other mental health services, as well as general community services relevant to the needs of the child and family.

Qualified Staff	Appropriately qualified staff must deliver the home-based services. Home-based professional staff must meet the qualifications of a child mental health professional. For home-based programs serving infants/toddlers (birth through age three) and their families, staff must be trained in infant mental health interventions. For home-based programs serving children with developmental disabilities, the child mental health professional must meet the qualifications, as defined above, and also be a Qualified Mental Retardation Professional (QMRP). Trained paraprofessional assistants may assist home-based services professional staff with implementation of treatment plan behavioral goals related to positive skill development and development of age-appropriate social behaviors. Services to be provided by the home-based services assistant must be identified in the family plan of service, must relate to identified treatment goals, and must be under supervision of relevant professionals. Home-based services assistants must be trained regarding the beneficiary's treatment plan and goals, including appropriate intervention and implementation strategies, prior to beginning work with the beneficiary and family.
Plan of Service	Home-based services must be provided in accordance with an individual plan of services that focuses on the child and his family. The plan of service is a comprehensive plan that identifies child and family strengths and individual needs, determines appropriate interventions, and identifies supports and resources. It is developed in partnership with family members and other agencies, through a person-centered planning process.
Scope of Service	Home-based services programs combine individual therapy, family therapy, group therapy, crisis intervention, case management, and family collateral contacts. The family is defined as immediate or extended family or an individual acting in the role of family. Services provided in a home-based services program range from assisting beneficiaries to link to other resources that might provide food, housing, and medical care, as well as providing more therapeutic interventions such as family therapy or individual therapy.
Location of Service	Services are provided in the family home or community settings.

7.2 ELIGIBILITY CRITERIA

The criteria for home-based services are described below for children birth through age three years, children age four through age six, and children ages seven to seventeen years. These criteria do not preclude the provision of home-based services to an adult beneficiary who is a parent for whom it is determined home-based services would be the treatment modality that would best meet the needs of the adult beneficiary and the child. This would include a parent who has a diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care giving environment that places the child at-risk for serious emotional disturbance. These criteria do not preclude the provision of home-based services, when it is determined through a person-centered planning process that these services are necessary to meet the needs of the child and family. For continuing eligibility reviews during the transition to less intensive

services, the PIHP may maintain the child and family in Home-Based Services, even if they do not meet these criteria.

7.2.A. Birth Through Age Three

Unique criteria must be applied to define serious emotional disturbance for the birth to age three population, given:

- The magnitude and speed of developmental changes through pregnancy and infancy;
- The limited capacity of the very young to symptomatically present underlying disturbances;
- The extreme dependence of infants and toddlers upon caregivers for their survival and well-being; and
- The exceptional vulnerability of the very young to other relationship and environmental factors.

Operationally, the above parameters dictate that the mental health professional must be cognizant of the primary indicators of emotional disorder in very young children, and of the importance of assessing the constitutional/physiological and/or caregiving/environmental factors which reinforce the severity and intractability of the child's disorder. Furthermore, the rapid development of very young children results in transitory disorders and/or symptoms, requiring the professional to regularly re-assess children in the appropriate developmental context.

The following is the recommended procedure for determining when a beneficiary is considered seriously emotionally disturbed or at high risk for serious emotional disturbance, qualifying for Mental Health Home-Based Services provided through a PIHP. All of the dimensions must be considered when determining if a child is eligible for home-based services.

Diagnosis	A child has a mental, behavioral, or emotional disorder sufficient to meet diagnostic criteria specified within the current version of the DSM or ICD not solely the result of mental retardation or other developmental disability, drug abuse/alcoholism or those with a V-code diagnosis, and the beneficiary meets the criteria listed below for degree of disability/functional impairment and duration/service history.
Functional Impairment	Substantial interference with, or limitation of, the child's proficiency in performing age-appropriate skills as demonstrated by at least one indicator drawn from two of the following areas: ▪ General and/or specific patterns of reoccurring behaviors or expressiveness indicating affect/modulation problems, e.g., uncontrollable crying or screaming, sleeping and eating disturbances and recklessness; the absence of developmentally expectable affect, such as pleasure, displeasure, joy, anger, fear, curiosity; apathy toward environment and caregiver.

	▪ Distinct behavioral patterns coupled with sensory, sensory motor, or organizational processing difficulty (homeostasis concerns) that inhibits the child's daily adaptation and interaction/relationships. For example, a restricted range of exploration and assertiveness, dislike for changes in routine, and/or a tendency to be frightened and clinging in new situations, coupled with over-reactivity to loud noises or bright lights, inadequate visual-spatial processing ability, etc. ▪ Incapacity to obtain critical nurturing (often in the context of attachment-separation concerns), as determined through the assessment of child, caregiver and environmental characteristics. For example, the infant shows a lack of motor skills and/or language expressiveness, appears diffuse, unfocused and undifferentiated, expresses anger/obstinacy and whines, in the presence of a caregiver who often interferes with the infant's goals and desires, dominates the infant through over-control, does not reciprocate to the child's gestures, and/or whose anger, depression or anxiety results in inconsistent parenting. Assessment tools specifically targeting socio-emotional functioning of assistance in determining functional impairment include: ▪ Infant-Toddler Mental Health Status Exam; ▪ Attachment-Interaction-Mastery-Support (AIMS); ▪ Temperament and Atypical Behavior Score (TABS); and ▪ DC: 0-3 Classification System. Assessment instruments specifically targeting child development include: ▪ Bayley Scales of Infant Care and Development. Tools assessing child development in social context include: ▪ Infant-Toddler Family Instrument (ITFI); ▪ Infant-Toddler Developmental Assessment (IDA); ▪ Objectives/Problems Checklist; and ▪ Hawaii Early Learning Profile (HELP). Appropriate Screening Instruments for initial triaging include: ▪ Ages and Stages Questionnaire (ASQ) ; ▪ Parent's Evaluation of Developmental Status (PEDS); and ▪ Denver Developmental Screening Test II.
Duration / History	The very young age and rapid transition of infants and toddlers through developmental stages makes consistent symptomatology over time unlikely. However, indicators that a disorder is not transitory and will endure without intervention include: ▪ The infant/toddler disorder(s) is affected by persistent multiple barriers to normal development (regulatory disorders, inconsistent parenting, chaotic environment, etc); or ▪ Infant/toddler did not respond to less intensive, less restrictive intervention.

7.2.B. Age Four Through Six

Decisions regarding whether a child age four through six is seriously emotionally disturbed and in need of home-based services and supports utilize similar dimensions to older children. The dimensions include a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities and duration of condition. However, as with younger children birth through age three, assessment must be sensitive to the critical indicators of development and functional impairment for the age group. Significant impairments in functioning are revealed across life domains in the child's expression of affect/self-regulation, social development (generalization of attachment beyond parents, capacity for peer relationships and play, etc.), physical and cognitive development, and the emergence of a sense of self. All of the dimensions must be considered when determining if a child is eligible for home-based services.

Diagnosis	A child has a mental, behavioral or emotional disorder sufficient to meet diagnostic criteria specified within the current version of the DSM or ICD not solely the result of mental retardation or other developmental disability, drug abuse/alcoholism or those with a V-code diagnosis, and the beneficiary meets the criteria listed below for degree of disability/functional impairment and duration/service history.
Functional Impairment	Substantial interference with, or limitation of, the child's proficiency in performing age-appropriate skills across domains and/or consistently within specific domains as demonstrated by at least one indicator drawn from at least three of the following areas: ▪ Impaired physical development, sensory, sensory motor or organizational processing difficulty, failure to control bodily functions (e.g., bed wetting). ▪ Limited cognitive development, as indicated by restricted vocabulary, memory, cause and effect thinking, ability to distinguish between real and pretend, transitioning from self-centered to more reality-based thinking, etc. ▪ Limited capacity for self-regulation, inability to control impulses and modulate anxieties as indicated by frequent tantrums or aggressiveness toward others, prolonged listlessness or depression, inability to cope with separation from primary caregiver, inflexibility and low frustration tolerance, etc. ▪ Impaired or delayed social development, as indicated by an inability to engage in interactive play with peers, inability to maintain placements in day care or other organized groups, failure to display social values or empathy toward others, absence of imaginative play or verbalizations commonly used by preschoolers to reduce anxiety or assert order/control on their environment, etc. ▪ Caregiving factors which reinforce the severity or intractability of the childhood disorder and the need for multifaceted intervention strategies (e.g., home-based services) such as a chaotic household/constantly changing caregiving environments, inappropriate parental expectations, abusive/neglectful or inconsistent parenting, occurrence of traumatic events, subjection to others' violent or otherwise harmful behavior.

	Assessment tools of assistance in determining functional impairment include, but are not limited to: ▪ Preschool and Early Childhood Functional Assessment Scale (PECFAS); and ▪ Child and Adolescent Level of Care Utilization System (CALOCUS).
Duration /History	The following specify length of time criteria for determining when the youth's functional disabilities justify his referral for enhanced support services: ▪ Evidence of three continuous months of illness; ▪ Three cumulative months of symptomatology/dysfunction in a six-month period; or ▪ Conditions that are persistent in their expression and are not likely to change without intervention.

7.2.C. Age Seven Through Seventeen

Decisions regarding whether a child or adolescent has a serious emotional disturbance and is in need of home-based services is determined by using the following dimensions: the child has a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities, and duration of the condition. For children age seven to seventeen, the Child and Adolescent Functional Assessment Scale (CAFAS) is used to make discriminations within the functional impairment dimension. All of the dimensions must be considered when determining if a child is eligible for home-based services.

Diagnosis	The child/adolescent currently has, or had at any time in the past, a diagnosable behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of the DSM or ICD, excluding those with a diagnosis other than, or in addition to: alcohol or drug disorders, a developmental disorder, or social conditions (V Codes).
Functional Impairment	For purposes of qualification for home-based services, children and adolescents may be considered markedly or severely functionally impaired if the minor has: ▪ An elevated subscale score (20 or greater) on at least two elements of the Child/Adolescent Section of the CAFAS; or ▪ An elevated subscale score (20 or greater) on one element of the CAFAS Child/Adolescent Section, combined with an elevated subscale score (20 or greater) on at least one CAFAS element involving Caregiver/Caregiving Resources; or ▪ A total impairment score of 80 or more on the CAFAS Child/Adolescent Section.

Duration / History	The following specify the length of time the youth's functional disability has interfered with his/her daily living and led to his/her referral for home-based services: ▪ Evidence of six continuous months of illness, symptomatology, or dysfunction; ▪ Six cumulative months of symptomatology/dysfunction in a twelve-month period; or ▪ On the basis of a specific diagnosis (e.g., schizophrenia), disability is likely to continue for more than one year.

SECTION 8 – INPATIENT PSYCHIATRIC HOSPITAL ADMISSIONS

The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PIHP. This means that the PIHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services, defined as follows:

- **Screening** means the PIHP has been notified of the beneficiary and has been provided enough information to make a determination of the most appropriate services. The screening may be provided on-site, face-to-face by PIHP personnel, or over the telephone.
- **Authorization/certification** means that the PIHP has screened the beneficiary and has approved the services requested. Telephone screening must be followed-up by the written certification.

PIHP responsibilities include:

- Pre-admission screening to determine whether alternative services are appropriate and available. Severity of Illness and Intensity of Service clinical criteria will be used for such pre-screening. Inpatient pre-screening services must be available 24-hours-a-day, seven-days-a-week.
- Provision of notice regarding rights to a second opinion in the case of denials.
- Coordination with substance abuse treatment providers, when appropriate.
- Provision of, or referral to and linkage with, alternative services, when appropriate.
- Communication with the treating and/or referring provider.
- Communication with the primary care physician or health plan.
- Planning in conjunction with hospital personnel for the beneficiary's after-care services.

In most instances, the beneficiary will receive services in a community-based psychiatric unit in the PIHP service area where he resides. There may be instances when a PIHP is responsible for a resident that they have placed into a community program in another county or state. In these cases, the responsible PIHP, i.e., the one managing the case, is responsible for authorizing admission and/or continuing stay.

If a beneficiary experiences psychiatric crisis in another county, the PIHP in that county should provide crisis intervention/services as needed and contact the PIHP for the county of the beneficiary's residence for disposition.

8.1 ADMISSIONS

The PIHPs will make authorization and approval decisions for these services according to Level of Care guidelines established by MDCH and appearing in this section. All admission and continuing stay responsibilities and procedures must be conducted in accordance with the terms of the contract between the hospital and the PIHP.

Emergency Room Services	When necessary, the beneficiary may seek services through the emergency room. Disposition of the psychiatric emergency will be the responsibility of the PIHP and may result in: ▪ Inpatient admission; ▪ Referral to an alternative service when appropriate and available; or ▪ Disposition of the crisis through provision of immediate services/interventions, with follow-up as necessary. The PIHP is involved in the psychiatric aspect of the emergency situation. Any medical treatment needed by the beneficiary is beyond the general purview of the PIHP.
Admissions to In-State Out-of-Area Hospitals	Medicaid beneficiaries may seek inpatient psychiatric services from hospitals located outside their county of residence/PIHP catchment area. If the out-of-area hospital has a contract with the beneficiary's county/catchment area PIHP, the hospital should contact that PIHP to obtain the required pre-admission authorization/approval for the beneficiary. If the out-of-area hospital does not have a contract with the beneficiary's designated county/catchment area PIHP, the hospital must contact the PIHP that serves the county in which the hospital is located to obtain pre-admission approval/authorization. The hospital-area PIHP will conduct the pre-admission review and will consult with the designated county/catchment area PIHP to determine the appropriate disposition of the request for admission authorization/approval. Payment responsibility for authorized days of care will rest with the PIHP that authorized the services.
Admission to Out-of-State Non-Borderland Inpatient Psychiatric Hospitals	The PIHP for the beneficiary's county of residency must prior authorize the admission for psychiatric inpatient care as medically necessary, as with in-state hospitals. The PIHP is responsible for continued stay reviews and payment to these hospitals.

8.2 APPEALS

PIHPs will make authorization and approval decisions for services according to Level of Care guidelines. If the hospital disagrees with the decision of the PIHP, regarding either admission authorization/approval or the number of authorized days of care, the hospital may appeal to the PIHP according to the terms of its contract with the PIHP. If the hospital does not have a contract or agreement with the PIHP, any appeals by the hospital will be conducted through the usual and customary procedures that the PIHP employs in its contracts with other enrolled hospital providers.

If a beneficiary or his legal representative disagrees with a PIHP decision related to admission authorization/approval or approved days of care, he may request a reconsideration and second opinion from the PIHP. If the PIHP's initial decision is upheld, the beneficiary has further redress through the Medicaid fair hearing process. Medicaid beneficiaries can request the Medicaid fair hearing without going through local review processes.

8.3 Beneficiaries Who Do Not Have Medicaid Eligibility Upon Admission

For beneficiaries whose enrollment in Medicaid is determined after the end of an episode of inpatient psychiatric or partial hospitalization care (eligibility extends back and encompasses the dates of the episode of care), the PIHP will conduct a retrospective review of the episode of care to determine if services were medically necessary and appropriate for Medicaid reimbursement, unless the PIHP has previously reviewed and certified the admission and authorized days of care under other contractual and payment arrangements with the hospital. If the PIHP has conducted the pre-admission authorization and continuing stay reviews for these beneficiaries during the episode of care, this will be considered as a certification that authorized services are eligible for reimbursement by the PIHP under the Medicaid program once the beneficiary's retroactive Medicaid eligibility has been established.

As noted above, the purpose of a retrospective review is to determine if services rendered were medically necessary and hence qualify for Medicaid reimbursement. Since the hospital will not receive reimbursement for any care rendered which does not meet the test of medical necessity, it is advantageous for hospitals to involve PIHPs during the episode of care for any beneficiary that the facility believes may be eligible for Medicaid.

8.4 Medicare

For Medicare-covered services, the PIHP may only pay up to a Medicare-enrolled beneficiary's obligation to pay (i.e., co-insurance and deductibles). This limitation also applies if the beneficiary is eligible for, but not enrolled in, Medicare. (Refer to the Coordination of Benefits Chapter in this manual for more information.)

8.5 Eligibility Criteria

8.5.A. Inpatient Psychiatric and Partial Hospitalization Services

Medicaid requires that hospitals providing inpatient psychiatric services (Provider Types 68 and 73) or partial hospitalization services (Provider Types 41 and 75) obtain authorization and certification of the need for admission and continuing stay from PIHPs. A PIHP reviewer determines authorization and certification by applying criteria outlined in this document. The hospital or attending physician may request a reconsideration of adverse authorization/certification determinations made by the initial PIHP reviewer.

The criteria described below employ the concepts of Severity of Illness (SI) and Intensity of Service (IS) to assist reviewers in determinations regarding whether a particular care setting or service intensity is appropriately matched to the beneficiary's current condition.

- Severity of Illness (SI) refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the beneficiary's psychiatric disorder.
- Intensity of Service (IS) refers to the setting of care, to the types and frequency of needed services and supports, and to the degree of restrictiveness necessary to safely and effectively treat the beneficiary.

Medicaid coverage for inpatient psychiatric services is limited to beneficiaries with a current primary psychiatric diagnosis, as described in the criteria below. It is recognized that some beneficiaries will have other conditions or disorders (e.g., developmental

disabilities or substance abuse) that co-exist with a psychiatric disturbance. In regard to developmental disabilities, if a person with developmental disabilities presents with signs or symptoms of a significant, serious, concomitant mental illness, the mental illness will take precedence for purposes of care and placement decisions, and the beneficiary may be authorized/certified for inpatient psychiatric care under these guidelines.

For beneficiaries who present with psychiatric symptoms associated with current active substance abuse, it may be difficult to determine whether symptoms exhibited are due to a primary mental illness or represent a substance-induced disorder, and to make an informed level of care placement decision. A beneficiary exhibiting a psychiatric disturbance in the context of current active substance use or intoxication may require acute detoxification services before an accurate assessment of the need for psychiatric inpatient services can be made. In these situations, the hospital and the PIHP must confer to determine the appropriate location (acute medical setting or psychiatric unit) for the detoxification services.

The crucial consideration in initial placement decisions for a beneficiary with psychiatric symptoms associated with current active substance abuse is whether the beneficiary's immediate treatment needs are primarily medical or psychiatric. If the beneficiary's primary need is medical (e.g., life-threatening substance-induced toxic conditions requiring acute medical care and detoxification), then detoxification in an acute medical setting (presuming the beneficiary's condition meets previously published acute care detoxification criteria) is indicated. If the beneficiary's primary need is psychiatric care (the person meets the SI/IS criteria for inpatient psychiatric care), they should be admitted to the psychiatric unit and acute medical detoxification provided in that setting.

Hospitals are reminded that they must obtain PIHP admission authorization and certification for all admissions to a distinct part psychiatric unit or freestanding psychiatric hospital.

8.5.B. Inpatient Admission Criteria: Adults

Inpatient psychiatric care may be used to treat a person with mental illness who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based upon the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

Diagnosis	The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM Axis I, or ICD diagnosis (not including V Codes).

Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least **one** of the following manifestations is present: ▪ Severe Psychiatric Signs and Symptoms ➢ Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) severe enough to cause seriously disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care. ➢ Disorientation, seriously impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others. ➢ A severe, life-threatening psychiatric syndrome or an atypical or unusually complex psychiatric condition exists that has failed, or is deemed unlikely, to respond to less intensive levels of care, and has resulted in substantial current dysfunction. ▪ Disruptions of Self-Care and Independent Functioning ➢ The person is unable to attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essentials of daily living due to psychiatric disorder. ➢ There is evidence of serious disabling impairment in interpersonal functioning (e.g., withdrawal from relationships; repeated conflictual interactions with family, employer, co-workers, neighbors) and/or extreme deterioration in the person's ability to meet current educational/occupational role performance expectations. ▪ Harm to Self ➢ Suicide: Attempt or ideation is considered serious by the intention, degree of lethality, extent of hopelessness, degree of impulsivity, level of impairment (current intoxication, judgment, psychological symptoms), history of prior attempts, and/or existence of a workable plan. ➢ Self-Mutilation and/or Reckless Endangerment: There is evidence of current behavior, or recent history. There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations. Other Self-Injurious Activity: The person has a recent history of drug ingestion with a strong suspicion of overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder. ▪ Harm to Others ➢ Serious assaultive behavior has occurred, and there is a risk of escalation or repetition of this behavior in the near future.

	➢ There is expressed intention to harm others and a plan and/or means to carry it out, and the level of impulse control is non-existent or impaired (due to psychotic symptoms, especially command or verbal hallucinations, intoxication, judgment, or psychological symptoms, such as persecutory delusions and paranoid ideation). ➢ There has been significant destructive behavior toward property that endangers others. ▪ Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care ➢ The person has experienced severe side effects from using therapeutic psychotropic medications. ➢ The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care. **Special Consideration: Concomitant Substance Abuse -** The underlying or existing psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represent the primary reason observation and treatment is necessary in the psychiatric unit or hospital setting.
Intensity of Service	The person meets the intensity of service requirements if inpatient services are considered medically necessary for the beneficiary's treatment/diagnosis, and if the person requires at least **one** of the following: ▪ Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications. ▪ Close and continuous skilled medical observation is necessary due to otherwise unmanageable side effects of psychotropic medications. ▪ Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) is needed to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur. ▪ A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

8.5.C. Inpatient Admission Criteria: Children Through Age 21

Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based on the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

Diagnosis	The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM Axis I, or ICD diagnosis (not including V Codes).
Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least **one** of the following manifestations is present: ▪ Severe Psychiatric Signs and Symptoms ➢ Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care. ➢ Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others. ➢ Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction. ▪ Disruptions of Self-Care and Independent Functioning ➢ Beneficiary is unable to maintain adequate nutrition or self care due to a severe psychiatric disorder. ➢ The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has been a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance. ▪ Harm to Self ➢ A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, or impulsivity.

- There is a specific plan to harm self with clear intent and/or lethal potential.
- There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment or a history of prior attempts.
- There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking or other self-endangering behavior.
- There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.
- There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.

- Harm to Others
  - Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.
  - There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired.
  - There has been significant destructive behavior toward property that endangers others, such as setting fires.
- Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care
  - The person has experienced severe side effects from using therapeutic psychotropic medications.
  - The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.
  - There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

Special Consideration: Concomitant Substance Abuse - The underlying psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represents the primary reason observation and treatment are necessary in the hospital setting.

Intensity of Service	The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least **one** of the following: ▪ Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications. ▪ Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications. ▪ Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur. ▪ A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

8.5.D. Inpatient Psychiatric Care – Continuing Stay Criteria: Adults, Adolescents and Children

After a beneficiary has been certified for admission to an inpatient psychiatric setting, services must be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in an inpatient setting. Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arrestment of potentially life-threatening self/other harm inclinations, management of adverse biologic reactions to treatment and/or regulation of complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the patient's problems and dysfunctions.

Continuing treatment in an inpatient setting may be certified when signs, symptoms, behaviors, impairments, harm inclinations or biologic/medication complications, similar to those which justified the patient's admission certification, remain present, and continue to be of such a nature and severity that inpatient psychiatric treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the inpatient unit. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

The individual must meet all three criteria outlined in the table below:

Diagnosis	The beneficiary has a validated current version of DSM Axis I or ICD mental disorder (excluding V codes) that remains the principal diagnosis for purposes of care during the period under review.
Severity of Illness (signs, symptoms, functional impairments and risk potential)	▪ Persistence/intensification of signs/symptoms, impairments, harm inclinations or biologic/medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care. ▪ Continued severe disturbance of cognition, perception, affect, memory, behavior or judgment. ▪ Continued gravely disabling or incapacitating functional impairments or severely and pervasively impaired personal adjustment. ▪ Continued significant self/other harm risk. ▪ Use of psychotropic medication at dosage levels necessitating medical supervision, dosage titration of medications requiring skilled observation, or adverse biologic reactions requiring close and continuous observation and monitoring. ▪ Emergence of new signs/symptoms, impairments, harm inclinations or medication complications meeting admission criteria.
Intensity of Service	▪ The beneficiary requires close observation and medical supervision due to the severity of signs and symptoms, to control risk behaviors or inclinations, to assure basic needs are met or to manage biologic/medication complications. ▪ The beneficiary is receiving active, timely, treatment delivered according to an individualized plan of care. ▪ Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or biologic/medication complications that necessitated admission to inpatient care. ▪ The beneficiary is making progress toward treatment goals as evidenced by a measurable reduction in signs/symptoms, impairments, harm inclinations or biologic/medication complications or, if no progress has been made, there has been a modification of the treatment plan and therapeutic program, and there is a reasonable expectation of a positive response to treatment.

Discharge criteria and aftercare planning are documented in the beneficiary's record.

SECTION 9 – INTENSIVE CRISIS STABILIZATION SERVICES

Intensive/crisis stabilization services are structured treatment and support activities provided by a mental health crisis team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated.

A crisis situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following applies:

- The individual can reasonably be expected within the near future to physically injure himself or another individual, either intentionally or unintentionally.
- The individual is unable to provide himself clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
- The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the mental health professional, his continued behavior, as a result of the mental illness, developmental disability, or emotional disturbance, can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

9.1 ENROLLMENT

Medicaid providers wishing to become providers of intensive/crisis services must enroll as an intensive/crisis services provider with the approval of MDCH and meet the program components outlined below.

9.2 POPULATION

These services are for beneficiaries who have been assessed to meet criteria for psychiatric hospital admissions but who, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services if such services will result in a shortened inpatient stay.

Beneficiaries must have a diagnosis of mental illness or mental illness with a co-occurring substance abuse disorder or developmental disability.

9.3 SERVICES

Intensive/crisis services are intensive treatment interventions delivered by an intensive/crisis stabilization treatment team, under psychiatric supervision. Component services include:

- Intensive individual counseling/psychotherapy;
- Assessments (rendered by the treatment team);
- Family therapy;
- Psychiatric supervision; and

- Therapeutic support services by trained paraprofessionals.

9.4 Qualified Staff

Intensive/crisis services must be provided by a treatment team of mental health professionals under the supervision of a psychiatrist. The psychiatrist need not provide on-site supervision at all times, but must be available by telephone at all times. Professionals providing intensive/crisis stabilization services must be mental health care professionals. Nursing services/consultation must be available.

The professional treatment team may be assisted by trained paraprofessionals under appropriate supervision. The trained paraprofessionals must have at least one year of satisfactory work experience providing services to beneficiaries with serious mental illness. Activities of the trained paraprofessionals include assistance with therapeutic support services.

9.5 Location of Services

Intensive/crisis stabilization services may be provided where necessary to alleviate the crisis situation, and to permit the beneficiary to remain in, or return more quickly to, his usual community environment.

Exceptions: Intensive/crisis stabilization services may not be provided in:

- Inpatient settings;
- Jails or other settings where the beneficiary has been adjudicated; or
- Crisis residential settings.

9.6 Individual Plan of Service

Intensive/crisis stabilization services may be provided initially to alleviate an immediate or serious psychiatric crisis. However, following resolution of the immediate situation (and within no more than 48 hours), an intensive/crisis stabilization services treatment plan must be developed. The intensive/crisis stabilization treatment plan must be developed through a person-centered planning process in consultation with the psychiatrist. Other professionals may also be involved if required by the needs of the beneficiary. The case manager (if the beneficiary receives case management services) must be involved in the treatment and follow-up services.

The individual plan of service must contain:

- Clearly stated goals and measurable objectives, derived from the assessment of immediate need, and stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis.
- Identification of the services and activities designed to resolve the crisis and attain his goals and objectives.
- Plans for follow-up services (including other mental health services where indicated) after the crisis has been resolved. The role of the case manager must be identified, where applicable.

For children's intensive/crisis stabilization services, the treatment plan must address the child's needs in context with the family needs. Educational services must also be considered and the treatment plan must be developed in consultation with the child's school district staff.

SECTION 10 – OUTPATIENT PARTIAL HOSPITALIZATION SERVICES

The PIHP is responsible for authorizing and paying for Medicaid admissions and continued stays in partial hospitalization programs by Medicaid beneficiaries.

- Admissions - beneficiaries may be referred to a partial hospitalization program from psychiatric inpatient hospitals or psychiatric units, referring providers, or PIHPs, or they may present themselves at the outpatient hospital without a referral.
- Continued stays must be authorized by the PIHP.

Authorization for the partial hospitalization admission and continued stay includes authorization for all services related to that admission/stay, including laboratory, pharmacy, and radiology services. The outpatient partial hospitalization program must bill the PIHP for authorized services according to procedures and rates established between the facility and the PIHP.

10.1 PARTIAL HOSPITALIZATION ADMISSION CRITERIA: ADULT

Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week, in a licensed setting. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs. The SI/IS criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

Diagnosis	The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD Diagnosis (not including V Codes).
Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least **two** of the following manifestations are present: ▪ Psychiatric Signs and Symptoms

- Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) or behavior exists (intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation are not so severe, extreme or unstable so as to require frequent restraints or to pose a danger to others.
- Disruptions of Self-Care and Independent Functioning
  - The person seriously neglects self-care tasks (hygiene, grooming, etc.) and/or does not sufficiently attend to essential aspects of daily living (does not shop, prepare meals, maintain adequate nutrition, pay bills, complete housekeeping chores, etc.) due to a mental disorder.
  - Beneficiary is able to maintain adequate nutrition, shelter or other essentials of daily living only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program.
  - The person's interpersonal functioning is significantly impaired (seriously dysfunctional communication, extreme social withdrawal, etc.).
  - There has been notable recent deterioration in meeting educational/occupational responsibilities and role performance expectations.
- Danger to Self
  - There is modest danger to self reflected in intermittent self-harm ideation, expressed ambivalent inclinations without a plan, non-intentional threats, mild and infrequent self-harm gestures (low lethality/intent) or self-mutilation, passive death wishes, or slightly self-endangering activities.
  - The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk.
- Danger to Others
  - Where assaultive tendencies exist, there have been no overt actions and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb these inclinations.
  - There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions.
  - There has been minor destructive behavior toward property without endangerment of others.

	▪ Drug/Medication Complications ➢ The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs, and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.
Intensity of Service	The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least **one** of the following: ▪ The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care. ▪ The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments. ▪ Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

10.2 Partial Hospitalization Admission Criteria: Children and Adolescents

Partial hospitalization services may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week, in a licensed setting. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs. The SI/IS criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skill, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) does not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

Diagnosis	The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD diagnosis (not including V Codes).

Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least **two** of the following manifestations are present: ▪ Psychiatric Signs and Symptoms ➢ Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) or behavior exists (intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation is not so severe, extreme or unstable so as to require frequent restraints or to pose a danger to others. ▪ Disruptions of Self-Care and Independent Functioning ➢ The child/adolescent exhibits significant impairments in self-care skills (feeding, dressing, toileting, hygiene/bathing/grooming, etc.), in the ability to attend to age-appropriate responsibilities, or in self-regulation capabilities, due to a mental disorder or emotional illness. ➢ The child/adolescent is able to maintain adequate self-care and self-regulation only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program. ➢ There is recent evidence of serious impairment/incapacitation in the child's/adolescent's interpersonal and social functioning (seriously dysfunctional communication, significant social withdrawal and isolation, repeated disruptive, inappropriate or bizarre behavior in social settings, etc.). ➢ There is recent evidence of considerable deterioration in functioning within the family and/or significant decline in occupational/educational role performance due to a mental disorder or emotional illness. ▪ Danger to Self ➢ There is modest danger to self reflected in: non-accidental self-harm gestures or self-mutilation actions which are not life-threatening in either intent or lethal potential; intermittent self-harm ideation; expressed ambivalent inclinations without a plan; non-intentional threats; passive death wishes, or slightly self-endangering activities. ➢ The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk.

	▪ Danger to Others ➢ Assaultive tendencies exist, and some assaultive behavior may have occurred, but any overt actions have been without any serious or significant injury to others, and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb any serious expression of these inclinations. ➢ There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have adequate impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions. ➢ There has been minor destructive behavior toward property without endangerment of others. ▪ Drug/Medication Complications ➢ The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.
Intensity of Service	The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least **one** of the following: ▪ The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care. ▪ The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive, treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments. ▪ Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

10.3 Partial Hospitalization Continuing Stay Criteria for Adults, Adolescents and Children

After a beneficiary has been certified for admission to a partial hospitalization program, services will be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in a partial hospitalization setting. Treatment within a partial hospitalization program is directed at resolution or stabilization of acute symptoms, elimination or amelioration of disabling functional impairments, maintenance of self/other safety and/or regulation of precarious or complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the partial program remains the most appropriate, least restrictive, level of care for treatment of the patient's problems and dysfunctions.

Continuing treatment in the partial program may be certified when symptoms, impairments, harm inclinations or medication complications, similar to those which justified the patient's admission certification, remain present, and continue to be of such a nature and severity that partial hospitalization treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the program. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

The individual must meet all three criteria outlined in the table below:

Diagnosis	The beneficiary has a validated current version of DSM or ICD mental disorder (excluding V Codes), which remains the principal diagnosis for purposes of care during the period under review.
Severity of Illness (signs, symptoms, functional impairments and risk potential)	▪ Persistence of symptoms, impairments, harm inclinations or medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care. ▪ Emergence of new symptoms, impairments, harm inclinations or medication complications meeting admission criteria. ▪ Progress has been made in ameliorating admission symptoms or impairments, but the treatment goals have not yet been fully achieved and cannot currently be addressed at a lower level of care.
Intensity of Service	▪ The beneficiary is receiving active, timely, intensive, structured multi-modal treatment delivered according to an individualized plan of care. ▪ Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or medication complications that necessitated admission to the program. ▪ The beneficiary is making progress toward treatment goals or, if no progress has been made, the treatment plan and therapeutic program have been revised accordingly and there is a reasonable expectation of a positive response to treatment.

Discharge criteria and aftercare planning are documented in the beneficiary's record.

SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS

Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing his own personal daily activities. Services may be provided only in a licensed foster care setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by DHS.

Personal care services are covered when authorized by a physician or the case manager or supports coordinator, in accordance with an individual plan of services, and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.

11.1 SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);
- Eating/feeding;
- Toileting;
- Bathing;
- Grooming;
- Dressing;
- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in an Adult Foster Care setting licensed and certified by the state under the 1987 Department of Mental Health Administrative Rule R330.1801-09 (as amended in 1995).

11.3 DOCUMENTATION

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

- An assessment of the beneficiary's need for personal care.
- An individual plan of services that includes the specific personal care services to be delivered that is reviewed and approved at least once per year during person-centered planning.
- Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.

SECTION 12 – SUBSTANCE ABUSE SERVICES

12.1 COVERED SERVICES

The following Medicaid-covered services and supports must be provided, based on medical necessity, to eligible beneficiaries who reside in the specified region and request services:

Access Assessment and Referral (AAR) Services	The AAR service is the system utilized to improve the accessibility to substance abuse treatment. This service must provide client informed choice of available treatment providers and an objective unbiased process to determine beneficiary need, level of care, referral and placement for substance abuse treatment. The substance abuse Assessment Process begins with the AAR service and continues as the beneficiary enters the substance abuse treatment program. The Assessment Process is the process for evaluating the condition of an individual relevant to treatment. The AAR service must include the following: ▪ The use of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) to determine an initial diagnostic impression (also known as provisional diagnosis). The diagnostic impression must include all five axes. ▪ The use of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria to determine substance abuse treatment placement/admission, continued stay and discharge/transfer. ▪ Any program/agency performing any or all portions of the AAR service must be appropriately licensed by the state.
Outpatient Treatment	▪ Individual therapy is face-to-face counseling services with the beneficiary. ▪ Family therapy is face-to-face counseling with the beneficiary and his significant other and/or traditional or non-traditional family members. ▪ Group therapy is face-to-face counseling with three or more beneficiaries, and can include didactic lectures, therapeutic interventions/counseling, and other group-related activities. Outpatient treatment is an organized, non-residential treatment service or an office practice with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week. Examples include weekly or twice weekly individual therapy, group therapy, or a combination of the two. The treatment may be in association with participation in self-help groups. Treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and beneficiary characteristics including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care and discharge, must be based on the American Society of Addiction Medicine (ASAM) patient placement criteria. Beneficiary participation in referral and continuing care planning must occur prior to discharge.

Intensive Outpatient (IOP) Treatment	Intensive outpatient (IOP) treatment is a planned and organized non-residential treatment service in which AOD trained/educated clinicians provide several AOD treatment service components to beneficiaries. Treatment consists of regularly scheduled treatment, usually group therapy, within a structured program, for at least three days and at least nine hours per week. Examples include day or evening programs in which patients attend a full spectrum of treatment programming but live at home or in special residences. Treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and beneficiary characteristics, including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care and discharge, must be based on the ASAM patient placement criteria. Beneficiary participation in referral and continuing planning must occur prior to discharge.
Office of Pharmacological and Alternative Therapies/Center for Substance Abuse Treatment (OPAT/CSAT) approved Pharmacological Supports	Covered services for Methadone and Levo-Alpha-Acetyl-Methadone (LAAM) pharmacological supports and laboratory services, as required by OPAT/CSAT regulations and the Administrative Rules for Substance Abuse Service Programs in Michigan, include: Methadone or LAAM medication — Physician encounters (monthly) Nursing services — Laboratory tests Physical examination — TB skin test (as ordered by physician). Opiate-dependent patients may be provided chemotherapy using methadone or LAAM as an adjunct to therapy. Such services must be performed under the care of a physician licensed to practice medicine in the state of Michigan. The physician must be licensed to prescribe controlled substances, as well as licensed to work at a methadone program. The methadone component of the substance abuse treatment program must be licensed as such by the state and be certified by the OPAT/CSAT and licensed by the Drug Enforcement Administration (DEA). MDCH Enrollment Criteria for Methadone Maintenance and Detoxification Program attached to the MDCH PIHP contract must be followed.

12.2 Allowable Services

The PIHPs may provide allowable services from Medicaid savings within their capitation payment (refer to the contract).

12.3 Excluded Services

- Room and board;
- All other services not addressed within Covered or Allowable Services; and
- Medicaid Substance Abuse Services funded Outside the PIHP Plan.

Some Medicaid-covered services are available to substance abuse beneficiaries, but are provided outside of the PIHP Plan. The PIHPs are not responsible to pay for the following:

- Acute detoxification.

- Laboratory services related to substance abuse (with the exception of lab services required for Methadone and LAAM).
- Medications used in the treatment/management of addictive disorders.
- Emergency medical care.
- Emergency transportation.
- Substance abuse prevention and treatment that occurs routinely in the context of providing primary health care.
- Routine transportation to substance abuse treatment services which is the responsibility of the local DHS.

SECTION 13 – TARGETED CASE MANAGEMENT

Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

13.1 PROVIDER QUALIFICATIONS

Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the individual plan of service developed through the person-centered planning process.

13.2 DETERMINATION OF NEED

The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports. Justification as to whether case management is needed or not must be documented in the beneficiary's record.

13.3 CORE REQUIREMENTS

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.
- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.
- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.

- Assuring the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status.
- Identifying and addressing gaps in service provision.
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.
- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care.
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.
- Assisting beneficiaries with crisis planning.
- Identifying the process for after-hours contact.

Assessment	The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The individual plan of services must also reflect such changes.
Documentation	The beneficiary's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs. The case manager must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.
Monitoring	The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

13.4 Staff Qualifications

A primary case manager must be a qualified mental health or mental retardation professional (QMHP or QMRP); or if the case manager has only a bachelor's degree but without the specialized training or experience they must be supervised by a QMHP or QMRP who does possess the training or experience.

SECTION 14 – CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER (CWP)

The Children's Home and Community Based Services Waiver Program (CWP) provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the CWP. Children enrolled in the CWP who had reached age 18 years prior to October 1, 1996 may continue to receive waiver services until age 26.

The Children's Waiver is a fee-for-service program administered by the CMHSP. The CMHSP will be held financially responsible for any costs incurred on behalf of the CWP beneficiary that were authorized by the CMHSP and exceed the Medicaid fee screens or amount, duration and scope parameters.

Services, equipment and Environmental Accessibility Adaptations (EAAs) that require prior authorization from MDCH must be submitted to the CWP Clinical Review Team at MDCH. The team is comprised of a physician, registered nurse, psychologist, and master's level social worker with consultation by a building specialist and an occupational therapist.

14.1 KEY PROVISIONS

The CWP enables Medicaid to fund necessary home- and community-based services for children with developmental disabilities who reside with their birth or legally adoptive parent(s) or with a relative who has been named legal guardian under the laws of the State of Michigan, regardless of their parent's income.

The CMHSP is responsible for assessment of potential waiver candidates. The CMHSP is also responsible for referring potential waiver candidates by completing the CWP "pre-screen" form and sending it to the MDCH to determine priority rating.

Application for the CWP is made through the CMHSP. The CMHSP is responsible for the coordination of the child's waiver services. The case manager, the child and his family, friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services. All services and supports must be included in the Individual Plan of Services (IPOS). The IPOS must be reviewed, approved and signed by the physician.

A CWP beneficiary must receive at least one children's waiver service per month in order to retain eligibility.

14.2 ELIGIBILITY

The following eligibility requirements must be met:

- The child must have a developmental disability (as defined in Michigan state law), be less than 18 years of age and in need of habilitation services.
- The child must have a score on the Global Assessment of Functioning (GAF) Scale of 50 or below.
- The child must reside with his birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.

- The child is at risk of being placed into an ICF/MR facility because of the intensity of the child's care and the lack of needed support, or the child currently resides in an ICF/MR facility but, with appropriate community support, could return home.
- The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).
- The child's intellectual or functional limitations indicate that he would be eligible for health, habilitative and active treatment services provided at the ICF/MR level of care. Habilitative services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

14.3 Covered Waiver Services

Covered Medicaid services that continue to be available to CWP beneficiaries are listed in the Covered Services Section of this chapter. Refer to the Children's Waiver Community Living Support Services Appendix of this chapter for criteria for determining number of hours. Services covered under CWP include:

Community Living Supports	Community Living Supports (CLS) provides assistance to a family in the care of their child while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. The supports, as identified in the individual plan of services, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings. Individuals who are identified in the individual plan of services to provide CLS to the child and family must meet provider qualifications. The CMHSP must maintain the following documentation: ▪ A log of the CLS must be maintained in the child's record, documenting the provision of activities outlined in the plan. ▪ Provider qualifications and standards must be maintained for all staff providing services and supports to the child and family. All service costs must be maintained in the child's file for audit purposes.

Enhanced Transportation	Transportation costs may be reimbursed when separately specified in the individual plan of services and provided by people other than staff performing CLS, in order to enable a child served by the CWP to gain access to waiver and other community services, activities and resources. Transportation is limited to local distances, where local is defined as within the child's county or a bordering county. This service is an enhancement of transportation services covered under Medicaid. Family, neighbors, friends, or community agencies that can provide this service without charge must be utilized before seeking funding through the CWP. The availability and use of natural supports should be documented in the record. Parents of children served by the waiver are not entitled to enhanced transportation reimbursement.
Environmental Accessibility Adaptations (EAAs)	Environmental Accessibility Adaptations (EAAs) include those physical adaptations to the home, specified in the individual plan of services, which are necessary to ensure the health, welfare and safety of the child, or enable him to function with greater independence in the home and without which the child would require institutionalization. Home adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are essential to support the child's medical equipment. Requests for EAAs must be prior authorized by the CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, Children's Special Health Care Services (CSHCS), Medicaid. All services shall be provided in accordance with applicable state or local building codes. A prescription or CMN is required and is valid for one year from the date of signature. Standards of value purchasing must be followed. The EAA must be the most reasonable alternative, based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded EAA (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. EAAs shall exclude costs for improvements exclusively required to meet local building codes. The EAA must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values. The EAA must demonstrate cost-effectiveness. The family must apply, with the assistance of the case manager if needed, to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. Acceptances or denials by these funding sources must be documented in the child's records. The CWP is a funding source of last resort.

	Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of parents, and are not of direct medical or remedial benefit to the child. EAAs that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a child's home. All work must be completed while the child is enrolled in the CWP. Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the child's family must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that the CWP and MDCH are not obligated for any restoration costs. If a family purchases a home, or builds a home or addition while the child is receiving waiver services, it is the family's responsibility to assure that the home will meet the child's basic needs, such as having a ground floor bath/bedroom if the child has mobility limitations. The CWP does not cover construction costs in a new home or addition, or a home purchased after the beneficiary is enrolled in the waiver. The CWP funds may be authorized to assist with the adaptation noted above (e.g., ramps, grab bars, widening doorways) for a home recently purchased. Additional square footage may be prior authorized following a MDCH specialized housing consultation if it is determined that adding square footage is the only alternative available to make the home accessible and the most cost-effective alternative for housing. Additional square footage is limited to the space necessary to make the home wheelchair-accessible for a child with mobility impairments to prevent institutionalization; the amount will be determined by the direct medical or remedial need of the beneficiary. The family must exhaust all applicable funding options, such as the family's ability to pay, housing commission grants, MSHDA and community development block grants. Acceptances or denials by these funding sources must be documented in the child's records.
Family Training (previously called Didactic Services)	This provides for training and counseling services for the families of children served on the CWP. For purposes of this service, "family" is defined as the people who live with or provide care to a child served on the CWP, and may include a parent or siblings. Family does not include individuals who are employed to care for the child. Training includes instruction about treatment regimens and use of equipment specified in the plan of services, and must include updates as necessary to safely maintain the child at home. Family training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs. All family training must be included in the child's individual plan of services and must be provided on a face-to-face basis.
Non-Family Training (previously called Psychological/Behavioral Treatment)	This service provides coaching, supervision and monitoring of CLS staff by professional staff (LLP, MSW, or QMRP). The professional staff will work with parents and CLS staff to implement the plan that addresses services designed to improve the child's social interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive, injurious to the child or others, or that cause property damage.

Respite Care	Respite care services are provided to the child on an intermittent or short-term basis because of the absence or need for relief of the parent. Respite is intended to support the parent who is the primary caregiver. This service can be provided by a qualified provider under contract with the CMHSP in the child's home, foster home, group home, licensed respite care facility, licensed camp, or the home of a friend or relative. A parent or guardian may not be considered a provider, nor be reimbursed for this service. The maximum monthly respite allocation is 96 hours. In addition to monthly respite, vacation respite can be used up to 14 days per year and must be used in 24-hour increments. The cost of room and board cannot be included as part of respite care, unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/MR, nursing facility, or hospital) is not covered by the CWP. When a child requires skilled nursing interventions for 24 hours, the maximum daily amount that one nurse can provide is 16 hours. When the family is not available to provide the additional eight hours of care, a second nurse will be required to provide services for the remainder of the 24-hour period. If a nurse provides respite to more than one child at the same time, the nurse can only provide skilled nursing interventions to one child at a time. Therefore, service for that child would be covered as RN or LPN respite, and services to the other child(ren) would be covered as aide-level respite.
Specialized Medical Equipment and Supplies	Specialized medical equipment and supplies may include devices, controls, or appliances specified in the individual plan of services which enable the child to increase his abilities to perform activities of daily living or to perceive, control or communicate with the environment in which he lives. This service includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under Medicaid or through other insurance (Refer to the Medical Supplier Chapter of this manual for information about Medicaid-covered equipment and supplies). The CMHSP, or its contract agency, may locally authorize medical equipment and supplies as defined in the most current version of the Instructional Manual for CWP. All other requests for specialized medical equipment and supplies must be prior authorized by the CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, CSHCS, Medicaid. The item must be of direct medical or remedial benefit to the child. "Direct medical or remedial benefit" is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that is essential to the implementation of the individual plan of services. The plan must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented.

	A prescription or CMN is required and is valid for one year from the date of signature. All items must be determined to be essential to the health, welfare, safety, and independent functioning of the child as specified in the individual plan of services. There must be documented evidence that the item is the most cost-effective alternative to meet the child's need following value purchasing standards. All items must meet applicable standards of manufacture, design and installation. The CMHSP, or its contract agency, must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase. Repairs to specialized medical equipment that are not covered benefits through other insurances may be covered with prior approval by the CWP. There must be documentation in the individual plan of services that the specialized medical equipment continues to be of direct medical or remedial benefit to the child. All applicable warranty and insurance coverages must be sought and denied before requesting funding for repairs through the CWP. The CMHSP, or its contract agency, must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the CMHSP, or its contract agency, must provide evidence of training in the use of the equipment to prevent future incidents. Exclusions include: ▪ Items that are not of direct medical or remedial benefit or that are considered to be experimental are not covered. "Experimental" means that the validity of use of the item has not been supported in one or more studies in a refereed professional journal. ▪ Furnishings and other non-custom items that may routinely be found in a home are excluded. ▪ Items that would normally be available to any child and would ordinarily be provided by families. ▪ Items that are considered family recreational choices are not covered. ▪ The purchase or lease of a vehicle and any repairs or routine maintenance to the vehicle is not covered. ▪ Educational supplies and equipment expected to be provided by the school. Vehicle modifications are limited to the installation of lifts, tie-down systems and raised roof or doors in a family-owned full-size van. The modification must be necessary to ensure the accessibility of the child with mobility impairments and the vehicle is the child's primary means of transportation. Generators may be covered for a beneficiary who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment.

Specialty Services	Specialty Services include: ▪ Music Therapies; ▪ Recreation Therapies; ▪ Art Therapies; and ▪ Massage Therapies. Specialty services may include the following activities: Child and family training; coaching and supervision of staff; monitoring of progress related to goals and objectives; and recommending changes in the plan. This may be used in addition to the traditional professional therapy model included in Medicaid. Services must be directly related to an identified goal in the individual plan of service and approved by the physician. Service providers must meet the CMHSP provider qualifications, including appropriate licensure/certification. Services are limited to four sessions per therapy per month. The CMHSP must maintain a record of all Specialty Service costs for audit purposes. Hourly care services are not covered under Specialty Services.

14.4 Provider Qualifications

14.4.A. Individuals Who Provide Respite and CLS

Individuals who provide respite and CLS must:

- Be at least 18 years of age.
- Be able to practice prevention techniques to reduce transmission of any communicable diseases from themselves to others in the environment where they are providing support.
- Have a documented understanding and skill in implementing the individual plan of services and report on activities performed.
- Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- Be able to perform basic first aid and emergency procedures.
- Be trained in recipient rights.
- Be an employee of the CMHSP or its contract agency, or an employee of the parent who is paid through a Choice Voucher arrangement. The Choice Voucher System is the designation or set of arrangements that facilitate and support accomplishing self-determination through the use of an individual budget, a fiscal intermediary and direct consumer-provider contracting.

14.4.B. Individuals Performing Case Management Functions

Individuals performing case management functions must meet the requirements for a Qualified Mental Retardation Professional (QMRP) and have:

- A minimum of a Bachelor's degree in a human services field.
- One year of experience working with people with developmental disabilities.

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Service selection guidelines for beneficiaries with developmental disabilities should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDCH enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/MR level of care services; and
- Chooses to participate in the HSW in lieu of ICF/MR services.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDCH Bureau of Community Mental Health Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

15.1 WAIVER SUPPORTS AND SERVICES [CHANGE MADE 4/1/06]

Chore Services	Services to maintain the home in a clean, sanitary, and safe environment, include: ▪ Heavy household chores such as washing walls, floors and exterior windows; ▪ Tacking down loose rugs and tiles; ▪ Moving heavy furniture in order to provide safe mobility within the home; and ▪ Removing snow to provide safe access to, and egress from, the home.

	These services will only be provided in cases where neither the beneficiary, nor anyone else in the household, is capable of performing or financially providing for them and where no other relative, caregiver, support/service provider, landlord, community/ volunteer agency, or third party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the rental or lease agreement, must be examined prior to authorization of the service. This service may not be provided to beneficiaries who live in licensed settings because the activities are the responsibility of the home's licensee.
Community Living Supports (CLS)	Community Living Supports (CLS) facilitate an individual's independence and promote integration into the community. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings, and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are: ▪ Assisting*, reminding, observing, guiding or training the beneficiary with: ➢ Meal preparation; ➢ Laundry; ➢ Routine, seasonal, and heavy household care and maintenance; ➢ Activities of daily living, such as bathing, eating, dressing, personal hygiene; and ➢ Shopping for food and other necessities of daily living. ▪ Assistance, support and/or training the beneficiary with: ➢ Money management; ➢ Non-medical care (not requiring nurse or physician intervention); ➢ Socialization and relationship building; ➢ Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through DHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence); ➢ Leisure choice and participation in regular community activities; ➢ Attendance at medical appointments; and ➢ Acquiring procedure goods other than those listed under shopping and non-medical services

	▪ Reminding, observing, and/or monitoring of medication administration. The CLS do not include the costs associated with room and board. Payment for CLS does not include payments made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian. The HSW services cannot supplant Medicaid services. The beneficiary must use the DHS Home Help or Enhanced Home Help services for assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living (bathing, eating, dressing, personal hygiene), and shopping. *CLS services may not supply state plan services, such as Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping in the beneficiary's own unlicensed home). If such assistance is needed the beneficiary, with the help of the PIHP supports coordinator, must request Home Help, and if necessary Expanded Home Help, from DHS. CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. The PIHP supports coordinator must assist, if necessary, the beneficiary in filling out and sending a request for a Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs based on the findings of the DHS assessment. CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the beneficiary's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training or these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.
Enhanced Dental	**(deleted per bulletin MSA 06-09 effective 3/15/06)**
Enhanced Medical Equipment and Supplies	Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances (Refer to the Medical Supplier Chapter of this manual for more information about Medicaid-covered equipment and supplies). All enhanced medical equipment and supplies must be specified in the plan of service, and must enable the beneficiary to increase his abilities to perform activities of daily living; or to perceive, control, or communicate with the environment. Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the beneficiary, are excluded from coverage. ▪ "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service. ▪ "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal.

	The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. All items must be ordered on a prescription or Certificate of Medical Necessity (CMN) as defined in the General Information Section of this chapter. An order is valid one year from the date it was signed. This coverage includes: ▪ Adaptations to vehicles; ▪ Items necessary for life support; ▪ Ancillary supplies and equipment necessary for proper functioning of such items; and ▪ Durable and non-durable medical equipment not available under the Medicaid state plan. Generators may be covered for an individual who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment. Assessments and specialized training needed in conjunction with the use of such equipment, as well as warranted upkeep and repair, shall be considered as part of the cost of the services. Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home are not included. Items that are considered family recreational choices are not covered. The purchase or lease of a vehicle, as well as any repairs or routine maintenance to the vehicle, is not covered. Educational equipment and supplies are expected to be provided by the school as specified in the Individual Education Plan and are not covered. Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. The PIHP should have a process in place that gives notice to a medical equipment supplier that purchase of the equipment or supply has been authorized. Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the individual plan of services that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverage must be sought and denied before paying for repairs. The PIHP must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

Enhanced Pharmacy	Physician-ordered, nonprescription "medicine chest" items as specified in the beneficiary's support plan. Items that are not of direct medical or remedial benefit to the beneficiary are not allowed. Only the following items are allowable: ▪ Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies; ▪ Vitamins and minerals; ▪ Special dietary juices and foods that augment, but do not replace, a regular diet; ▪ Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either: ➢ A history of aspiration pneumonia, **(modified 4/1/06)** or ➢ Documentation that the beneficiary is at risk of insertion of a feeding tube without thickening agents for safe swallowing; ▪ First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads); ▪ Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, toothbrushes, anti-plaque rinses, antiseptic mouthwashes); ▪ Special items (i.e. accommodating common disabilities—longer, wider handles), tweezers and nail clippers; and Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products) are not included. However, products necessary to ameliorate negative visual impact of serious facial disfigurements (e.g., massive scarring) and/or skin conditions (including exposed area eczema, psoriasis, and/or acne) will be covered. Refer to the Pharmacy Chapter in this manual for information about Medicaid-covered prescriptions.
Environmental Modifications	Physical adaptations to the home and/or workplace required by the beneficiary's support plan that are necessary to ensure the health, safety, and welfare of the beneficiary, or enable him to function with greater independence within the environment(s) and without which the beneficiary would require institutionalization. Adaptations may include: ▪ The installation of ramps and grab bars; ▪ Widening of doorways; ▪ Modification of bathroom facilities; and ▪ Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary.

	Physical adaptations to the home and/or workplace required by the beneficiary's support plan that are necessary to ensure the health, safety, and welfare of the beneficiary, or enable him to function with greater independence within the environment(s) and without which the beneficiary would require institutionalization. Adaptations may include: ▪ The installation of ramps and grab bars; ▪ Widening of doorways; ▪ Modification of bathroom facilities; and ▪ Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary. Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary (e.g., carpeting, roof repair) are not included. The HSW does not cover construction costs in a new home, or additions to a home purchased after the beneficiary is enrolled in the waiver. HSW funds may be authorized to assist with the adaptations noted above (e.g. ramps, grab bars, widening doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under constructions that require special adaptation to the plan (e.g. roll-in shower), the HSW may be used to fund the difference between the standard fixture and the modification required to accommodate the beneficiary's need. "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service. The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. All items must be ordered on a prescription or CMN as defined in the General Information Section of this chapter. An order is valid for one year from the date it was signed. Central air-conditioning is included only when prescribed by a physician and specified with extensive documentation in the plan as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use. The PIHP must assure there is a signed contract or bid proposal with the builder prior to the start of an environmental modification. It is the responsibility of the PIHP to work with the beneficiary and builder to ensure that the work is completed as outlined in the contract or bid proposal.

	The environmental modification must be the most reasonable alternative, based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded modifications (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. Environmental modifications shall exclude costs for improvements exclusively required to meet local building codes. The environmental modification must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values. The beneficiary, with the direct assistance by the PIHP supports coordinator when necessary, must make a reasonable effort to access all available funding sources, such as housing commission grants, Michigan State Housing Development Authority (MSHDA), and community development block grants, for assistance. A record of efforts to apply for alternative funding sources must be documented in the beneficiary's records, as well as acceptances or denials by these funding sources. The HSW is a funding source of last resort. Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of the beneficiary and are not of direct medical or remedial benefit. Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air-conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs. Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a beneficiary's home. Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner, the beneficiary, and the PIHP must specify any requirements for restoration of the property to its original condition if the occupant moves. If a beneficiary or his family purchases or builds a home while receiving waiver services, it is the beneficiary's or family's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. The HSW does not cover construction costs in a new home, or a home purchased after the beneficiary is enrolled in the waiver. HSW funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, etc.) for a home recently purchased. Environmental modifications for **licensed settings** includes only the remaining balance of previous environmental modification costs that accommodate the specific needs of current waiver beneficiaries, and will be limited to the documented portion being amortized in the mortgage, or the lease cost per bed. Environmental modifications exclude the cost of modifications required for basic foster care licensure or to meet local building codes.

	Adaptations to the **work environment** are limited to those necessary to accommodate the person's individualized needs, and cannot be used to supplant the requirements of Section 504 of the Rehabilitation Act or the Americans with Disabilities Act (ADA), or covered by the Michigan Rehabilitation Services. All services must be provided in accordance with applicable state or local building codes. Assessments and specialized training needed in conjunction with the use of such environmental modifications are included as a part of the cost of the service.
Family Training	Training and counseling services for the families of beneficiaries served on the waiver. For purposes of this service, "family" is defined as the family members who live with or provide care to the beneficiary in the HSW, and may include parent, spouse, children, relatives, foster family, unpaid caregivers, or in-laws. Training includes instructions about treatment regimens and use of equipment specified in the individual plan of services, and includes updates as needed to safely maintain the person at home. Family training goals, and the content, frequency, and duration of the training and/or counseling, should be identified in the beneficiary's individual plan of services. Not included are individuals who are employed to provide waiver services for the beneficiary.
Out-of-Home Nonvocational Habilitation	Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and the supports services, including transportation to and from, incidental to the provision of that assistance that takes place in a non-residential setting, separate from the home or facility in which the beneficiary resides. Examples of incidental support include: ▪ Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where habilitation is provided in the community. ▪ When necessary, helping the person to engage in the habilitation activities (e.g., interpreting). Services must be furnished four or more hours per day on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the beneficiary's plan of service. **(modified per bulletin MSA 06-09 effective 3/15/06)** These supports focus on enabling the person to attain or maintain his maximum functioning level, and should be coordinated with any physical, occupational, or speech therapies listed in the plan of services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Personal Emergency Response Systems (PERS)	Electronic devices that enable beneficiaries to secure help in the event of an emergency. The beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once the button is activated. PERS coverage should be limited to beneficiaries living alone (or living with a roommate who does not provide supports), or who are alone for significant parts of the day; who have no regular support or service provider for those parts of the day; and who would otherwise require extensive routine support and guidance.
Prevocational Services	Services aimed at preparing a beneficiary for paid or unpaid employment, but that are not job task-oriented. They include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. Prevocational services are provided to people not expected to be able to join the general workforce, or to participate in a transitional sheltered workshop within one year (excluding supported employment programs). Transportation provided between the beneficiary's place of residence and the site of the prevocational services, or between habilitation sites, is included as part of the prevocational and/or habilitation services. Activities included in these services are primarily directed at reaching habilitative goals, such as improving attention span and motor skills, not at teaching specific job skills. These services must be reflected in the person's individual plan of services and directed to habilitative objectives rather than employment objectives. When compensated, beneficiaries are paid at less than 50 percent of the minimum wage. This service must not otherwise be available to the beneficiary through the Rehabilitation Act of 1973, or Education of the Handicapped Act (P.L. 94-142). Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for work activity or supported employment services provided by Michigan Rehabilitation Services (MRS). Information must be updated when MRS eligibility conditions change.
Private Duty Nursing (PDN)	Private Duty Nursing (PDN) services are provided to individuals age 21 and older up to a maximum of 16 hours per day and consist of nursing procedures to meet an individual's health needs directly related to his developmental disability. PDN includes the provision of nursing treatments and observation provided by licensed nurses within the scope of the State's Nurse Practice Act consistent with physician's orders. The individual receiving PDN must also require at least one of the following rehabilitative services, whether being provided by natural supports or through the waiver: ▪ Community living supports ▪ Out-of-home non-vocational habilitation ▪ Prevocational or supported employment

	PIHPs must find that the beneficiary meets Medical Criteria I or II. **(modified per bulletin MSA 06-09 effective 3/15/06)** **Medical Criteria I** – The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means: ▪ Mechanical ventilation four or more hours per day or assisted respiration (Bi-PAP or CPAP); or ▪ Oral or tracheostomy suctioning eight or more times in a 24-hour period; or ▪ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or ▪ Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or ▪ Continuous oxygen administration, in combination with a pulse oximeter and a documented need for observations and adjustments in the rate of oxygen administration.
	Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments or interventions (as described in III below) due to a substantiated medical condition directly related to the developmental disability. **(modified per bulletin MSA 06-09 effective 3/15/06)** Definitions: ▪ "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder. ▪ "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

For beneficiaries described in II above, the requirement for frequent episodes of medical instability is applicable only to the initial determination for private duty nursing. A determination of need for continued private duty nursing services is based on the continuous skilled nursing care.

- "Directly related to the developmental disability" means an illness, diagnosis, or syndrome occurred during the developmental period prior to age 22, is likely to continue indefinitely, and results in significant functional limitations in 3 or more areas of life activity. Illnesses or disability acquired after the developmental period, such as stroke or heart conditions, would not be considered directly related to the developmental disability. **(per bulletin MSA 06-09 effective 3/15/06)**
- "Substantiated" means documented in the clinical/medical record, including the nursing notes.

Medical Criteria III – The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

Definitions:

- "Continuous" means at least once every 3 hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled nursing services.
- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to, performing assessments to determine the basis for acting or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; injections; indwelling central venous catheter care; managing mechanical ventilation; oxygen administration and evaluation; and tracheostomy care.

Licensed nurses provide the nursing treatments, observation, and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services.

These services should be provided to a beneficiary at home or in the community. A physician's prescription is required.

The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champus, Worker's Compensation, an indemnity policy, automobile insurance) for private duty nursing and will assist the beneficiary in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.

An exception process to ensure the beneficiary's health, safety and welfare is available if the beneficiary's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the beneficiary's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care, and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition.

Exceptions must be based on the increased identified medical needs of the beneficiary or the impact on the beneficiary's needs due to the unavailability of the primary unpaid caregiver. Consideration for an exception is limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

- A temporary alteration in the beneficiary's care needs, resulting in one or both of the following:
  - A temporary increase in the intensity of required assessments, judgments, and interventions.
  - A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

  The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.
- The temporary inability of the primary unpaid caregiver(s) to provide the required care, as the result of one of the following:
  - In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.

	➢ The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/CMHSP. ➢ The death of an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days. "Inability" is defined as the caregiver is either unable to provide care, or is prevented from providing care. "Primary caregiver" is defined as the caregiver who provides the majority of unpaid care. "Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home Help provider or Community Living Supports staff. This exception is not available if the beneficiary resides in a licensed setting or in a home where all care is provided by paid caregivers. **(per bulletin MSA 06-09 effective 3-15-06)** **Private Duty Nursing is a Medicaid coverage for beneficiaries under age 21 who meet the medical criteria for eligibility and, therefore, private duty nursing services covered by this waiver are not available to that age group. Refer to the Private Duty Nursing Chapter of this manual for additional information.**
Respite Care	Respite is intended for beneficiaries whose primary caregivers typically are the same people day after day (e.g., family members and/or adult family foster care providers), and is provided during those portions of the day when the caregivers are not being paid to provide care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes, and not by respite care.

	Services must only be provided on a short-term basis because of the absence or need for relief of those persons normally providing the care of a waiver beneficiary during times when they are not being paid to provide care. "Short-term" means the respite service is provided during a limited period of time, for example, a few hours, a few days, weekends, or for vacations. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work full-time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver. **(modified per bulletin MSA 06-09 effective 3/15/06)** Respite services may be provided in the following settings: ▪ Waiver beneficiary's home or place of residence. ▪ Licensed foster care home. ▪ Facility approved by the State that is not a private residence, such as: ➢ Group home; or ➢ Licensed respite care facility. ▪ Home of a friend or relative (not the parent of a minor beneficiary or the spouse of the beneficiary served or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with a respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS. Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/MR, nursing facility, or hospital) or MDCH approved day program site is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.
Supports Coordination	Supports coordination involves working with the waiver beneficiary and others that are identified by the beneficiary, such as family member(s), in developing a written individual plan of services (IPOS) through the person-centered planning process. Functions performed by a supports coordinator, coordinator assistant, or supports broker include an assurance of the following: ▪ Planning and/or facilitating planning using person-centered principles. ▪ Developing an IPOS using the person-centered planning process. ▪ Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Habilitation Supports Waiver, other mental health services and community services/supports. ▪ Brokering of providers of services/supports ▪ Assistance with access to entitlements and/or legal representation. ▪ Coordination with the Medicaid Health Plan, Medicaid fee-for-service, or other healthcare providers.

The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, in lieu of a supports coordinator. When a supports coordinator assistant is used, a qualified supports coordinator must supervise the assistant.

The beneficiary may select an independent supports broker to serve as personal agent and perform supports coordination functions. However, parents of a minor-aged beneficiary, spouse or legal guardian of an adult beneficiary may not provide supports broker services to the beneficiary. The primary roles are to assist the beneficiary in making informed decisions about what will work best for him, are consistent with his needs and reflect the beneficiary's circumstances. The supports broker helps the beneficiary explore the availability of community services and supports, housing, and employment and then makes the necessary arrangements to link the beneficiary with those supports. Supports brokerage services offer practical skills training to enable beneficiaries to remain independent, including the provision of information on recruiting/hiring/managing workers, effective communication and problem solving.

Whenever independent supports brokers perform any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or supports coordinator assistant employed by the PIHP or its provider network that assures the other functions above are in place, and that the functions assigned to the supports broker are being performed. The IPOS must clearly identify which functions are the responsibility of the supports coordinator, the supports coordinator assistant and the supports broker. The independent supports broker must work under the supervision of a qualified supports coordinator.

The PIHP must assure that it is not paying for the supports coordinator or supports coordinator assistant and the supports broker to perform the same function. Likewise, when a supports coordinator or supports coordinator assistant facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any supports broker who also attends. During its on-site visits, MDCH will review the IPOS to verify that there is no duplication of service provision when both a supports coordinator or supports coordinator assistant and a supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Support coordinators will work closely with the beneficiary to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports coordination is reported only as face-to-face contact with the beneficiary; however, the function includes not only the face-to-face contact but also related activities (e.g., making telephone calls to schedule appointments or arrange supports) that assure:

- The desires and needs of the beneficiary are determined.
- The supports and services desired and needed by the beneficiary are identified and implemented.
- Persons chosen by the beneficiary are involved in the planning process.
- Housing and employment issues* are addressed.
- Social networks are developed.

	▪ Appointments and meetings are scheduled. ▪ Person-centered planning is provided and independent facilitation of person-centered planning is made available. ▪ Natural and community supports are used. ▪ The quality of the supports and services, as well as the health and safety of the beneficiary, is monitored. ▪ Income/benefits are maximized. ▪ Information is provided to assure the beneficiary (and his representative(s), if applicable) is informed about self-determination. ▪ Monitoring of individual budgets (when applicable) for over- or under-utilization of funds is provided. ▪ Activities are documented. ▪ Plans of supports/services are reviewed at such intervals as are indicated during planning. Additionally, the supports coordinator coordinates with the qualified mental retardation professional (QMRP) on the process of evaluation and reevaluation of beneficiary level of care (e.g., supply status and update information, summarize input from supports providers, planning committee members, etc.). While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverages and/or short-term provision of supports, it may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The frequency and scope of supports coordination contacts must take into consideration health and safety needs of the beneficiary. *Supports coordination does not include any activities defined as Out-of-Home Non-Vocational Habilitation, Prevocational Services, Supported Employment, or CLS. **(per bulletin MSA 06-09 effective 3/15/06)**
Supported Employment	Supported employment is the combination of ongoing support services and paid employment that enables the beneficiary to work in the community. For purposes of this waiver, the definition of "supported employment" is: ▪ Community-based, taking place in integrated work settings where workers with disabilities work alongside people who do not have disabilities. ▪ For beneficiaries with severe disabilities who require ongoing intensive supports such as job coach, employment specialist, or personal assistant.

	Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training, job coach, employment specialist services, personal assistance and consumer-run businesses. Supported employment services cannot be used for capital investment in a consumer-run business. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting. FFP may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as: ▪ Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; ▪ Payments that are passed through to users of supported employment programs; or ▪ Payments for vocational training that is not directly related to an individual's supported employment program. Transportation provided between the beneficiary's place of residence and the site of the supported employment service, or between habilitation sites (in cases where the beneficiary receives habilitation services in more than one place), is included as part of the supported employment and/or habilitation service. This service must not otherwise be available to the beneficiary through the Rehabilitation Act of 1973, as amended, or under the Individuals with Disabilities Education Act (IDEA), or Michigan Rehabilitation Services.

15.2 Supports and Service Provider Qualifications

Providers of Habilitation/Supports Waiver supports and services are chosen by the beneficiary and others assisting him during the person-centered planning process, and must meet the staffing qualifications contained in Michigan's 1915(c) Waiver.

15.2.A. Supports Coordinator Qualifications

- A minimum of a Bachelor's degree in a human services field or be a QMRP as defined in the Definition of Terms subsection.
- One year of experience working with people with developmental disabilities.

15.2.B. Trained Supports Coordinator Assistant Qualifications

- Minimum of equivalent experience (i.e., provides knowledge, skills and abilities similar to supports coordinator qualifications).
- Functions under the supervision of a supports coordinator.

15.2.C. AIDE QUALIFICATIONS

Minimum qualifications are noted below for aide level work (chore, respite, CLS, and out-of-home habilitation). The planning team should also identify other competencies that will assure the best possible outcomes for the beneficiary. Aide level staff who provide services and supports must be:

- At least 18 years of age.
- Able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports.
- Able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed.
- In good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- Able to perform basic first aid procedures.

15.2.D. SUPPORTS BROKER QUALIFICATIONS [NEW SUBSECTION 4/1/06]

- Selected by the beneficiary.
- Demonstrates competence in areas of job responsibilities for supports broker.
- Functions under the supervision of a supports coordinator. **(per bulletin MSA 06-09 effective 3/15/06)**

SECTION 16 – MENTAL HEALTH AND SCHOOL BASED SERVICES

This section is applicable to all PIHP programs/provider requirements and pertains to beneficiaries with mental illness and/or developmental disabilities.

The School-Based Services (SBS) policy requires cooperative agreements between the PIHP and the SBS provider. These agreements are not changed by the policies in this chapter. Any required releases of information are part of the existing requirements of the SBS provider.

The quality assurance standards for SBS also requires the coordination of care with other human service agencies where appropriate, including local public health departments, community mental health agencies and the beneficiary's physician or managed care providers. In addition, enrolled SBS providers are required to cooperate with other human service agencies operating within the same service area and are not expected to replace or substitute services already provided by other agencies.

When a beneficiary receives active treatment from a SBS provider, the services must be coordinated with the PIHP. If the PIHP provides mental health services for a special education student with serious emotional disturbance or a developmental disability, PIHP must coordinate such services and information with special education and other human services agencies serving the student.

(Refer to the School Based Services Chapter of this manual for additional information.)

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)

Certain Medicaid-funded mental health supports and services may be provided, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

Community Inclusion and Participation	The individual uses community services and participates in community activities in the same manner as the typical community citizen. Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with mental retardation).
Independence	"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning. For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.

Productivity	Engaged in activities that result in or lead to maintenance of or increased self-sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness. For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

17.2 Criteria for Authorizing B3 Supports and Services

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter and the MDCH/PIHP Contract, Section 1.2; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in MDCH/PIHP Contract, Attachment P.3.2.1, Medical Necessity Criteria, as amended; and
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.

17.3 B3 Supports and Services

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

17.3.A. Assistive Technology

Assistive technology is an item or set of items that enable the individual to increase his ability to perform activities of daily living with a greater degree of independence than without them; to perceive, control, or communicate with the environment in which he lives. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual plan of service. All

items must be ordered by a physician on a prescription or Certificate of Medical Necessity as defined in the General Information section of this chapter. An order is valid for one year from the date it was signed.

Coverage includes:

- Adaptations to vehicles
- Items necessary for independent living (e.g., Lifeline, sensory integration equipment)
- Communication devices
- Special personal care items that accommodate the person's disability (e.g., reachers, full-spectrum lamp)
- Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions
- Ancillary supplies and equipment necessary for proper functioning of assistive technology items
- Repairs to covered assistive technology that are not covered benefits through other insurances

Assessments by an appropriate health care professional, specialized training needed in conjunction with the use of the equipment, and warranted upkeep will be considered as part of the cost of the services.

Coverage excludes:

- Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home.
- Items that are considered family recreational choices.
- The purchase or lease of a vehicle, and any repairs or routine maintenance to the vehicle.
- Educational supplies required to be provided by the school as specified in the child's Individualized Education Plan.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase.

In order to cover repairs of assistive technology items, there must be documentation in the individual plan of services that the assistive technology continues to meet the criteria for B3 supports and services as well as those in this subsection. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

17.3.B. COMMUNITY LIVING SUPPORTS

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting, reminding, observing, guiding and/or training in the following activities:
  - meal preparation
  - laundry
  - routine, seasonal, and heavy household care and maintenance
  - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
  - shopping for food and other necessities of daily living

  CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance is needed, the beneficiary, with the help of the PIHP case manager or supports coordinator **must** request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. The PIHP case manager or supports coordinator must assist, if necessary, the beneficiary in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization amount, scope and duration of Home Help does not accurately reflect the beneficiary's needs based on findings of the DHS assessment.
- Staff assistance, support and/or training with activities such as:
  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
  - attendance at medical appointments
  - acquiring or procuring goods, other than those listed under shopping, and non-medical services
- Reminding, observing and/or monitoring of medication administration

- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan Personal Care services. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

CLS **assistance** with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

17.3.C. ENHANCED PHARMACY [CHANGE MADE 4/1/06]

Enhanced pharmacy items are physician-ordered, nonprescription "medicine chest" items as specified in the individual's plan of service. There must be documented evidence that the item is not available through Medicaid or other insurances, and is the most cost-effective alternative to meet the beneficiary's need.

The following items are covered only for adult beneficiaries living in independent settings (i.e., own home, apartment where deed or lease is signed by the beneficiary):

- Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
- First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads)

The following items are covered for beneficiaries living in independent settings, with family, or in licensed dependent care settings:

- Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, tooth brushes, anti-plaque rinses, antiseptic mouthwashes)
- Vitamins and minerals
- Special dietary juices and foods that augment, but do not replace, a regular diet
- Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either:
  - A history of aspiration pneumonia, **(modified 4/1/06)** or
  - Documentation that the beneficiary is at risk of insertion of a feeding tube without the thickening agents for safe swallowing.

Coverage excludes:

- Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products)

17.3.D. Environmental Modifications

Physical adaptations to the beneficiary's own home or apartment and/or work place. There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing, or in the case of vehicle modification, alternative transportation. All modifications must be prescribed by a physician. Prior to the environmental modification being authorized, PIHP may require that the beneficiary apply to all applicable funding sources (e.g., housing commission grants, MSHDA, and community development block grants), for assistance. It is expected that the PIHP case manager/supports coordinator will assist the beneficiary in his pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.

Coverage includes:

- The installation of ramps and grab-bars
- Widening of doorways
- Modification of bathroom facilities
- Special floor, wall or window covering that will enable the beneficiary more independence or control over his environment, and/or ensure health and safety
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary
- Assessments by an appropriate health care professional and specialized training needed in conjunction with the use of such environmental modifications
- Central air conditioning when prescribed by a physician and specified as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.
- Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, limited to the requirements for safe operation of the specified equipment.
- Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs

Coverage excludes:

- Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary, or do not support the identified goals of community inclusion and participation, independence or productivity.
- Adaptations or improvements to the home that are of general utility or cosmetic value and are considered to be standard housing obligations of the beneficiary. Examples of exclusions include, but are not limited to, carpeting (see exception above), roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs.
- Cost for construction of a new home or new construction (e.g., additions) in an existing home.
- Environmental modifications costs for improvements exclusively required to meet local building codes
- Adaptations to the work environment that are the requirements of Section 504 of the Rehabilitation Act, or the Americans with Disabilities Act; or are the responsibilities of the Michigan Rehabilitation Services.

The PIHP must assure there is a signed contract with the builder for an environmental modification and the homeowner. It is the responsibility of the PIHP to work with the beneficiary and the builder to ensure that the work is completed as outlined in the contract and that issues are resolved among all parties. In the event that the contract is terminated prior to the completion of the work, Medicaid capitation payments may not be used to pay for any additional costs resulting from the termination of the contract.

The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with all local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance.

The environmental modification must incorporate reasonable and necessary construction standards and comply with applicable state or local building codes. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the beneficiary must specify any requirements for restoration of the property to its original condition if the occupant moves, and must indicate that Medicaid is not obligated for any restoration costs.

If a beneficiary purchases an existing home while receiving Medicaid services, it is the beneficiary's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. Medicaid funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways) for a recently purchased existing home.

17.3.E. Extended Observation Beds (23 Hours)

This program, that must be pre-approved by MDCH (refer to the Programs Requiring Special Approval subsection of this chapter), is a hospital-based service, less than 24 hours in duration, involving rapid diagnosis, treatment and stabilization of an individual with a psychiatric or substance abuse emergency, and that results in sufficient amelioration of the situation to allow the person to be discharged and transferred to an outpatient care service.

17.3.F. Family Support and Training

Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. The services target the family members who are caring for and/or living with an individual receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his ability to achieve goals of:

- performing activities of daily living;
- perceiving, controlling, or communicating with the environment in which he lives; or
- improving his inclusion and participation in the community or productive activity, or opportunities for independent living.

The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's individual plan of service, along with the beneficiary's goal(s) that are being facilitated by this service.

Coverage includes:

- Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the person at home as specified in the individual plan of service.
- Counseling and peer support provided one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.

17.3.G. Housing Assistance

Housing assistance is assistance with short-term, interim, or one-time-only expenses for beneficiaries transitioning from restrictive settings into more independent, integrated living arrangements while in the process of securing other benefits (e.g., SSI) or public programs (e.g., governmental rental assistance and/or home ownership programs) that will become available to assume these obligations and provide needed assistance.

Additional criteria for housing assistance:

- The beneficiary must have in his individual plan of services a goal of independent living, and either live in a home/apartment that he/she owns, rents, or leases; or be in the process of transitioning to such a setting; and
- Documentation of the beneficiary's control (i.e., beneficiary-signed lease, rental agreement, deed) of his living arrangement in the individual plan of service; and
- Documentation of efforts (e.g., the person is on a waiting list) under way to secure other benefits, such as SSI or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these become available they will assume these obligations and provide the needed assistance.

Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to owning or leasing/renting a dwelling
- Limited term or temporary assistance with living expenses for beneficiaries transitioning from restrictive settings
- Interim assistance with utilities, insurance or living expenses when the beneficiary already living in an independent setting experiences a temporary reduction or termination of his own or other community resources
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the individual would be unable to move there, or if already living there, would be forced to leave for health and safety reasons.

Coverage excludes:

- Funding for on-going housing costs
- Costs for room and board that are not directly associated with transition arrangements while securing other benefits
- Home maintenance that is of general utility or cosmetic value and is considered to be a standard housing obligation of the beneficiary

Replacement or repair of appliances should follow the general rules under assistive technology. Repairs to the home must be in compliance with all local codes and be performed by the appropriate contractor (refer to the general rules of the Environmental Modifications subsection of this chapter). Replacement or repair of appliances, and repairs to the home or apartment do not need a prescription or order from a physician.

17.3.H. Peer-Delivered or -Operated Support Services [Change Made 4/1/06]

Peer-delivered or peer-operated support services are programs that provide individuals with opportunities to learn and share coping skills and strategies, move into more active assistance and away from passive patient roles and identities, and to build and/or enhance self-esteem and self-confidence.

17.3.H.1. Peer Specialist Services [New Subsection 4/1/06]

Peer specialist services provide individuals with opportunities to support, mentor and assistant beneficiaries to achieve community inclusion, participation, independence, recovery, resiliency and/or productivity. Peers are individuals who have a unique background and skill level from their experience in utilizing services and supports to achieve their personal goals of community membership, independence and productivity. Peers have a special ability to gain trust and respect of other beneficiaries based on shared experience and perspectives with disabilities, and with planning and negotiating human services systems.

- Vocational assistance provides support for beneficiaries seeking education and/or training opportunities, finding a job, achieving successful employment activities, and developing self-employment opportunities (reported as skill-building or supported employment).
- Housing assistance provides support locating and acquiring appropriate housing for achieving independent living; finding and choosing roommates; utilizing short-term, interim, or one-time-only financial assistance in order to transition from restrictive settings into independent integrated living arrangements; making applications for Section 8 Housing vouchers; managing costs or room and board utilizing an individual budget; purchasing a home; etc. (reported as supports coordination*).
- Services and supports planning and utilization assistance provides assistance and partnership in:
  - The person-centered planning process (reported as either treatment planning or supports coordination*);
  - Developing and applying arrangements that support self-determination;
  - Directly selecting, employing or directing support staff;
  - Sharing stories of recovery and/or advocacy involvement and initiative for the purpose of assisting recovery and self-advocacy;
  - Accessing entitlements;
  - Developing wellness plans;
  - Developing advance directives;
  - Learning about and pursuing alternatives to guardianship;
  - Providing supportive services during crises;
  - Developing, implementing and providing ongoing guidance for advocacy and support groups.

Activities provided by peers are completed in partnership with beneficiaries for the specific purpose of achieving increased beneficiary community inclusion and participation, independence and productivity.

* Peer case managers, supports coordinators or supports specialists must be trained and supervised by a PIHP or CMHSP case manager or supports coordinator who meets the qualifications of case manager or supports coordinator. Peer counselors must be trained and supervised by a qualified mental health therapist.

Individuals providing Peer Support Services must be able to demonstrate their experience in relationship to the types of guidance, support and mentoring activities they will provide. Individuals providing these services should be those generally recognized and accepted to be peers. Beneficiaries utilizing Peer Support Services must freely choose the individual who is providing Peer Support Services. For individuals who are functioning as Peer Support Specialists serving beneficiaries with mental illness, MDCH may require specialized training and/or certification as it deems necessary. **(added per bulletin MSA 06-09 effective 3/15/06)**

17.3.H.2. Drop-In Centers [Changes Made 4/1/06]

Peer-Run Drop-In Centers provide an informal, supportive environment to assist beneficiaries with mental illness in the recovery process. If a beneficiary chooses to participate in Peer-Run Drop-In Center services, such services may be included in an IPOS if medically necessary for the beneficiary. Peer-Run Drop-In Centers provide opportunities to learn and share coping skills and strategies, to move into more active assistance and away from passive patient roles and identities, and to build and/or enhance self-esteem and self-confidence. Under no circumstances may Peer-Run Drop-In Centers be used as respite for caregivers (paid or non-paid) or residential providers of individuals.

PIHPs must seek approval from MDCH prior to establishing new drop-in programs. Proposed drop-in centers will be reviewed against the following criteria:

- Staff and board of directors of the center are 100% primary consumers;
- PIHP actively supports consumers' autonomy and independence in making day-to-day decisions about the program;
- PIHP facilitates consumers' ability to handle the finances of the program;
- The drop-in center is at a non-CMH site;
- The drop-in center has applied for 501(c)(3) non-profit status;
- There is a contract between the drop-in center and the PIHP, or its subcontractor, identifying the roles and responsibilities of each party; and
- There is a liaison appointed by the PIHP to work with the program.

Some beneficiaries use drop-in centers anonymously and do not have a drop-in center listed as a service in their IPOS. For those beneficiaries who do have drop-in specified in their IPOS, it must be documented to be medically necessary and identify:

- Goals and how the program supports those goals; and
- The amount, scope and duration of the services to be delivered.

The individual clinical record provides evidence that the services were delivered consistent with the plan. **(modified per bulletin MSA 06-09 effective 3/15/06)**

17.3.I. Prevention-Direct Service Models

Prevention-direct service models are programs using individual, family and group interventions designed to reduce the incidence of behavioral, emotional or cognitive dysfunction, thus reducing the need for individuals to seek treatment through the public mental health system. One or more of the following direct prevention models must be made available by the PIHP or its provider network:

- Child Care Expulsion Prevention,
- School Success Programs,
- Children of Adults with Mental Illness/Integrated Services,
- Infant Mental Health when not enrolled as a Home-Based program, and
- Parent Education.

Coverage includes:

Child Care Expulsion Prevention (CCEP)	CCEP provides consultation to child care providers and parents who care for children under the age of six who are experiencing behavioral and emotional challenges in their child care settings. Sometimes these challenges may put children at risk of expulsion from the child care setting. CCEP aims to reduce expulsion and increase the number of families and child care providers who successfully nurture the social and emotional development of children 0-5 in licensed child care programs. CCEP programs provide short-term child/family-centered mental health consultation for children with challenging behaviors which includes: ▪ Observation and functional assessment at home and at child care ▪ Individualized plan of service developed by team ▪ Intervention (e.g., coaching and support for parents and providers to learn new ways to interact with child, providing educational resources for parents and providers, modifying the physical environment, connecting family to community resources, providing counseling for families in crisis) Provider qualifications: ▪ Early childhood mental health professional (MA, MSW, PhD)
School Success Program	Works with parents so that they can be more involved in their child's life, monitor and supervise their child's behaviors; works with youth to develop pro-social behaviors, coping mechanisms, and problem solving skills; and consults with teachers in order to assist them in developing relationships with these students. Mental Health staff also act as a liaison between home and school. Provider qualifications: ▪ Mental health therapist (BSW, MSW, or MA)

Children of Adults with Mental Illness/ Integrated Services	Designed to prevent emotional and behavioral disorders among children whose parents are receiving services from the public mental health system and to improve outcomes for adult clients who are parents. The Integrated Services approach includes assessment and service planning for the adult beneficiaries related to their parenting role and their children's needs. Treatment objectives, services, and supports are incorporated into the service plan through a person-centered planning process for the adult beneficiary who is a parent. Linking the adult beneficiary and child to available community services, respite care and providing for crisis planning are essential components. These services are provided by the adult beneficiary's mental health services coordinator and/or therapist employed by or under contract to the PIHP or its provider network.
Infant Mental Health	Provides home-based parent-infant support and intervention services to families where the parent's condition and life circumstances, or the characteristics of the infant, threaten the parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. Services reduce the incidence and prevalence of abuse, neglect, developmental delay, behavioral and emotional disorder. PIHPs or their provider networks may provide infant mental health services as a specific service when it is not part of a Department certified home-based program. Provider qualifications ▪ Masters-prepared mental health therapist who is trained in Infant Mental Health interventions.
Parent Education	Provided to parents using evaluated models that promote nurturing parenting attitudes and skills, teach developmental stages of childhood (including social-emotional developmental stages), teach positive approaches to child behavior/discipline and interventions the parent may utilize to support healthy social and emotional development, and to remediate problem behaviors. Provider qualifications: ▪ Parent education is provided by a mental health professional who is trained in the model.

17.3.J. Respite Care Services

Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the **unpaid** primary care giver. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence
- Licensed family foster care home

- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp
- In community (social/recreational) settings with a respite worker trained, if needed, by the family

Respite care may not be provided in:

- day program settings
- ICF/MRs, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

17.3.K. SKILL-BUILDING ASSISTANCE

Skill-building assistance consists of activities that assist a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the beneficiary's residence or in community settings.

Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for sheltered work services provided by Michigan Rehabilitation Services (MRS). Information must be updated when the beneficiary's MRS eligibility conditions change.

Coverage includes:

- Out-of-home adaptive skills training: Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and supports services incidental to the provision of that assistance, including:
  - Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where adaptive skills training is provided in the community.
  - When necessary, helping the person to engage in the adaptive skills training activities (e.g., interpreting).

Services must be furnished on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services and should be coordinated with any physical, occupational, or speech therapies listed in the plan of supports and services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

- Work preparatory services are aimed at preparing a beneficiary for paid or unpaid employment, but are not job task-oriented. They include teaching such concepts as attendance, task completion, problem solving, and safety. Work preparatory services are provided to people not able to join the general workforce, or are unable to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

  Activities included in these services are directed **primarily** at reaching habilitative goals (e.g., improving attention span and motor skills), not at teaching specific job skills. These services must be reflected in the beneficiary's person-centered plan and directed to habilitative or rehabilitative objectives rather than employment objectives.
- Transportation from the beneficiary's place of residence to the skill building assistance training, between skills training sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Services that would otherwise be available to the beneficiary.

17.3.L. SUPPORT AND SERVICE COORDINATION

Functions performed by a supports coordinator, coordinator assistant, case manager assistant, supports and services broker, or otherwise designated representative of the PIHP that **include** assessing the need for support and service coordination, and assurance of the following:

- Planning and/or facilitating planning using person-centered principles
- Developing an individual plan of service using the person-centered planning process
- Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Specialty Services and Supports and other community services/supports.
- Brokering of providers of services/supports
- Assistance with access to entitlements and/or legal representation
- Coordination with the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers.

The role of supports coordinator **assistant** and the case manager **assistant** is to perform the functions listed above, as they are needed, in lieu of a supports coordinator or case manager. A beneficiary would have only one of the four possible options: targeted case management, supports coordinator, case management assistant, or supports coordinator assistant. When a supports coordinator assistant is used, a qualified supports coordinator must supervise the assistant. When a case manager

assistant is used, a qualified case manager must supervise the assistant. The role and qualifications of the targeted case manager are described in the Targeted Case Management section of this chapter.

A services and supports broker is used to explore the availability of community services and supports, housing, and employment and then to make the necessary arrangement to link the beneficiary with those supports. The role of the supports coordinator, supports coordinator assistant, or case manager assistant when a services and supports broker is used is to perform the remainder of the functions listed above as they are needed, and to assure that brokering of providers of services and supports is performed.

Whenever independent supports and services brokers provide any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or case manager, or their assistant employed by the PIHP or its provider network that assures that the other functions above are in place.

If a beneficiary has both a supports coordinator, assistant case manager, or coordinator assistant, AND a services and supports broker, the individual plan of service must clearly identify the staff who is responsible for each function. The PIHP must assure that it is not paying for the supports coordinator (or supports coordinator assistant or case manager assistant) and the services and supports broker to perform service brokering. Likewise, when a supports coordinator (or supports coordinator assistant or case manager assistant) facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any services and supports broker who also attends. During its annual on-site visits, the MDCH will review individual plans of service to verify that there is no duplication of service provision when both a supports coordinator assistant and a services and supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Supports coordinators will work closely with the beneficiary to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports coordination is reported only as a face-to-face contact with the beneficiary; however, the function includes not only the face-to-face contact but also related activities that assure:

- The desires and needs of the beneficiary are determined
- The supports and services desired and needed by the beneficiary are identified and implemented
- Housing and employment issues are addressed
- Social networks are developed
- Appointments and meetings are scheduled
- Person-centered planning is provided, and independent facilitation of person-centered planning is made available
- Natural and community supports are used

- The quality of the supports and services, as well as the health and safety of the beneficiary, are monitored
- Income/benefits are maximized
- Activities are documented
- Plans of supports/services are reviewed at such intervals as are indicated during planning

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverage and/or short-term provision of supports, it may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The frequency and scope of supports coordination contacts must take into consideration the health and safety needs of the individual.

Qualifications of Supports Coordinators	A minimum of a Bachelor's degree in a human services field and one year of experience working with people with developmental disabilities if supporting that population; or a Bachelor's degree in a human services field and one year of experience with people with mental illness if supporting that population.
Qualifications of Supports Coordinator Assistants, Case Manager Assistants, and Supports and Services Brokers	Minimum of a high school diploma and equivalent experience (i.e., possesses knowledge, skills and abilities similar to supports coordinator qualifications) and functions under the supervision of a qualified supports coordinator. Independent supports and services brokers must meet these qualifications and function under the guidance and oversight of a qualified supports coordinator or case manager.

17.3.M. Supported / Integrated Employment Services

Provide job development, initial and ongoing support services to assist beneficiaries to obtain and maintain paid employment that would otherwise be unachievable without such supports. Supports services are provided continuously as needed throughout the period of employment. Capacity to intervene to provide assistance to the individual and/or employer in episodic occurrences of need is included in this service. Supported/ integrated employment must be provided in integrated work settings where the beneficiary works alongside people who do not have disabilities.

Coverage includes:

- Job development, job placement, job coaching, and long-term follow-along services required to maintain employment.
- Consumer-run businesses (e.g., vocational components of Fairweather Lodges, supported self-employment)

- Transportation provided from the beneficiary's place of residence to the site of the supported employment service, among the supported employment sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Employment preparation.
- Services otherwise available to the beneficiary under the Individuals with Disabilities Education Act (IDEA).

17.3.N. Wraparound Services for Children and Adolescents

Wraparound services for children and adolescents is a highly individualized planning process performed by specialized case managers who coordinate the planning for, and delivery of, wraparound services and incidental non-staff items that are medically necessary for the child beneficiary. The planning process identifies strengths, needs, strategies (staffed services and non-staff items) and outcomes.

Wraparound utilizes a Child and Family Team with team members determined by the family, often representing multiple agencies, and informal supports. The Child and Family Team creates a highly individualized plan of service for the child beneficiary that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, waiver, or B3 services.

The plan may also consist of other non-mental health services that are secured from, and funded by, **other agencies** in the community. The wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child beneficiary and family, and is developed in partnership with other community agencies. This planning process tends to work more effectively with child beneficiaries who, due to safety and other risk factors, require services from multiple systems and informal supports. The Community Team that consists of parents, agency representatives, and other relevant community members oversees wraparound.

Child beneficiaries served in wraparound shall meet two or more of the following:

- Children who are involved in multiple systems.
- Children who are at risk of out-of-home placements or are currently in out-of-home placement.
- Children who have been served through other mental health services with minimal improvement

- The risk factors exceed capacity for traditional community-based options.
- Numerous providers are serving multiple children in a family and the outcomes are not being met.

Wraparound planning and service coordination is reported with procedure code T1016; and items and services purchased with non-Medicaid funds are reported with procedure code H2022 in the encounter data system.

17.3.O. Fiscal Intermediary Services [New Subsection 4/1/06]

Fiscal Intermediary Services is defined as services that assist the adult beneficiary, or a representative identified in the beneficiary's individual plan of services, to meet the beneficiary's goals of community participation and integration, independence or productivity while controlling his individual budget and choosing staff who will provide the services and supports identified in the IPOS and authorized by the PIHP. The fiscal intermediary helps the beneficiary manage and distribute funds contained in the individual budget. Fiscal intermediary services include, but are not limited to:

- Facilitation of the employment of service workers by the beneficiary, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- Tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures;
- Assuring adherence to federal and state laws and regulations; and
- Ensuring compliance with documentation requirements related to management of public funds.

The fiscal intermediary may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include selecting, contracting with or employing and directing providers of services, verification of provider qualifications (including reference and background checks), and assisting the beneficiary to understand billing and documentation requirements.

Fiscal intermediary services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences, and/or do not promote achievement of the goals contained in the beneficiary's plan of service so as to promote independence and inclusive community living for the beneficiary, or when they are acting in a manner that is in conflict with the interests of the beneficiary.

Fiscal intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Neither providers of other covered services to the beneficiary, family members, or guardians of the beneficiary may provide fiscal intermediary services to the beneficiary. **(added per bulletin MSA 06-09 effective 3/15/06)**

SECTION 18 - ADDITIONAL SUBSTANCE ABUSE SERVICES (B3S)

Certain Medicaid-funded substance abuse services may be provided in addition to the Medicaid State Plan Specialty Supports and Services through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). These B3 substance abuse services are to be provided to eligible beneficiaries who both reside in the PIHP's region and request the services. The B3 services may be purchased with the Medicaid capitation or with Medicaid savings as described in the MDCH/PIHP contract. Medicaid funds may not be used to pay for room and board for B3 services.

The PIHP may provide these services only when the service:

- Meets medical necessity criteria for the beneficiary (Refer to MDCH/PIHP Contract, Attachment P.3.2.1, Medical Necessity Criteria); and
- Is based on individualized determination of need; and
- Is cost effective; and
- Does not preclude the provision of a necessary state plan service; and
- Meets access standards contained in the Substance Abuse Services Section, Covered Services subsection of this chapter, including a level of care (LOC) determination based on an evaluation of the six assessment dimensions of the current ASAM Patient Placement Criteria

18.1 SUB-ACUTE DETOXIFICATION

Sub-acute detoxification is defined as medically supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Sub-acute detoxification must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician.

This service is limited to stabilization of the medical effects of the withdrawal, and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting.

Authorization requirements:

- Symptom alleviation is not sufficient for purposes of admission. There must be documentation of current client status that provides evidence the admission is likely to directly assist the beneficiary in the adoption and pursuit of a plan for further appropriate treatment and recovery.
- Admission to sub-acute detoxification must be made based on:
  - Medical necessity criteria
  - AAR service requirements found in the Substance Abuse Services Section, Covered Services subsection of this chapter
  - LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Patient Placement Criteria.
- Initial length-of-stay authorizations may be for up to three days, with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization requirements continue to be met.

18.2 Residential Treatment

Residential Treatment is defined as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program, and treatment is provided by appropriate credentialed professional staff, including substance abuse specialists. Residential treatment must be staffed 24-hours-per-day.

This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment.

Authorization requirements:

- The effects of the substance use disorder must be so significant and the resulting impairment so great that outpatient and intensive outpatient treatments have not been effective or cannot be safely provided, and when the beneficiary provides evidence of willingness to participate in treatment.
- Admissions to Residential Treatment must be based on:
  - Medical necessity criteria
  - AAR service requirements found in the Substance Abuse Services Section, Covered Services subsection of this chapter
  - LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Patient Placement Criteria
- The PIHP may authorize up to 22 days of treatment.
- Additional days may be authorized when authorization requirements continue to be met, if there is evidence of progress in achieving treatment plan goals, and reauthorization is necessary to resolve cognitive and behavioral impairments which prevent the beneficiary from benefiting from less intensive treatment.

CHILDREN'S WAIVER COMMUNITY LIVING SUPPORT SERVICES APPENDIX

SECTION 1 - CHILDREN WITH CHALLENGING BEHAVIORS

1.1 PURPOSE

This Section is to help the CMHSP determine whether the challenging behavioral needs of the child support hourly care and other support services, and to determine the appropriate range of hourly care that can be authorized under the Community Living Support (CLS) waiver service. The following categories do not, in and of themselves, establish eligibility for publicly funded hourly care.

The amount of CLS services (i.e. the number of hours) that can be authorized for a child is based on several factors, including the child's care needs which establish waiver eligibility, child's and family's circumstances, and other resources for daily care (e.g. private health insurance, trusts bequests, private pay). In addition to identifying the family situation and the specific behaviors as described in the category definitions, the following elements contribute to the overall assessment of need:

- Type of behaviors identified;
- Frequency, intensity, and duration of identified behaviors;
- How recently serious behaviors occurred;
- Actual specific effects of the behavior on persons in family and property;
- Level of family intervention required to prevent behavioral episodes;
- Extent to which family must alter normal routine to address behavioral needs of the child;
- Prognosis for change in the child's behavior;
- Whether or not child functions more effectively in any current setting than in other settings; and
- Age, size, and mobility of child.

1.2 CATEGORIES OF CARE

1.2.A. CATEGORY IV

Qualifications	Demonstrates mild level behaviors that may interfere with the daily routine of the family.
Definitions	**Mild Behavior:** Infrequent or intermittent behaviors including pinching, hitting, slapping, kicking, head banging, and/or elopement without careful supervision when there is evidence of lack of judgment regarding danger, or an extremely high activity level requiring extensive supervision and redirection.

1.2.B. CATEGORY III

Qualifications	Demonstrates a daily pattern of medium level behaviors including self-injurious, physically aggressive or assaultive behaviors that have not resulted in hospitalization or emergency room treatment for injuries in the past year, or has engaged in occasional, significant property destruction that is not life-threatening.
Definitions	**Pattern of Behavior:** In addition to a single serious episode in the last year, significant daily behaviors are documented. **Medium Behavior:** Includes behaviors defined in the Category II definition of "moderate behavior" when emergency room treatment or hospitalization have not been required for treatment of injuries resulting from the behavior. Examples include head banging resulting in bleeding and bruising without concussion or detached retina, hair pulling without removing hair from the scalp, smearing feces without PICA, and biting without drawing blood. **Occasional Property Destruction:** Property destruction that occurs with a frequency not greater than one time per week.

1.2.C. CATEGORY II

Qualifications	Demonstrates a daily pattern of moderate self-injurious, physically aggressive or assaultive behavior when medical intervention, or emergency room treatment has been required for treatment of injuries in the past year without resulting hospitalization, or if the child has engaged in frequent, significant property destruction that is not life-threatening.
Definitions	**Moderate Behavior:** Includes behaviors that pose a significant risk of injury to self or others in the immediate environment. Examples include physical assault or self-abuse resulting in injuries requiring hospital emergency room treatment without hospital admission in the past year, biting that breaks the skin, hair pulling resulting in removal of clumps of hair from the scalp, multiple daily episodes of smearing feces with associated PICA, and head banging resulting in documented concussion or detached retina.

1.2.D CATEGORY I

Qualifications	Demonstrates a pattern of severe self-injurious, physically aggressive or assaultive behavior, or life-threatening property destruction that has occurred one or more times in the past year. Documented evidence of additional behavioral problems on a frequent basis each day supports a need for one-to-one intensive behavioral treatment.
Definitions	**Severe Behavior:** Poses a very significant risk of serious injury or death to self, a family member, or others in the immediate environment. Examples include fire setting, physical assault or self-abuse resulting in injuries to self or others requiring inpatient hospital admission for treatment in the past year.

SECTION 2 – MEDICALLY AND PHYSICALLY COMPLEX CHILDREN

2.1 PURPOSE

The purpose of this Section is to help the CMHSP determine whether CLS services are medically necessary. The following categories do not, in and of themselves, establish eligibility for publicly funded hourly care.

2.1.A. CATEGORY IV

Qualifications	A medical condition and requires significant levels of daily assistance or guidance with activities of daily living (ADLs). In addition, medical condition is stable and observations and interventions are required infrequently. Interventions require minimal training and are associated with minimal or no risk to health status.
Examples	Includes levels of support that would exceed those expected for a person of the child's age in the areas of: ▪ Assistance and/or guidance in ADLs including eating, toileting, bathing, grooming, dressing, and mobility (ambulation and transferring); ▪ Assistance and/or guidance with physical transfer (e.g. bed to chair); ▪ Assistance and/or guidance with therapeutic positioning and physical therapy; or ▪ The child weighs 80 pounds or more and is not ambulatory and/or not mobile and unable to assist the primary caregiver.

2.1.B. CATEGORY III

Qualifications	A medical condition that routinely requires daily hourly care or support in order to maintain and/or improve health status. Clinical observations and interventions may be intermittent. Medical interventions are typically associated with minimal risk to health status, and delayed interventions are not associated with imminent risk to health status.
Examples	Includes a combination of interventions such as: ▪ G-tube feedings with no oral suctioning needs; ▪ PRN oxygen administration less often than daily over the past 30 days with or without pulse oximeter; ▪ Daily oxygen administration at less than two liters without pulse oximeter and without the need for on-going judgments and observations for oxygen needs (e.g. routine nightly administration without other skilled nursing interventions); ▪ Catheterization fewer than five times per day; ▪ Routine chest physiotherapy four or more times per day; ▪ Ostomy care;

	▪ Total feeding or formal feeding program requiring more than 45 minutes per meal with need for special trunk-head positioning; ▪ Concurrent diagnosis of severe hypertonicity, severe contractures, or severe scoliosis that requires therapeutic positioning every two hours; or ▪ Documented evidence that positioning causes apnea and cyanosis, and that positioning is limited to positions with the body in less than a 45 degree angle to horizontal plane.

2.1.C. CATEGORY II AND CATEGORY I

Services for Category II and Category I children are covered under the Medicaid State Plan private duty nursing (PDN) benefit. Refer to the Private Duty Nursing Chapter of this manual for PDN coverage criteria.

SECTION 3 – COVERAGE DECISIONS

3.1 DECISION RESPONSIBILITY

The MDCH Children's Waiver Review Team will continue to review all plans of service and current assessments, and prior authorize waiver services, for those children who:

- Qualify for Category of Care I; or
- Any child who has been approved to receive additional CLS hours under the exception process.

The responsible CMHSP, following the Children's Waiver Decision Guide in the following subsection, will review and prior authorize waiver services for those Children's Waiver beneficiaries who are determined to qualify for Categories II, III, or IV.

3.2 DECISION GUIDE

The determination of the amount of hourly care should result from a person-centered planning/family-centered practice process that considers both the child's and family's needs. The Children's Waiver Decision Guide Table below assists in identifying the range of hours provided for children based on their category of care and the family's resources to provide that care. It is expected that hourly care services will be provided within the range for which the child qualifies. Within the four Categories of Care are five sections that apply to the child's family status. In determining the total number of hours, it is acceptable to use the highest range within the appropriate section of the eligible category. If the child is receiving Home Help services, those hours must be considered as part of the total hours allowable. For example, a child determined to have Category III level of care needs is eligible for a maximum of six hours a day while in school. If that child receives two hours per day of Home Help, CWP could then provide a maximum of four hours of CLS staffing per day. The range of hours identified in the guide is an average daily amount that is provided seven days a week, based on a monthly total authorization.

If the child is attending school an average of 25 hours per week, the Section VI maximum would apply unless the maximum exceeds the range qualified for in Sections I-V. In that case, the maximum range in Sections I-V would apply. The Section VI maximum would not be required during school breaks, such as Christmas, Easter, and summer vacations, or if the child is out of school due to illness for 5 or more consecutive days.

CHILDREN'S WAIVER DECISION GUIDE TABLE				
	DOCUMENTED CATEGORY OF NEED FOR HOURLY CARE AUTHORIZATION			
ADDITIONAL FAMILY RESOURCES	CATEGORY IV	CATEGORY III	CATEGORY II	CATEGORY I
Section I – Number of Caregivers 1. Two or more caregivers live in home; both work F/T 2. Two adult caregivers; one works F/T 3. Two adult caregivers; neither is employed 4. One adult caregiver lives in home and works F/T 5. One adult caregiver; does not work F/T	4 - 8 2 - 8 2 - 4 4 - 8 2 - 6	6 - 10 2 - 8 2 - 6 4 - 10 2 - 8	8 - 12 4 - 10 4 - 8 8 - 12 8 - 10	12 - 16 10 - 16 8 - 12 12 - 16 10 - 14
Section II – Health Status of Caregivers 1. Significant health issues 2. Some health issues	6 - 8 4 - 6	6 - 10 4 - 8	10 - 14 8 - 12	12 - 16 10 - 12
Section III – Additional Dependent Children 1. Applicant has one or more siblings age 5 or older 2. Applicant has one or more siblings under age 5	2 - 4 4 - 6	2 - 6 4 - 8	4 - 8 6 - 8	8 - 12 8 - 12
Section IV – Additional Children with Special Needs 1. Applicant has one or more siblings with nursing needs 2. Applicant has one or more siblings with non-nursing special needs	4 - 8 2 - 4	6 - 8 2 - 6	4 - 8 N/A	8 - 12 N/A
Section V – Night Interventions 1. Requires 2 or fewer interventions at night or total time less than one hour 2. Requires 3 or more interventions requiring one hour or more to complete	2 - 4 4 - 8	2 - 6 6 - 8	4 - 8 6 - 10	8 - 12 8 - 12
Section VI – School Child attends school an average of 25 hours per week	6 max	6 max	8 max	12 max

3.3 Decision Guide Table Definitions

The definitions used in each section of the Decision Guide Table are as follows:

SECTION	DEFINITIONS
SECTION I – Number of Caregivers	Caregiver is defined as a legally responsible adult(s) living in the home or adult(s) who is not legally responsible but chooses to participate in providing care for the child. Full-Time (F/T) is defined as a person who works 30 or more hours per week for wages, or a person who attends school 30 or more hours per week.
SECTION II – Health Status of Caregivers	Significant health concerns of a caregiver is defined as one or more of the primary caregivers have a significant health or emotional condition which prevents that caregiver from providing care for the child. Example: A parent that recently had back surgery with full body cast or similar condition. Some health concerns of a caregiver is defined as one or more primary caregivers (as defined above) have a health or emotional condition that interferes with, but does not prevent, provision of care. Examples: Alcoholism, depression, lupus, back pain when lifting, lifting restrictions and similar health concerns; or primary caregiver is in therapy three or more times per month.
SECTION III - Additional Dependent Children	This section applies when the child has one or more siblings or related individuals under age 18, who reside in the home full-time and the caregiver is not paid for providing care.
SECTION IV - Additional Children With Special Needs	Additional special needs are identified when the child has one or more siblings or related individuals who reside in the home and do not currently receive hourly care supports. Siblings with nursing needs are children who meet the criteria for Intensity of Care-High or Intensity of Care-Medium (refer to the Additional Mental Health Services (B3s) Section of this chapter), whether or not those children are developmentally disabled. Siblings without skilled nursing needs are children with needs as identified in Category of Care I-IV definitions.
SECTION V – Night Interventions	If the child requires one or two interventions at night and the time required to complete the interventions is one hour or less, Section V-1 applies. If the child requires an average of three or more interventions per night, or the time required to complete the interventions is more than one hour, Section V-2 applies.

SECTION VI – School	Average hours of school should be used to determine the appropriate range of hours. Include transportation time if provided by the school. The number of hours of school attendance is based on the school year that applies to the child's educational classification. Variations in hours may be seen for children without a summer program. This factor limits the maximum number of hours that can be authorized for a child of any age in a center-based school program for more than 25 hours per week, or a child who has reached the age of 6 and for whom there is no medical justification for a home-bound school program. The school maximum is also waived for that time period when a child is out of school for at least 5 consecutive days due to illness, surgery, or scheduled school breaks.

3.4 Exception Process

The exception process ensures the safety and quality of care of children served by the waiver through consideration of the unique needs of each child and family, and special circumstances that may arise. When occasional relief through respite services is not sufficient, an exception of hourly care may be authorized.

Contingent upon the availability of funds and upon receipt of a Prior Review and Approval Request (PRAR), limited authority to exceed the published hourly care amount defined in the Decision Guide subsection may be granted by the MDCH to a CMHSP to better serve identified children with exceptional care needs. The PRAR must be developed pursuant to family request, person-centered planning/family-centered practice team recommendation, and CMHSP administrative concurrence.

The PRAR must document and substantiate both a current clinical (either medical or psychological) necessity for the exception **and** a current lack of natural supports requisite for the provision of the needed level of care. The hourly care services must be essential to the successful implementation of a plan of active treatment as defined by CMS ICF/MR rules, and any enhancements must be essential to maintain the child within their home. Consideration for an exception will be limited to situations outside the family's control that place the child in jeopardy of serious injury or significant deterioration of health status such as:

- A temporary deterioration of the child's clinical condition (e.g. need for nursing care following an acute hospitalization or surgical procedure, or an acute cyclic exacerbation of challenging behaviors);
- A temporary inability of the primary caregivers to provide the requisite level of care (e.g. an acute illness or injury);
- Health condition requires continuous implementation of high risk medically prescribed procedures requiring licensed nursing personnel that are not already addressed within the Decision Guide subsection. The procedures must be beyond the demonstrated capacity of the parents to provide;
- Behavior treatment needs significantly exceed the recommended ranges for the assigned category of care **and** this exception is essential to prevent an otherwise inevitable (i.e. previously documented) deterioration in behavior. The enhanced staffing must be continuously active in the implementation of the behavior treatment plan;

- Natural supports are unable to provide the requisite level of care (e.g. only available care providers have a physical, mental, or emotional disability or they cannot demonstrate competence with the procedures essential to the implementation of the treatment plan). The plan of service must also address plans to rectify the condition or circumstance.

Exceptions may be granted for a specified period not to exceed 180 days. Renewal requests must substantiate the continuing clinical necessity and lack of natural supports.

Exceptions approved by MDCH can occur in one of the following ways:

- Temporary emergency basis only. Verbal approval can be given to the CMHSP, with written justification to be forwarded to MDCH within 10 days; or
- In a nonemergency situation, the CMHSP provides the MDCH with written documentation of the specific rationale to support the exception (i.e. physician's prescription). This would include a revised Plan of Care, highlighting the care needs to be provided with the additional staffing hours, and all current assessments. A response from MDCH will occur within 10 working days.
- When approval of an exception is not granted through either of the two processes listed above, the family, case manager, or MDCH may request a meeting in order to clarify and reconsider the basis for the exception.

MDCH has the option to request a home visit to meet the child when it is necessary for an effective decision.

3.5 Appeal Process

The child and family have the right, under the Michigan Mental Health Code, to appeal a negative coverage decision to the director of the CMHSP. The child and family may also request a recipient's rights investigation through their CMHSP.

The CMS approval of the Children's Waiver requires the availability of a fair hearing for any Medicaid-eligible child enrolled in the Children's Waiver Program when that child is subject to a negative action. A negative action results when a Medicaid-covered service or benefit is taken away, reduced, or denied to a Medicaid beneficiary. The Medicaid beneficiary must be notified of the negative action in writing. The negative action notice must indicate:

- The beneficiary's right to appeal through the MDCH administrative hearing process;
- The beneficiary has 90 days to submit an appeal; and
- Where to send the appeal.

The MDCH appeal process may occur simultaneously with a recipient's rights or CMHSP administrative appeal process. Individuals and their families are encouraged to resolve disputes regarding waiver services at the local CMHSP level.

The CMHSP is financially responsible for any services that may be approved as a result of the judgment from the administration appeal process.

CHILDREN'S SERIOUS EMOTIONAL DISTURBANCE HOME AND COMMUNITY-BASED SERVICES WAIVER APPENDIX [NEW APPENDIX ADDED 4/1/06]

(Appendix added per bulletin MSA 06-09 effective 4/1/06)

SECTION 1 – GENERAL INFORMATION

The Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW) Program provides services that are enhancements or additions to Medicaid state plan coverage for children up to age 18 with serious emotional disturbance (SED) who are enrolled in the SEDW. MDCH operates the SEDW through contracts with the CMHSPs. The SEDW is a fee-for-service program administered by the CMHSP in partnership with other community agencies. The CMSHP will be held financially responsible for any costs authorized by the CMHSP and incurred on behalf of a SEDW beneficiary.

1.1 KEY PROVISIONS

The SEDW enables Medicaid to fund necessary home and community-based services for children up to age 18 with SED who meet the criteria for admission to a state inpatient psychiatric hospital and who are at risk of hospitalization without waiver services. The CMHSP is responsible for assessment of potential waiver candidates.

Application for the SEDW is made through the CMHSP. The CMHSP is responsible for the coordination of the SEDW services. The Wraparound Facilitator, the child and his family and friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services. All services and supports must be included in an IPOS.

A SEDW beneficiary must receive at least one SED waiver service per month in order to retain eligibility.

1.2 ELIGIBILITY

To be eligible for this waiver, the child must meet medical and financial eligibility criteria below.

1.2.A. MEDICAL CRITERIA

The child must:

- Meet current MDCH contract criteria for the state psychiatric hospital, and
- Demonstrate serious functional limitations that impair his ability to function in the community (functional criteria will be identified using the Child and Adolescent Functional Assessment Scale [CAFAS])
  - CAFAS score of 90 or greater for children age 12 or younger; or
  - CAFAS score of 120 or greater for children ages 13 to 18.

  These scores identify the top 25th percentile of children served by CMHSPs.

1.2.B. Financial Criteria

- Meet criteria for low-income families with children as described in Section 1931 of the Social Security Act; or
- SSI recipients; or
- Optional categorically needy, aged, or disabled individuals who have income at 100% of the federal poverty level (FPL); or
- Special home and community-based waiver individuals who:
  - Would be eligible for Medicaid if they were in an institution; and
  - Have been determined to need home and community-based services in order to remain in the community; and
  - Are covered under the terms of this waiver; and
  - Have a special income level equal to 300% of the SSI Federal Benefits Rate (FBR).

1.3 Coverage Area

Waiver services are limited to 43 children in the counties whose CMHSPs have:

- An approved SED Waiver plan with the MDCH;
- Demonstrated strong collaboration with essential community partners;
- The capacity to provide intensive community-based services; and
- The fiscal capacity to manage interagency funding appropriately.

SECTION 2 – COVERED WAIVER SERVICES

Each child must have a comprehensive IPOS that specifies the services and supports that the child and his family will receive. The IPOS is to be developed through the Wraparound Planning Process. Each child must have a Wraparound Facilitator who is responsible to assist the child/family in identifying, planning and organizing the Child and Family Team, developing the IPOS, and coordinating services and supports. The Wraparound Facilitator is responsible for monitoring supports and service delivery, as well as the health and safety of the child, as part of their regular contact with the child and family, with oversight by the Community Team.

In addition to Medicaid state plan services, children enrolled in the SEDW may receive the SED waiver services as identified in the IPOS.

2.1 COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, thus facilitating a beneficiary's achievement of his goals of community inclusion and remaining in their home. The supports may be provided in the beneficiary's home or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

CLS provides assistance to the family in the care of their child while facilitating the child's independence and integration into the community. The supports, as identified in the IPOS, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. Skills related to activities of daily living (such as personal hygiene, household chores, and socialization) may be included. CLS may also promote communication, relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child enabling the child to attain or maintain their maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Community Living Supports includes:

- Assistance with skill development related to:
  - Activities of daily living (such as personal hygiene);
  - Household chores;
  - Socialization;
  - Improving communication and relationship-building skills; and
  - Participation in leisure and community activities.
- Staff assistance, support and/or training with such activities as:
  - Improving the child's social interactions and internal controls by instilling positive behaviors and increasing resiliency factors that should reduce risk factors;
  - Non-medical care (i.e., not requiring nurse or physician intervention);
  - Transportation (excluding to and from medical appointments) from the beneficiary's home to community activities, among community activities, and from the community activities back to the beneficiary's residence;

- Participation in regular community activities and recreation opportunities (attending classes, movies, concerts and events in a park; volunteering; etc.);
- Assisting the family in relating to and caring for their child;
- Attendance at medical appointments; and
- Acquiring or procuring goods other than those listed as shopping and non-medical services.

- Reminding, observing, rewarding and monitoring of pro-social behaviors.
- Medication administration.
- Staff assistance with preserving the health and safety of the beneficiary in order that he may reside or be supported in the most integrated, independent community setting.

2.2 Family Training/Support

Family Training/Support provides training and counseling services for the families of beneficiaries served by this waiver. For purposes of these services, "family" is defined as the person(s) who lives with or provides care to a beneficiary served by the waiver, and may include a parent and/or siblings or the foster parent(s) for a child in Therapeutic Child Foster Care. Training includes instruction about treatment interventions and support intervention plans specified in the IPOS, and shall include updates as necessary to safely maintain the beneficiary at home.

Family Training/Support is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs and to help the child remain at home. All family training must be included in the child's IPOS and must be provided on a face-to-face basis (i.e., in person and with the family present).

2.3 Respite Care

Respite care is services provided to beneficiaries unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Federal Financial Participation (FFP) may not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care can be provided in the following locations:

- Beneficiary's home or place of residence
- Family friend's home in the community
- Licensed Foster Home
- Licensed Group Home

2.4 Child Therapeutic Foster Care

Child Therapeutic Foster Care (CTFC) is an evidence-based practice. It provides an intensive therapeutic living environment for a child with challenging behaviors. Important components of CTFC include:

- intensive parental supervision,

- positive adult-youth relationships,
- reduced contact with children with challenging behaviors, and
- family behavior management skills.

CTFC seeks to change the negative trajectory of a child's behavior by improving his social adjustment, family adjustment and peer group. CTFC attempts to decrease negative behavior, increase appropriate behavior, and build pro-social skills. Foster parents, teachers, therapists and other adults act as change agents for the child. The change agents contribute to the treatment of the child and the preparation of his family for the child's return to the home and community. Foster parents are specially recruited, trained and supervised. The total number of individuals (including beneficiaries served in the waiver) living in the home who are unrelated to the primary caregiver may not exceed one.

In addition to being licensed, all CTFC programs under this waiver are to be pre-enrolled by MDCH to ensure they meet the requirements set forth in this policy. Separate payment will not be made for homemaker or chore services, for community living services provided by the foster parents, or for respite care furnished for the foster care parents to a child receiving CTFC services since these services are integral to, and inherent in, the provision of CTFC.

2.5 Therapeutic Overnight Camp

A group recreational and skill building service in a camp setting aimed at meeting the goal(s) detailed in the beneficiary's IPOS. A session can be one or more days and nights of camp. Room and Board costs are excluded from the SEDW payment for this service.

Additional criteria:

- Camps are licensed by the Department of Human Services (DHS);
- The child's IPOS includes Therapeutic Overnight Camp; and
- Camp staff is trained in working with children with SED.

Coverage includes:

- Camp fees, including enrollment and other fees;
- Transportation to and from the camp;
- Additional costs for staff with specialized training with this population.

Coverage excludes:

- Room and board for the camp.

2.6 Transitional Services

Transitional services is a one-time-only expense to assist beneficiaries returning to their family home and community while the family is in the process of securing other benefits (e.g., SSI) or resources (e.g., governmental rental assistance and/or home ownership programs) that may be available to assume these obligations and provide needed assistance.

Additional criteria for using Transitional Services:

- The beneficiary must have in his/her IPOS a goal to return to his/her home and community; and
- Documentation of the family's control (i.e., signed lease, rental agreement, deed) of their living arrangement in the family-centered plan of service; and
- Documentation of efforts (e.g., the family is on a waiting list) under way to secure other benefits (such as SSI) or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these benefits become available, they will assume the obligation and provide the needed assistance.

Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to the beneficiary's family home;
- Interim assistance with utilities, insurance, or living expenses when the beneficiary's family, already living in an independent setting, experiences a temporary reduction or termination of their own or other community resources;
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the beneficiary would be unable to move there or, if already living there, would be forced to leave for health and safety reasons.

All services provided must be in accordance with applicable state or local building codes. Standards of value purchasing must be followed. The home maintenance must be the most reasonable alternative, based on the results of a review of all options. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved must be in compliance with any applicable local codes. The home maintenance involved shall exclude costs for improvements required exclusively to meet local building codes. The home maintenance must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The home maintenance or repair cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Coverage excludes those home maintenance or repairs to the home that are:

- Of general utility or are cosmetic;
- Considered to be standard housing obligations of the beneficiary's family;
- Not of direct medical or remedial benefit to the child;
- On-going housing costs;
- Costs for room and board that are not directly associated with transition arrangements while securing other benefits.

Requests for transitional services must be prior authorized by the CMHSP following denial by all other applicable resources (e.g., private insurance, Medicaid). All services shall be provided in accordance with applicable state or local building codes.

2.7 Wraparound Services

Wraparound Service Facilitation and Coordination for Children and Adolescents is a highly individualized planning process performed by specialized wraparound facilitators employed by the CMHSP, other approved community-based mental health and developmental disability services providers, or its provider network who, using the Wraparound model, coordinate the planning for, and delivery of, services and supports that are medically necessary for the child.

The planning process identifies the child's strengths and needs, as well as strategies and outcomes. Wraparound utilizes a Child and Family Team with team members determined by the family, often representing multiple agencies and informal supports. The Child and Family Team creates a highly individualized family-centered plan of service for the child that consists of mental health specialty treatment, services and supports covered by the Medicaid Mental Health State Plan or the SED waiver. The plan may also consist of other non-mental health services that are secured from and funded by other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values, and preferences of the child and family and is developed in partnership with other community agencies. The Community Team, which consists of parents, agency representatives, and other relevant community members, oversees wraparound services.

Coverage includes:

- Planning and/or facilitating planning using the Wraparound process, including at least one monthly face-to-face contact;
- Developing an IPOS utilizing the Wraparound process;
- Linking to, coordinating with, follow-up of, advocacy for, and/or monitoring of SED waiver and other Medicaid State Plan services with the Wraparound Community Team and other community services and supports;
- Brokering of providers of services with the assistance of the Wraparound Community Team;
- Assistance with access to other entitlements; and
- Coordination with the Medicaid Health Plan or other health care providers.

Coverage excludes:

- Case management that is the responsibility of the child welfare, juvenile justice, or foster care systems;
- Case management for legal or court-ordered non-medically necessary services;
- Direct service provision; and
- Services and supports that are the responsibility of other agencies on the Community Team.

2.7.A. Respite and CLS Provider Qualifications

Individuals who provide respite and CLS must, in addition to the specific training, supervision and standards for each support/service, be:

- A responsible adult at least 18 years of age;

- Free from communicable disease;
- Able to read and follow written plans of service/supports as well as beneficiary-specific emergency procedures;
- Able to write legible progress and/or status notes;
- In "good standing" with the law (i.e., not a fugitive from justice, a convicted felon or illegal alien); and
- Able to perform basic first aid and emergency procedures.
- The individual must also have successfully completed Recipient Rights Training.

2.7.B. Wraparound Facilitator Provider Qualifications

Wraparound facilitators must:

- Complete MDCH wraparound training;
- Possess a bachelor's degree in human services or a related field, or other approved work/personal experience in providing direct services or linking of services for children with SED;
- Have a criminal history screen, including state and local child protection agency registries; and
- Be supervised by an individual who meets criteria as a qualified mental health professional who has completed MDCH required training.

2.7.C. Child Therapeutic Foster Care Provider Qualifications

Child Therapeutic Foster Care must be:

- Licensed as a Foster Care Provider (MCL 722.122);
- Certified by DHS;
- Enrolled by MDCH as a CTFC provider; and
- Trained in the child's IPOS.

2.7.D. Therapeutic Overnight Camp Provider Qualifications

Therapeutic Overnight Camps must be:

- Licensed and certified by DHS;
- Trained in the child's IPOS.

NURSING FACILITY

This chapter is comprised of three parts:

The **COVERAGES** portion of the chapter outlines nursing facility requirements for beneficiary eligibility and admission, for providing services, and for informing beneficiaries of their rights and responsibilities.

The **SURVEY, CERTIFICATION & ENFORCEMENT APPENDIX** includes information regarding Medicaid certification of nursing facilities, staff certification, the survey process, and enforcement remedies.

The **COST REPORTING & REIMBURSEMENT APPENDIX** contains Medicaid policy pertaining to nursing facility ownership, reimbursement, costs, and financial reporting.

Nursing Facility

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION

This chapter discusses Medicaid nursing facility coverage which is intended to assist beneficiaries in attaining or maintaining the highest practical physical, mental, and psychosocial well-being and maximize independence and decision-making. The chapter outlines nursing facility requirements for beneficiary eligibility and admission, for providing services, and for informing beneficiaries of their rights and responsibilities.

Nursing facilities provide services to many of the state's most vulnerable citizens. Medicaid, as the primary payer for beneficiaries who reside in nursing facilities, adheres to all State and Federal regulations that govern care provided in these facilities. Governing regulations include, but are not limited to:

- Americans with Disabilities Act (ADA)
- 42 CFR §431, §438, §440, §441, §448, §483, §485, §488
- State Medicaid Operations Manual
- Medicare Catastrophic Coverage Act of 1988, Public Law 100-360
- Certificate of Need Commission §22215, §1819, §1905, §1902
- Social Security Act
- Omnibus Reconciliation Act of 1987 (Public Law 100-203), 1988, 1989, 1990, and 1994
- Michigan Medicaid State Plan

Only those services covered by the Medicaid Program, as outlined in this chapter, are reimbursable. Included is a full description of:

- Covered Services:
  - Services covered by the facility's per diem rate; and
  - Ancillary services that must be billed separately by the service provider.
- Non-Covered Services that the beneficiary may purchase with their patient-pay amount.

A Medicaid-certified nursing facility is defined as a nursing home, county medical care facility, or hospital long-term care unit with Medicaid certification. Also included are swing beds and nursing facilities for Mental Illness (MI) beds as defined in the Federal State Operations Manual (SOM) and/or State Medicaid Policy.

Beneficiary is defined as a Medicaid beneficiary, or a person legally sanctioned to make medical decisions on his behalf (i.e., guardian, conservator, activated Durable Power of Attorney).

Resident is defined as a nursing facility resident (irrespective of payer source) or a person legally sanctioned to make medical decisions on his behalf (i.e., guardian, conservator, activated Durable Power of Attorney).

Individual, as used in this chapter, means any person.

SECTION 2 – QUALITY

The Michigan Department of Community Health (MDCH) is committed to a quality long-term care system that supports people with long-term care needs, regardless of the setting in which the individual receives those services, including nursing facilities, supported living settings, and their own home. Medicaid supports a system that moves away from the traditional medical model for care to one of enhanced beneficiary participation. Nursing facilities with Medicaid certification are expected to assess and plan care with resident participation and to provide services in ways that promote and support person-centered planning and quality service delivery.

2.1 QUALITY INDICATORS

Quality is indicated by the following components:

- Regular, ongoing, and systematic monitoring and revision of individualized plans of care, progress and outcomes by the beneficiary and his support system. In order to participate, beneficiaries may require support, such as regular opportunities and assistance in reviewing key considerations. Planning results should be documented in ways that are meaningful to the beneficiary and useful to people with responsibilities for implementing the plan.
- Risk and safety concerns are considered and plans developed to minimize risk of harm while promoting independence and safety.
- Behavioral interventions and medication management are used only when necessary, and are appropriately managed and monitored.
- Care coordination must support the individual's participation in his care.
- Support for personal responsibility and community relationships that avoid the unintended and detrimental consequences of organizational involvement. Facilities should minimize the disempowerment of beneficiaries or displacement of family members by professional decision-makers and/or service providers, assume the beneficiary is competent and capable of participating in his relationships and the community, and provide assistance and support only when there are unmet needs.
- Individual freedom to exercise civic rights and decision-making authority exists to the maximum extent possible.
- Individuals are free to exercise their due process and grievance rights, and are provided the information necessary to do so.
- Individuals and their support system express satisfaction and the care leads to positive outcomes.
- Diverse cultural and ethnic backgrounds are supported.
- A system of continuous quality improvement that includes input from residents and families.

Current models that utilize person-centered planning and introduce the systems/culture change to support ongoing quality in nursing facilities include, among others, The Eden Alternative™, Wellspring™, and Gentlecare™.

2.2 Quality of Life

Nursing facilities must provide services for residents in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life. Elements of quality of life include dignity, self-determination, participation in community life and in other activities, participation in resident and family groups, and accommodation of needs through the end of life. Quality of life is defined, measured, and evaluated by residents and their support systems, and may include quality of care outcomes.

2.3 Quality of Care

Nursing facilities must meet the needs of residents in compliance with State and Federal laws, rules, codes, and established clinical guidelines and practices. (Refer to the Nursing Facility section of the Directory Appendix for specific website links for Best Practice Information.)

Complaints regarding the quality of care in any Michigan nursing facility can be made to the Health Facility Complaint Line. (Refer to the Nursing Facility Section of the Directory Appendix for contact information.)

SECTION 3 – BENEFICIARY RIGHTS

All nursing facility residents have the right to:

- A dignified existence;
- Self-determination; and
- Communication with, and access to, persons and services inside and outside the facility.

In accordance with Federal and State rules and regulations, nursing facilities are required to protect and promote beneficiary rights. These rights include, but are not limited to:

- The right to exercise their rights as citizens of the United States;
- The right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising their rights;
- The right to receive notice of their rights, rules and regulations, both orally and in writing, in a language that the resident understands;
- Access to their medical records and information;

  (In accordance with Federal regulations, a beneficiary [or his representative] must be allowed to inspect his records within 24 hours [excluding weekends and holidays] of such request. Also, in accordance with Michigan Public Health Code, a beneficiary [or his representative] is entitled to receive and examine an explanation of his bill or an itemized statement setting forth services paid for and services rendered, regardless of the source of payment.)
- The right to be informed about their health status;
- The right to refuse treatment;
- The right to non-discrimination, including non-discrimination based on payment source;
- Notification of covered and noncovered services, and any additional costs;
- Notification of any changes in room, policies, physician, health status, and treatment;
- Protection and appropriate management of resident funds;
- The right to covered services;
- Notification of transfer or relocation;
- The right to pain and symptom management at the end of life; and
- The right to re-admission to the nursing facility and to have their bed held during an emergency hospital stay, as defined in the Holding a Bed subsection of this chapter.

In general, beneficiaries cannot be charged for Medicaid-covered services, except for approved patient-pay amounts, co-pays or deductibles, whether they are enrolled as a fee-for-service beneficiary, MDCH is paying their Health Maintenance Organization (HMO) premium to a contracted health plan, or services are provided under Community Mental Health Services Program (CMHSP) or Substance Abuse Coordinating Agency (CA) capitation. However, beneficiaries may be charged if they choose to obtain a service from an out-of-network or non-participating provider, as long as they have prior knowledge they will be obligated to pay the entire charge and, with that knowledge, they request the service.

Medicaid beneficiaries may not be charged the difference between the provider's charge and the Medicaid payment for a service, nor can they be charged for missed appointments.

Medicaid beneficiaries cannot be charged for the copying of medical records for the purpose of providing them to another health care provider.

SECTION 4 – BENEFICIARY ELIGIBILITY AND ADMISSION PROCESS

4.1 NURSING FACILITY ELIGIBILITY

There are five components for determining eligibility for Medicaid nursing facility reimbursement.

4.1.A. Verification of Medicaid Eligibility

Medicaid payment for nursing facility services for an individual requires a determination of Medicaid eligibility for that individual by the Michigan Department of Human Services (DHS). When a Medicaid-eligible or potentially-eligible individual is admitted to a nursing facility, or when a resident becomes Medicaid eligible while in the facility, the nursing facility must submit the Facility Admission Notice (MSA-2565-C) to the local DHS office to establish/confirm the individual's eligibility for Medicaid benefits. A copy of the form is available on the MDCH website and in the Forms Appendix of this manual.

A facility is considered officially notified of an individual's Medicaid eligibility when they have received the completed MSA-2565-C.

In order for Medicaid to reimburse for nursing facility services, the beneficiary must be in a Medicaid-certified bed.

Federal regulations require annual recertification that residents meet Medicaid financial eligibility requirements. The annual recertification process is performed by the Michigan Department of Human Services.

4.1.B. Correct/Timely Preadmission Screening/Annual Resident Review (PASARR)

The Preadmission Screening/Annual Resident Review (PASARR) process must be performed prior to admission as described in the PASARR Process Section of this chapter.

A Level I Preadmission Screen must be performed for all individuals admitted to a Medicaid-certified nursing facility regardless of payer source. When a Level II evaluation is required, placement options are determined through the federal PASARR screening process requirements. The Level I screening form (Preadmission Screening [PAS]/Annual Resident Review [ARR]; DCH-3877) may be found at the MDCH website. (Refer to the Directory Appendix for website information.)

MDCH performs retrospective reviews, randomly and when indicated, to determine that the nursing facility has complied with federal PASARR requirements.

The nursing facility is required to ensure that the PASARR Level I screening has been completed and passed by the individual prior to admission. MDCH reviews retrospectively to determine that the Level I screening was performed, and that the Level II evaluation was performed when indicated.

MDCH is required to recover any payments made to nursing facilities for the period that a participant may have been admitted to a nursing facility when the PASARR screening process was not completed.

4.1.C. Physician Order for Nursing Facility Services

A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be dated and the physician's degree must appear with the signature. The physician must initial a rubber-stamped signature.

With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (MD or DO) must approve a beneficiary's need for long-term care not more than 30 calendar days prior to the beneficiary's admission to a nursing facility.

For an individual who applies for Medicaid while a resident in a nursing facility, the physician must reaffirm the need for long-term care not more than 30 calendar days prior to the submission of the application for Medicaid eligibility.

4.1.D. Appropriate Placement Based on Michigan Medicaid Nursing Facility Level of Care Determination

4.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination

For nursing facility admissions and readmissions on and after November 1, 2004, nursing facilities must verify beneficiary appropriateness for nursing facility services by completing an electronic web-based version of the Michigan Medicaid Nursing Facility Level of Care (LOC) Determination form. A nursing facility may not bill Medicaid for services provided if the beneficiary does not meet the established criteria identified through the Michigan Medicaid Nursing Facility LOC Determination or Nursing Facility LOC Exception Process, and may not bill the beneficiary unless the beneficiary has been advised of the denial and elects, in advance, to pay privately for services.

Services will only be reimbursed if the determination demonstrates functional/medical eligibility through the electronic web-based tool. Providers must submit the information via the web no later than 14 calendar days following the start of service.

Applicants must be evaluated prior to the start of Medicaid-reimbursable services.

The electronic web-based tool, a copy of the Michigan Medicaid Nursing Facility LOC Determination form, Field Definition Guidelines, and other information referenced in this section are available on the MDCH website. (Refer to the Directory Appendix for website information.) The website also contains contact information for technical support to:

- register to utilize the web-based tool
- complete the LOC Determination form

- complete the exception process
- complete the immediate review process
- transition beneficiaries

The Michigan Medicaid Nursing Facility LOC Determination must be used by a health professional (physician, registered nurse, licensed practical nurse, clinical social worker [BSW or MSW], or physician assistant) representing the proposed provider. Non-clinical staff may perform the evaluation with clinical oversight by a professional. The nursing facility must bill Medicaid for only those residents who meet the criteria.

For residents admitted to the facility prior to November 1, 2004, the Michigan Medicaid Nursing Facility LOC Determination must be applied no earlier than the next anniversary date of their admission to the facility. All residents admitted prior to November 1, 2004 must be evaluated no later than October 31, 2005.

Residents who are assessed at their admission anniversary date, and who qualify under only Door 7, must be offered the opportunity and assistance to transition to the community, but may not be required to do so. In applying the criteria for Door 7, it is assumed that current services provided to residents are necessary to maintain function.

When the nursing facility determines that the resident who has been in the facility for less than 12 months is not eligible for services based on functional/medical criteria, the resident must be provided an adverse action notice and referred to appropriate service programs.

The Michigan Medicaid Nursing Facility LOC Determination must be completed using the electronic web-based tool for:

- All new admissions of Medicaid-eligible applicants where reimbursement is requested beyond co-insurance and deductible amounts.
- All readmissions of Medicaid-eligible applicants where Medicaid reimbursement is requested beyond co-insurance and deductible amounts, and a LOC Determination was not previously completed for the original admission.

  Readmissions in general do not require resubmission of the tool; this applies only if a tool was previously submitted for the resident.

  Example: If a nursing facility resident was transferred to the hospital on November 28, 2004, then readmitted to the nursing facility on December 4, 2004, the LOC Determination must be applied to that resident if he has not been previously screened.

  This protocol must be followed for readmissions from November 1, 2004 through October 31, 2005.
- Non-emergency transfer of Medicaid-eligible residents to another nursing facility, including transfers originating from a nursing facility that is undergoing a voluntary facility closure.

- Disenrollment of a beneficiary from a Medicaid Health Plan which has been paying for nursing facility services.
- Private-pay residents already residing in a nursing facility who are applying for Medicaid as the payer for nursing facility services.
- Dually eligible beneficiaries who wish to return to their Medicaid nursing facility bed and refuse their Medicare SNF benefit following a qualifying Medicare hospital stay.
- Any transfer of a Medicaid-eligible resident from a nursing facility that is undergoing an involuntary facility closure due to federal or state regulatory enforcement action.

  Nursing facilities do not need to complete the entire Michigan Medicaid Nursing Facility LOC Determination criteria, but must submit the information requested on the on-line Emergency/Involuntary Transfer form by selecting "Emergency/Involuntary Transfer" from the bottom of the LOC Determination welcome screen.

  Once admitted into the facility, however, the resident must meet the functional/medical eligibility criteria on an ongoing basis, as with all other residents covered under Medicaid fee-for-service as the primary payer. A proactive discharge plan must be provided to persons who fail to qualify, and an adverse action notice must be issued if appropriate. Retrospective review of transferred residents will still apply.
- Emergency transfer of a Medicaid-eligible resident from a nursing facility experiencing a hazardous condition (e.g., fire, flood, loss of heat) that could cause harm to residents when such transfers have been approved by the State Survey Agency.

  Nursing facilities do not need to complete the entire Michigan Medicaid Nursing Facility LOC Determination criteria, but must submit the information requested on the on-line Emergency/Involuntary Transfer form by selecting "Emergency/Involuntary Transfer" from the bottom of the LOC Determination welcome screen.

  Once admitted into the new facility, however, the resident must meet the functional/medical eligibility criteria on an ongoing basis, as with all other residents covered under Medicaid fee-for-service as the primary payer. A proactive discharge plan must be provided to persons who fail to qualify, and an adverse action notice must be issued if appropriate. Retrospective review of transferred residents will still apply.

Completion of the Michigan Medicaid Nursing Facility LOC Determination is not required for:

- Hospice beneficiaries who are being admitted to the nursing facility for any services.
- Nursing facility readmissions where a Michigan Medicaid Nursing Facility LOC Determination was previously completed for the original admission and the beneficiary met the nursing facility criteria.
- Cases where Medicare is the primary payer of the claim and the facility is only billing Medicaid for hospital leave days.
- Cases where Medicaid reimbursement is requested for coinsurance days.

Process Guidelines define required process steps for use of the electronic web-based tool and application of the criteria, informed choice, and specific discharge planning requirements. The Process Guidelines are available on the MDCH website.

The functional/medical criteria include seven domains of need:

- Activities of Daily Living
- Cognitive Performance
- Physician Involvement
- Treatments and Conditions
- Skilled Rehabilitation Therapies
- Behavior
- Service Dependency

For residents who qualify under one of three of these domains (Physician Involvement, Treatments and Conditions, and Skilled Rehabilitation Therapies), specific restorative nursing plans and assertive discharge planning must be evident and documented within the medical record (except for end-of-life care). These requirements are specified in the Process Guidelines.

The electronic web-based Michigan Medicaid Nursing Facility Level of Care Determination must be completed only once for each admission per individual provider.

4.1.D.2. Nursing Facility Level of Care Exception Process

An exception process is available for those applicants who have demonstrated a significant level of long term care need but do not meet the Michigan Medicaid Nursing Facility LOC Determination criteria. The Nursing Facility LOC Exception Process is initiated when the nursing facility telephones the MDCH designee and requests review after the applicant has been determined ineligible using the electronic web-based tool. The Nursing Facility LOC Exception Criteria is available on the MDCH website. An applicant need trigger only one element to be considered for an exception.

4.1.D.3. Telephone Intake Guidelines

The Telephone Intake Guidelines are questions that identify potential nursing facility residents. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the nursing facility. This document is available on the MDCH website.

4.1.D.4. Ongoing Assessments

The nursing facility must ensure that residents meet the Michigan Medicaid Nursing Facility LOC Determination criteria on an ongoing basis in order for services to be reimbursed by Medicaid. Quarterly and annual Minimum Data Set (MDS) assessments and progress notes must demonstrate that the resident has met the criteria on an ongoing basis.

4.1.D.5. Retrospective Review and Medicaid Recovery

At random and whenever indicated, the MDCH designee will perform retrospective review to validate the Michigan Medicaid Nursing Facility LOC Determination and the quality of Medicaid MDS data overall. If the resident is found to be ineligible for nursing facility services, MDCH will recover all Medicaid payments made for nursing facility services rendered during the period of ineligibility.

4.1.D.6. Adverse Action Notice

When the provider determines that the beneficiary does not qualify for services based on the Michigan Medicaid Nursing Facility LOC Determination, the provider must immediately issue an adverse action notice to the beneficiary or his authorized representative. The provider must also offer the beneficiary referral information about services that may help meet his needs. The action notice must include all of the language of the sample letters for long term care. These letters may be found on the MDCH website.

The beneficiary may request an administrative hearing for a benefit denial. The Administrative Tribunal Policies and Procedures Manual explains the process by which each different case is brought to completion. The manual is available for review on the MDCH website. (Refer to the Directory Appendix for contact information for the Administrative Tribunal.)

When a beneficiary appeals an adverse action notice to the MDCH Administrative Tribunal, the facility must notify MDCH LTC Services of the hearing. (Refer to the Directory Appendix for contact information.) Both a facility representative and an MDCH LTC Services representative must be present at the hearing.

Immediate Review-Adverse Action Notices

The MDCH designee will review all preadmission or continued stay adverse action notices upon request by a beneficiary (or representative). When a beneficiary requests an immediate review before noon of the first working day after the date of receipt of the notice the:

- MDCH designee will request that the nursing facility provide pertinent information by close of business of the first working day after the date the beneficiary (or representative) requests an immediate review.
- MDCH designee will review the records, obtain information from the beneficiary (or representative), and notify the beneficiary (or representative) and the provider of the determination by the first full working day after the date of receipt of the beneficiary's request and the required medical records.
- Beneficiary (or representative) may still request an MDCH appeal of the Level of Care Determination.

Beneficiaries may contact the MDCH designee to request an immediate review. (Refer to the Directory Appendix for contact information.)

4.1.E. Freedom of Choice

When an applicant has qualified for services under the nursing facility level of care criteria, they must be informed of their benefit options and elect to receive services in a specific program. This election must take place prior to initiating nursing facility services under Medicaid.

The applicant (or representative) must be informed of services available through:

- Medicaid-reimbursed nursing facilities
- The MI Choice program
- The Program of All-Inclusive Care for the Elderly (PACE) program, where available.

If applicants are interested in community-based care, the nursing facility must provide appropriate referral information as identified in the Access Guidelines to Medicaid Services for Persons with Long Term Care Needs. The guidelines are available on the MDCH website. Applicants who prefer a community long term care option, but are admitted to a nursing facility because of unavailable slots or other considerations, must also have an active discharge plan documented for at least the first year of care.

Applicants must acknowledge that they have been informed of their program options in writing by signing the Freedom of Choice form that is witnessed by the applicant's representative, when appropriate. A copy of the completed form for non-admissions must be retained for a period of three years. The completed form must be kept in the medical record if the applicant chooses to receive nursing facility services. The Freedom of Choice form is available on the MDCH website.

4.2 Appeals

4.2.A. Individual Appeals

4.2.A.1. Financial Eligibility

A determination that a beneficiary is not financially eligible for Medicaid is an adverse action. Beneficiaries may appeal such an action to DHS.

4.2.A.2. Functional/Medical Eligibility

A determination that a beneficiary is not functionally/medically eligible for nursing facility services is an adverse action. If the beneficiary (or representative) disagrees with the determination, he has the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found on the MDCH website. (Refer to the Directory Appendix for website information.)

4.2.B. Provider Appeals

A retrospective determination that a beneficiary is ineligible for nursing facility services based on review of the functional/medical screening is an adverse action for a nursing facility if MDCH proposes to recover payments made. If the facility disagrees with this

determination, an appeal may be filed with MDCH. Information regarding the MDCH appeal process may be found on the MDCH website. (Refer to the Directory Appendix for website information.)

4.3 Admission Process

Prior to or upon admission, the nursing facility must provide residents and their representatives the following information. The information must be provided both orally and in a written language that the beneficiary understands. Beneficiaries must be provided copies of those items noted with an asterisk (*).

- Rights as identified in federal regulations;
- All rules and regulations governing beneficiary conduct and responsibilities during their stay in the facility; *
- Rights as a Medicaid beneficiary and a list of Medicaid-covered services (services for which the resident may not be charged) as published in the Medicaid "Know your Rights" booklet; *
- Noncovered items and services, as well as the costs, for which the beneficiary may be charged (admission to a facility cannot be denied because the beneficiary is unable to pay in advance for noncovered services); *
- Facility policies regarding protection and maintenance of personal funds; *
- A description of the facility's policies to implement advance directives; *
- Facility policies regarding the availability of hospice care; *
- The name, specialty and contact information of the physician responsible for their care;
- Information about how to apply for Medicare and Medicaid; * and
- How to file a complaint.

Facilities must notify residents and their representatives (both orally and in a written language that the beneficiary understands) of any changes to the information listed above.

Receipt of the above information and any amendments must be acknowledged, in writing, by the beneficiary or his representative. Individual facilities may develop their own documentation for this process.

4.4 Preadmission Contracts

Nursing facilities must abide by all state and federal regulations regarding preadmission contracts.

Nursing facilities are prohibited from requiring a Medicaid-eligible person or a Medicaid beneficiary, his family, or his representative to pay the private-pay rate for a specified time before accepting Medicaid payment as payment in full. Nursing facilities violating this prohibition are subject to the appropriate penalties (i.e., revocation of their Medicaid provider agreement).

SECTION 5 – MEDICAL RECORDS

Nursing facilities are required to maintain a medical record for all residents as outlined in State and Federal statutes and regulations.

Nursing facilities are required to comply with all State and Federal requirements regarding medical record confidentiality, including compliance with all Health Insurance Portability and Accountability Act (HIPAA) requirements regarding privacy.

Nursing facilities must maintain all resident assessments completed within the previous 15 months in the resident's active record. Facilities with a "paperless" system in which clinical records are electronically maintained must be able to produce a paper copy if requested for record review by State surveyors.

Nursing facilities must respect the resident's access to their medical records as required by State and Federal laws and regulations.

SECTION 6 – CARE PLANNING PROCESS

Nursing facility care planning is a continuous and ongoing process of assessment, planning, evaluation, and revision. The purpose of the care planning process is to gather information from a variety of sources, and develop a written strategy to insure that the resident receives services and supports necessary to attain or maintain the highest practical physical, mental, and psychosocial well-being. Sources of information to support care planning include the resident, his family and friends, physicians, specialists, nurses, nurse aides, dietitians, therapists and assessment tools (including the Minimum Data Set [MDS] for Nursing Facility Resident Assessment and Care Screening). A comprehensive plan identifies and addresses all aspects of the resident's health and well-being (physical/medical, emotional, mental, spiritual), not just those services that will be provided by the facility or covered by insurance. Using the principles and essential elements of person-centered planning, facilities are expected to involve residents and their designated support system throughout the entire process.

6.1 PERSON-CENTERED PLANNING

Person-centered planning is an ongoing process that recognizes the worth and dignity of each individual and his ability to choose how supports, services and/or treatment may be used to improve his life. The following principles apply:

- **Participation in planning** – Each individual has unique strengths, abilities and preferences and is able to express preferences and make choices. Each individual can participate in planning his life, with appropriate support if needed.
- **Support for planning** – People trusted by the individual and committed to supporting the individual's choices must be involved in planning for long-term care. The process is dependent on the participation of supportive relationships, such as family members and friends, and encourages their involvement, to the extent that the choices of the individual are reflected. These relationships support the individual's right to choose, even the right to take risks.
- **Outcome orientation** - Person-centered planning is outcome-oriented. The planning should lead to positive outcomes in the individual's life, i.e., helping to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The individual determines what constitutes a positive outcome. For a younger adult with a disability, this may include building a career. For an older person near the end of life, the positive outcomes may include deciding where one dies and who is present.

Evidence of person-centered planning includes:

- An assessment process that offers the opportunity for gathering information concerning each resident's preferences, personal goals, needs and abilities, health status, and other available supports. This information should be used in developing an individualized plan of care. The individual's life plans should give direction to plans with service providers, such as discharge planning from nursing facilities into community-based settings. Nursing facilities should not exclude residents in the care planning process in order to meet facility requirements for writing care plans, obtaining signatures, and so forth.
- An assessment process that includes input from professionals and others chosen by the individual. In addition to the professionals required to participate in care planning, individuals should have support for making informed choices about the additional people and professionals they invite to their person-centered planning meetings. For example, federal guidelines require

an interdisciplinary team that includes a registered nurse who has responsibility for caring for the resident and prepares care plans. In addition, the resident may choose to invite a favorite nurse aide and a former neighbor/caregiver to participate in care planning.

- A plan of care that comprehensively addresses each individual's need for health care and other services in accordance with the individual's preferences and goals.
- Services delivered in accordance with the individualized plan of care.
- Informed choice, which includes, but is not limited to, choosing among covered services and enrolled service providers, decisions about the planning process, and evaluation of the planning and its outcomes. Informed choice means knowing the options in ways that are meaningful to the individual and having information when it is useful, not only at admission, but throughout the care process.
- Support for informed choice, which requires an organizational commitment to provide information and/or experiences that sufficiently inform an individual of their options. This commitment should be met through multiple and flexible means of providing information. These might include alternative forms of communication (e.g., Braille, sign language, audio-recorded documents), hands-on experiences with options, peer support from experienced participants, and so forth.

6.2 Assessment

In collaboration with the resident and individuals identified by the resident, appropriate facility staff must assess residents regularly and as needed to identify their preferences, wishes, goals, outcomes, capabilities, and medical and psychosocial needs. Nursing facilities should use assessment tools that are accessible (e.g., large print, verbal, appropriate language, etc.) to residents and individuals identified by the resident.

Assessment tools must include, but are not limited to, the Minimum Data Set (MDS) for Nursing Facility Resident Assessment and Care Screening. Nursing facilities are expected to use assessment tools and methods that accommodate the needs and preferences of individuals (e.g., mental health assessment tools, self-assessment tools in large print, etc.).

6.3 Minimum Data Set (MDS)

Nursing facilities must conduct a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity. The use of the current federally specified Resident Assessment Instrument (RAI), which includes the MDS, Triggers, Resident Assessment Protocols (RAPS) and utilization guidelines is mandatory. Michigan has made a determination not to have a state-specific Section-S, but reserves the right to develop and require its data collection as need arises.

The MDS assessment must be conducted:

- Promptly upon admission, but no later than 14 days of admission;
- Promptly after a significant change in the resident's physical or mental condition or within two weeks, whichever is sooner; and
- Not less than once every twelve months.

The facility must examine each resident once every three months, revising the assessment as appropriate to ensure its continuing accuracy.

Results of the MDS assessment must be used, in addition to other information gathered and in collaboration with the resident, for developing, reviewing, and revising the resident's plan of care. The assessment must be maintained in the resident's medical record and kept confidential.

Each MDS assessment must be conducted or coordinated (with the appropriate participation of other health professionals) by a licensed, registered nurse who signs and certifies the completion of the assessment. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion. Data accuracy resides with the nursing facility as the source of the data.

A facility must electronically transmit to the State, at least monthly, encoded, accurate, complete MDS data for all assessments conducted since the previous transmission. A facility that fails to transmit electronic RAI data to the State is considered out of compliance and, therefore, subject to enforcement actions. (Refer to the Nursing Facility Certification, Survey and Enforcement Appendix of this chapter.)

An individual who willfully and knowingly certifies a material and false statement, or causes another individual to do so, is subject to a civil money penalty.

Questions about the Resident Assessment Instrument should be directed to the RAI Coordinator in the State Survey Agency. (Refer to the Directory Appendix for contact information.)

Federal regulations require that facilities coordinate the PASARR process and MDS. MDCH recommends that nursing facility administrators establish mechanisms to track completion dates of PAS and ARR evaluations so that, to the maximum extent practicable, they are coordinated with resident assessments and completion of the MDS.

6.4 Preadmission Screening / Annual Resident Review (PASARR)

The Preadmission Screening and Annual Resident Review (PASARR) must be completed for all individuals seeking to enter a nursing facility regardless of payer source. Although not federally mandated, Michigan has elected to require the Annual Resident Review (ARR) for all residents in Medicaid-certified nursing facilities regardless of payer source.

The purpose of the PASARR process is to encourage community care by supporting the placement of individuals with Mental Illness (MI) or Mental Retardation (MR) in a nursing facility only when their medical needs clearly indicate that they require the level of care provided by a nursing facility. For individuals with mental illness or mental retardation, the PASARR process ensures the appropriate determination of the need for nursing facility services and the need for specialized services. The PASARR process also includes an appeals system for individuals who wish to dispute a PASARR determination.

Screening and evaluations performed under PASARR and all PASARR notices must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated.

(Refer to the PASARR Process section of this chapter for additional information.)

6.5 Plan of Care

Nursing facilities are required to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. A written individualized plan of care must be developed in the context of a person-centered planning process in order to specify services and activities, and to accommodate individual needs and preferences. The plan outlines the goals, strengths and needs of the resident and how those will be addressed. A comprehensive plan identifies and addresses all aspects of the resident's health and well being (physical/medical, emotional, mental, spiritual), not just those services that will be provided by the facility or covered by insurance. The plan also identifies the resident's wishes and capabilities regarding the potential of relocation to a lesser level of care and includes discharge planning.

The comprehensive plan of care must be developed with direct involvement of:

- The beneficiary, family and/or his/her representative;
- The attending physician;
- An RN who has assessed the beneficiary, or who is familiar with the assessment;
- Other appropriate staff disciplines; and
- Any other trusted individuals that the beneficiary might wish to include.

Medicaid requires that a nursing facility ensure that a licensed physician supervises a beneficiary's medical care. The physician must review the entire individualized plan of care on an on-going basis. The entire plan of care may include sections for:

- Nursing care;
- Rehabilitative services (if required);
- Medication;
- Treatment;
- Restorative services;
- Diet;
- Activities;
- Special plans for health and safety;
- Continuing care, measurable objectives and timetables;
- Discharge (as appropriate); and
- Mental health services.

All services rendered must be documented and consistent with the written individualized plan of care.

6.6 Evaluation / Re-assessment / Plan Revision

Care planning is a continuous and ongoing process that requires regular re-assessment and revision of the plan of care. Federal guidelines require that the facility examine each resident not less than once every three months, and revise the resident's assessment as appropriate to ensure its continuing accuracy. Re-assessment should also occur with significant changes in the resident's condition and at the request of the resident or his representative. Once the re-assessment is completed, the current plan should be evaluated and revised to meet current goals and needs.

SECTION 7 – PASARR PROCESS

Pre-admission Screening/Annual Resident Review (PASARR) in Michigan is a two-level screening and evaluation process. The Level I screening and Level II evaluation procedures and forms are the same for Pre-admission Screening (PAS) and Annual Resident Review (ARR). The forms may be obtained from the MDCH website.

The PASARR process must be completed:

- Prior to admission to a nursing facility;
- Promptly after a significant change in a resident's physical or mental condition; and
- Not less than annually.

The PASARR process is not required in the following situations:

- When an individual is admitted to an Intermediate Care Facility for the Mentally Retarded (ICF/MR - Provider Type 65).
- When an individual is admitted to and resides in a hospital swing bed. However, the PASARR process must be completed prior to admission if the individual transfers to a nursing facility.
- When an individual is readmitted to a nursing facility after a hospital stay. If the Annual Resident Review date occurs during a period of hospitalization, the screening must be completed within 30 days of admission or readmission to the nursing facility.
- For an individual transferring from one nursing facility to another, with or without an intervening hospital stay, unless a Level I screen has not been performed previously.
- For an individual returning to the nursing facility from therapeutic leave, unless the resident's condition has changed. Therapeutic leave does not change the due date for Annual Resident Review. Advance planning may be necessary to ensure timeliness of review.
- A beneficiary receiving Medicaid hospice services (LOC 16) entering a nursing facility for the five-day hospice respite benefit. A Level I screening must be completed if the beneficiary enters the facility for a length of time beyond the five-day respite period.

  The purpose of the Level I screening is to identify individuals who may be mentally ill or mentally retarded. If the patient is on antipsychotic, antianxiety, or antidepressant medications for purposes of pain control/symptom relief for end of life, note that information on the DCH-3877. This allows the Community Mental Health Services Program (CMHSP) to better evaluate the need for Level II screening. If the patient is on any of the above mentioned psychotropic medication groups for a related mental illness, the CMHSP will determine the need for Level II screening.

The following table outlines screening requirements.

Pre-admission Screening (PAS)	A Level I screening is required for all individuals seeking to enter a nursing facility regardless of payer source, except as noted above. The Level I screening, and the Level II evaluation when indicated, must be completed prior to admission to a nursing facility.

Annual Resident Review (ARR)	All residents in Medicaid-certified nursing facilities must be reviewed at least annually to determine if the resident is in need of mental health services and/or continued nursing care. Annually means within every fourth quarter after the previous Level I screening or Level II evaluation, whether it was completed for admission, condition change, or annual review. The Level I screening must be completed for all residents, and a Level II evaluation must be performed if indicated. If a resident was hospitalized when an ARR was due, the Level I screening must be completed within 30 days of readmission, and any subsequent Level II evaluation must be completed within the quarter following readmission to the nursing facility.
Condition Change	A Level I screening must be completed immediately or, at most, within 14 days when there is a significant change in the resident's mental health, or a physical change that may impact the resident's mental health needs. Federal regulations define a "significant change" as a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan or both. A Level II evaluation must be completed when indicated.
30-Month Rule	During the PASARR process, a nursing facility resident may be identified as no longer in need of nursing services but in need of specialized services. In this situation, if the resident has lived in a nursing facility for 30 continuous months, the CMHSP must advise the individual of their options, which may include community placement with specialized services or continued residence in the nursing facility with specialized services. Under these circumstances, no appeal needs to be filed in order to maintain nursing facility residency. The individual's status as a long-term resident must be evident in their nursing facility medical record. Individuals determined to need specialized services, who have resided in a nursing facility for less than 30 months, and who are found to no longer need nursing services must be assisted to transition to a more appropriate setting.
Transfer Trauma	Transfer trauma protections (see Transfer Trauma subsection in this chapter) apply to mentally ill or mentally retarded individuals determined to not need nursing facility services during PASARR Level II evaluations.

7.1 LEVEL I SCREENING

The purpose of the Level I Screening is to identify individuals who may be mentally ill or mentally retarded. Level I Screening is documented on the "Preadmission Screening (PAS)/Annual Resident Review (ARR) (Mental Illness/Developmental Disability Identification)" form (DCH-3877). (Refer to the Forms Appendix for a sample form.) The DCH-3877 must be completed and signed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or physician.

The professional who completes the Level I Screening must provide a copy of the DCH-3877 to the prospective nursing facility resident or their legal representative. Notification must also be adapted to the cultural background, language, ethnic origin and means of communication of the person being evaluated. (For the distribution of forms and documentation, refer to the Distribution of PASARR Documentation subsection later in this section.)

The following table contains a list of psychopharmacological drugs that may indicate the presence of a mental illness. Included are examples of anti-depressant and anti-psychotic medications. The list is not meant to be all-inclusive.

Anti-Depressant Medications	
Generic Name	**Brand Name**
Amitriptyline Hydrochloride	Elavil
Bupropion Hydrochloride	Wellbutrin
Citalopam	Celexa
Doxepin Hydrochloride	Sinequan
Fluoxetine Hydrochloride	Prozac
Fluroxamine	Luvox
Imipramine Hydrochloride	Tofranil
Mirtazapine	Remeron
Netazodone Hydrochloride	Serzone
Nortiptyline Hydrochloride	Aventyl, Pamelor
Paroxitine	Paxil
Sertraline Hydrochloride	Zoloft
Trazodone Hydrochloride	Desyrel
Venlafaxine Hydrochloride	Effexor

Anti-Psychotic Medications	
Generic Name	**Brand Name**
Chlorpromazine Hydrochloride	Thorazine
Clozapine	Clozaril
Fluphenazine Hydrochloride	Prolixin
Haloperidol	Haldol
Loxapine Hydrochloride	Loxitane
Mesorldazine Besylate	Serentil
Olanzapine	Zyprexa
Quetiapine Fumarate	Seroquel
Risperidone	Risperdal
Thioridazine Hydrochloride	Mellaril
Thiothixene	Navane
Trifluoperazine Hydrochloride	Stelazine
Ziprasidone	Geodon

Miscellaneous Products	
Generic Name	**Brand Name**
Lithium Citrate	Cibalith-S
Lithium Carbonate	Eskalith, Lithobid

7.2 Level II Evaluation

The purpose of the Level II evaluation is to assess individuals who are identified as mentally ill or mentally retarded to determine the need for nursing facility services, specialized services, and/or mental health services. All individuals identified by Level I screening as possibly mentally ill or mentally retarded (a "yes" response to any question on the Level I screening form, DCH-3877) must receive a Level II evaluation, unless it is documented that they meet one of the exemption criteria outlined in the next subsection, or the MDCH/CMHSP finds that the individual does not meet the criteria for a serious mental illness under the PASARR provisions. The CMHSP is responsible for providing the nursing facility and the individual and/or legal representative with written documentation that the individual does not meet the PASARR criteria for a serious mental illness. If the individual is seeking admission to a nursing facility, the Level II evaluation, when indicated, must be completed prior to admission.

7.3 Level II Evaluation Exemption

The Level II evaluation exemption form (DCH-3878) is used to claim an exemption to Level II evaluations. If the individual qualifies for an exemption to the Level II evaluation based on the criteria outlined below, the DCH-3878, "Mental Illness/Developmental Disability Exemption Criteria Certification" form must be completed. (Refer to the Forms Appendix for a sample form.) The DCH-3878 may be completed by a registered nurse, a certified or registered social worker, psychologist, physician's assistant, or physician and must be signed by a physician.

Exemptions to the Level II evaluation may be requested based on the following criteria:

- The individual is in a coma. If the individual is in a coma at the time the Level II evaluation is to be performed, the individual may be exempted from the Level II evaluation process. A physician must certify that the individual is in a coma. The individual may then be admitted to the nursing facility without a Level II evaluation. When the individual is no longer in a coma, the nursing facility must complete a Level I screening and refer for a Level II evaluation, if indicated.
- The individual has a primary diagnosis of dementia (such as Alzheimer's disease or another dementing illness). An exemption due to dementia cannot be claimed for any individual who is also identified as being mentally retarded or having a related condition, or for any individual with another primary psychiatric diagnosis. For example, an individual with dementia alone may be exempted. An individual diagnosed with dementia and depression may not be exempted. A physician must certify that the individual meets the clinical criteria for dementia and does not have another primary psychiatric diagnosis, mental retardation, or a related condition.
- The individual is convalescing after hospitalization for an acute illness and meets **all** of the following conditions:
  - The individual will be admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital. Treatment in an emergency room is not considered a hospital stay. An individual who received inpatient treatment in a psychiatric facility cannot be admitted to a nursing facility claiming this exemption, nor can an individual who comes directly from home or any other community placement.
  - The individual requires nursing facility services for the condition for which they received care in the hospital.
  - The attending physician has certified before admission to the nursing facility that the individual is likely to require less than 30 days nursing facility services.

Medicaid approves payment for a hospital discharge/convalescent care stay up to 30 days only. If the individual needs nursing care beyond 30 days, the nursing facility must notify the local CMHSP at least five working days before the end of the 30-day stay that a Level II evaluation is needed. The local CMHSP completes the Level II evaluation within 14 days of the date of notification and forwards the evaluation to MDCH. The entire determination process must be completed within 40 days of the individual's admission from the hospital. If MDCH determines that the individual no longer requires nursing facility services, Medicaid reimburses up to five days beyond the date of the determination to allow for appropriate discharge planning. It is expected that a nursing facility will begin discharge planning for residents at the time of admission from the hospital and discontinue this planning only when a determination is made that the resident will not be discharged from the nursing facility.

The person completing the Level II evaluation exemption must provide a copy of the DCH-3877 to the prospective nursing facility resident or their legal representative. Notification must also be adapted to the cultural background, language, ethnic origin and means of communication of the person being evaluated. (Refer to the Distribution of PASARR Documentation subsection of this chapter for additional information.)

7.4 Level II Evaluation Completion

Individuals who are identified at the Level I screening as having a mental illness or mental retardation, and who do not meet exemption criteria outlined previously, must be referred to the local CMHSP for a Level II evaluation. Level II evaluations are conducted by mental health professionals through the local CMHSP under contract with MDCH. The evaluation involves an interview with the individual, review of medical records, and consultation with nursing facility and/or hospital staff. The mental health professional must conduct the Level II evaluation in accordance with the MDCH OBRA Operations Manual. A copy of this manual may be requested from the MDCH OBRA office or the local CMHSP.

When a Level II Evaluation is required, it must be completed prior to nursing facility admission.

When a Level II evaluation is indicated for an Annual Resident Review (ARR), the nursing facility must notify the local CMHSP of the need for the Level II evaluation at least 30 days prior to the due date of the ARR by sending them a new DCH-3877 (Level I screening form). For example, if the initial Level II evaluation was completed on April 15, 2004, the ARR is due April 15, 2005, and the facility must notify the local CMHSP that a new Level II is due by March 15, 2005. The local CMHSP is responsible for timely completion of Level II evaluations and for providing facilities with written documentation of PASARR determinations in a timely manner.

Once completed, the CMHSP forwards all documentation of the Level II evaluation to MDCH. Based on this documentation, MDCH determines whether the individual requires nursing facility services or can be served in an alternate setting. MDCH also determines whether specialized services or other mental health services are needed to treat the individual's mental illness or mental retardation.

MDCH's decision regarding the need for nursing facility services and the need for specialized services is forwarded to the referring CMHSP. It is the responsibility of the CMHSP to explain the evaluation and determination to the individual and his legal representative within 30 days. The CMHSP must provide a copy of the evaluation and the MDCH determination letter to the individual and his representative, and explain the appeal rights to the individual and their legal representative. This information must also be adapted to the cultural background, language, ethnic origin and means of communication of the individual being evaluated.

The local CMHSP notifies the attending physician, nursing facility, and discharging hospital of the results of the evaluation and the MDCH determination in writing within 30 days of the review. A copy of this notification must be retained in the individual's record. (Refer to the Distribution of PASARR Documentation subsection of this chapter for additional information.)

Given that all other admission criteria outlined in this chapter are met, a nursing facility may admit an individual on the basis of a verbal Pre-admission Screening determination from MDCH. This determination may be communicated to the nursing facility by the CMHSP.

If the facility does not receive a written determination as follow-up to a verbal determination within 30 days of an admission, the facility must send a written reminder to the CMHSP and the MDCH OBRA Office within 45 days of the admission. (Refer to the Directory Appendix for contact information.)

The nursing facility is responsible for verifying that required PAS and ARR processes are completed and documented in the resident's record. The nursing facility medical record must include the determinations of the level of care, the need for specialized services, the original DCH-3877 and DCH-3878 forms, and the Level II evaluation report and supporting documents.

7.5 Distribution of PASARR Documentation

The following chart shows the correct distribution of copies of PASARR forms (DCH-3877, DCH-3878) and Level II evaluation documentation. All originals must be fully completed and signed.

Level I Screening Documentation (DCH-3877)		
Original	Nursing facility record	All nursing facility admissions
Copy	Individual or their representative	All nursing facility admissions
Copy	CMHSP	If "yes" answer(s)
Copy	MDCH via local CMHSP	If "yes" answer(s) and no exemption criteria met

Documentation of Exemption to Level II Evaluation (DCH-3878)	
Original	Nursing facility record
Copy	Individual or their representative
Copy	CMHSP
Copy	MDCH via local CMHSP

Level II Evaluation Documentation	
Original	MDCH OBRA Office
Copy	CMHSP
Copy	Individual or their representative
Copy	Nursing facility
Copy	Hospital, attending physician

MDCH Determination	
Original	CMHSP
Copy	MDCH
Copy	Individual or their representative
Copy	Hospital, attending physician
Copy	Nursing facility

7.6 Compliance

Failure of a nursing facility to comply with OBRA PASARR requirements will result in the loss of Medicaid reimbursement to the facility for services provided for that resident for any period during which a correct and timely screening or review was not completed for that resident. A claim should not be submitted for dates of services provided during periods for which required Pre-admission Screening or Annual Resident Review has not been completed.

The resident or parties responsible for the resident cannot be charged for the loss of reimbursement caused by the facility's failure to meet PASARR requirements.

The Level I screening is considered completed when the DCH-3877 has been filled out, signed, and distributed or, if exemption criteria are met, both the DCH-3877 and DCH-3878 have been filled out, signed, and distributed. The Level II evaluation process is completed when the CMHSP has completed the evaluation and the individual has been notified of the MDCH determination.

For a screening or evaluation to be correct, the completed forms must contain information consistent with documentation in the resident's nursing facility medical record.

Compliance is monitored through the survey process, complaint investigations, and audits. Retrospective payment adjustments through interim gross adjustments and/or final settlements are made to recover funds as necessary. A nursing facility is not penalized for failures to meet PASARR provisions for which it is not responsible and/or could not prevent.

7.7 Appeals of PASARR Determinations

Individuals adversely affected by PASARR determinations may appeal the determination or another person may appeal the determination on their behalf. Examples may include the determination that the individual no longer requires specialized services when they have received those services in the past and wish to continue. An individual may decline nursing facility admission or specialized services without appeal.

Information regarding the MDCH administrative hearing (appeal) process is available on the MDCH website. (Refer to the Directory Appendix for website information.)

7.8 Complaints

Complaints or concerns regarding a nursing facility's implementation of the PASARR regulations should be directed to the Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)

Complaints or concerns about local CMHSP implementation of PASARR policy should be sent to the MDCH OBRA Office. (Refer to the Directory Appendix for contact information.)

SECTION 8 – MEDICAID COVERED AND NON-COVERED SERVICES

Determination of medical necessity and appropriateness of Medicaid services is the responsibility of the attending physician (MD or DO) and is subject to MDCH review. Services must be within the scope of currently accepted medical practice, limitations of the Medicaid Program, and State and Federal requirements.

8.1 MEDICARE-COVERED SERVICES

For Medicare-covered services, MDCH only pays up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance and deductibles) or the Medicaid fee screen, whichever is less. This limitation also applies if the beneficiary is eligible for, but not enrolled in, Medicare. In addition, Medicaid covers the coinsurance and deductible amounts on any Medicare-covered service not normally covered by Medicaid.

If the beneficiary has a Medicare benefit available, that benefit must be utilized before Medicaid pays any portion of the claim. If a beneficiary who has Medicare coverage is receiving services under CMHSP or CA capitation, the CMHSP/CA assumes the MDCH payment liability described in this section.

For Medicare coinsurance days billed to Medicaid, the beneficiary may be in either a Medicare certified or Medicare/Medicaid dually certified bed.

Prior authorization is not required for billing the Medicare deductible and coinsurance amounts, even if the service would require prior authorization if Medicaid were the payer. However, if the facility is uncertain of Medicare coverage, prior authorization from Medicaid should still be obtained. This allows the facility to render the service, bill Medicare and then, if appropriate, bill Medicaid for its share of the service. If Medicare Part B covers an item or service that is included in the Medicaid per diem, the nursing facility is responsible for any coinsurance or deductible, even when billed by an ancillary provider.

Services for which Medicare has made a payment may not be used to offset the patient-pay amount. Coinsurance amounts are charged to the patient-pay amount, and Medicaid reimburses any applicable difference between the patient-pay amount and the coinsurance rate.

If a beneficiary has Medicare Part B coverage, and Medicare does not cover a service, Medicaid considers the service to be included in the Medicaid reimbursement for routine nursing care.

8.2 MEDICARE DENIAL OF BASIC CARE

Medicare covers only skilled care. Medicaid covers both basic and skilled care. In the event a dually eligible Medicare/Medicaid beneficiary requires basic care, Medicaid will cover the service if all other admission criteria are met (e.g., physician order for nursing facility care and beneficiary meets the Medicaid Nursing Facility LOC Determination for NF care).

8.3 Medicaid Reimbursement for a Nursing Facility Bed Following a Qualifying Medicare Hospital Stay

A dually eligible beneficiary who resides in a Medicaid-only certified bed and is admitted to a hospital for acute care services may be eligible for Medicare-reimbursed Skilled Nursing Facility (SNF) benefits at the time of hospital discharge. If that beneficiary wants to return to the Medicaid NF bed he originally occupied, he may refuse his Medicare SNF benefit and Medicaid will reimburse for all medically necessary nursing facility days and other medically necessary services. The days billed to Medicaid must be included in the Medicaid census statistics.

The nursing facility must advise beneficiaries of their right to refuse their Medicare SNF benefit in order to return to their Medicaid NF bed. This notice must be in a manner that the beneficiary, family member, or beneficiary's legal representative can understand or have clearly explained to them as needed.

8.3.A. Required Documentation

The facility must maintain, in the beneficiary's clinical and fiscal record, documentation that supports the beneficiary made the choice to forego Medicare-reimbursed services and return to his Medicaid-only certified bed. This documentation must be signed and dated by the beneficiary (or his authorized representative) and a nursing facility representative.

8.3.B. Medicare Part B

Required outpatient physical or occupational therapy, or outpatient speech pathology for NF beneficiaries must be provided and billed under Medicare Part B where applicable, even if no payments are made under Medicare Part A for the nursing facility stay.

8.4 Other Insurance

Many Medicaid beneficiaries have insurance coverage (either traditional health insurance or an HMO) through private and/or employer-based commercial policies. That insurance is always primary, and the rules of that insurer must be followed. This includes, but is not limited to, prior authorization requirements, qualifications of providers, and providing services through the insurer's provider network. MDCH does not pay for services denied by the primary insurer because the primary insurer's rules were not followed.

MDCH pays appropriate copays and deductibles up to the beneficiary's financial obligation to pay or the Medicaid fee screen, whichever is less. If the primary insurer has negotiated a rate for a service that is lower than the Medicaid fee screen, MDCH cannot be billed more than the negotiated rate. Medicaid-covered services not included in the primary insurer's plan are reimbursed by MDCH up to the Medicaid fee screen if all MDCH coverage rules are followed. If a beneficiary with other insurance coverage is enrolled in a MHP, or is receiving services under CMHSP or CA capitation, the MHP/CMHSP/CA assumes the MDCH payment liabilities described in this section.

8.5 Payment for Non-covered Services

For necessary medical or remedial care recognized under the State law but not covered by the Medicaid Program, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows nursing facility beneficiaries to access their patient-pay amount to pay for these services. If Medicare covers the medical service, then Medicaid will continue to cover the Medicare deductible and coinsurance in the event it does not exceed the Medicaid fee screen.

SECTION 9 - MEDICAID SERVICE DESCRIPTIONS

The following table outlines those services that are included in the facility's per diem rate or are an ancillary service that may be provided to beneficiaries in a nursing facility. Following the table is a more detailed description of each service.

The nursing facility should contact the ancillary provider or Medicaid Provider Inquiry Line to confirm Medicaid coverage of ancillary services.

All services required as a condition of licensure/certification are included in the per diem rate.

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Administrative Services	X		
Admission Kits (Limited to routine personal hygiene items (See Personal Hygiene Items description)	X		
Alcohol Abuse Treatment (See Substance Abuse Services and Treatment description)		X	
Ambulance Services – Emergency and non-Emergency (See Transportation description)		X	
Ancillary Services			X (some)
Beauty and Barber Services			X
Chiropractic Services		X	
Daily Oral Hygiene and Supplies (See Dental Services description)	X		
Dental Services		X	
Dietary Services and Food (including enteral tube feeding formula, supplies and equipment)	X		
Drug Dependency Treatment (See Substance Abuse Services and Treatment description)		X	
Dry Cleaning (See Laundry Services description)			X
Durable Medical Equipment – customized equipment		X	
Durable Medical Equipment – standard equipment	X		
End of Life Care	X		
Enrichment Programs	X		
Family Planning Services		X	
Food (See Dietary Services and Food description)	X		
Foot Care – Routine (See Podiatry Services description)	X		
Hearing Services		X	
Hospice Services – Nursing Facility Responsibility	X		

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Hospice Services – Hospice Responsibility		X	
Hospital Services (Inpatient and Outpatient)		X	
Housekeeping and Maintenance	X		
Intravenous Therapy – nursing supplies, equipment (including all pumps)	X		
Intravenous Therapy – pharmaceuticals		X	
Laboratory Services – routine	X		
Laboratory Services Requiring Special Laboratory and Professional Laboratory Staff		X	
Laundry Services	X		
Medically-Related Social Services	X		
Medication Reviews (See Pharmacy description)	X		
Mental Health Services – facility provided	X		
Mental Health Services – local CMHSP and referrals		X	
Nurse Aide Attendance for Medical Appointments (See Transportation description)	X		
Nursing Care – routine	X		
Orthotics		X	
Oxygen - intermittent and infrequent	X		
Oxygen – daily use		X	
Personal Comfort Items			X
Personal Hygiene Items	X		
Pharmacy – Medicaid Covered Over-the-Counter Drugs		X	
Pharmacy – Routine Over-the-Counter Drugs	X		
Pharmacy— Prescription Drugs		X	
Physician Services		X	
Podiatry Services		X	
Private Duty Nursing in a Nursing Facility			X
Private Room (if medically necessary)	X		
Private Room (no medical necessity)			X
Prosthetics		X	
Radiology		X	
Supplies and Accessories	X		
Therapies – Routine maintenance	X		
Therapies – Non-routine		X	
Total Parenteral Nutritional Formula, Equipment and Supplies (See Dietary Services and Food description)		X	

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Transportation Services - non-emergency	X		
Vaccines	X		
Vision Services		X	
Wound Dressings (see Supplies and Accessories)	X	X (some)	

9.1 Administrative Services

Nursing facilities must be administered in a manner that effectively and efficiently uses its resources to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in compliance with all applicable State and Federal licensure and certification laws, codes and regulations. Services rendered in the general administration of the facility are included in the facility's per diem rate. Services include, but are not limited to:

- Arranging appointments;
- Building, equipment, and grounds maintenance;
- Development, adoption, and posting of patient rights;
- Development of disaster plans;
- Development of patient councils;
- Infection control;
- Insect and vermin control;
- Management of patient trust funds;
- Nursing care determinations;
- Quality control;
- Record keeping; and
- Utilization control.

9.2 Admission Kits

Routine personal hygiene items in an admission kit are included in the per diem rate. Nonroutine personal hygiene items in an admission kit are not reimbursable and are not allowable costs.

9.3 Ancillary Services

Ancillary services (i.e., services other than daily care services) must be ordered and documented, in writing, by the beneficiary's attending physician, and the documentation must be retained in the beneficiary's medical record. The physician's signature on prior authorization forms, treatment plans, etc., certifies the necessity of ancillary services. The physician must review the beneficiary's progress resulting from the ancillary service not less than every 60 days and summarize the progress resulting from the ancillary service provided.

The orders must be for a specific beneficiary (no blanket orders) and prior to the service being rendered. Orders may be received by telephone but must be written in the beneficiary's medical record. Such services must be provided and billed by the appropriate enrolled provider. It is suggested that the facility contact the ancillary provider or the Medicaid Provider Inquiry Line to ascertain whether the service is covered prior to arranging for the provision of the service. (Refer to the Directory Appendix for contact information.)

The facility is responsible for arranging all ancillary and non-covered medical services. Arranging appointments and transportation for these services is included in the per diem rate.

The beneficiary or beneficiary's representative may choose to purchase non-covered services directly from an ancillary provider. The beneficiary pays the ancillary provider directly for the services provided. The nursing facility must retain, in the beneficiary's fiscal record, receipts showing that the beneficiary paid for the particular non-covered service. Medicaid post-payment reviews will be conducted to assure that the beneficiary's fiscal record contains the receipts.

Nursing facilities may not bill Medicaid for ancillary services except for therapies, oxygen, pharmacy, and the Medicare coinsurance or deductible for ancillary services. Otherwise, the ancillary provider must bill for the service. Some nursing facilities are exempt from billing certain ancillary services (e.g., only a Provider Type 62 - Hospital Long Term Care Unit can bill for pharmacy). The Billing & Reimbursement for Institutional Providers Chapter contains the allowable nursing facility provider types that can bill for ancillary services.

Therapies may be billed by the facility regardless of coverage by Medicare. However, Medicaid remains the payer of last resort.

Ancillary services (e.g., physical therapy) provided to a beneficiary on the day of discharge may be billed to Medicaid, even if the beneficiary was admitted and discharged on the same date.

9.4 Beauty and Barber Services

Services of a professional beautician or barber are not included in the per diem rate and are not covered by the Medicaid Program. The beneficiary may purchase such services from personal funds. A beneficiary's patient-pay amount may not be used to cover these costs.

9.5 Chiropractic Services (Medically-necessary)

Chiropractic services, such as x-rays and treatment, are an ancillary service and are not included in the facility's per diem rate.

9.6 Dental Services

The facility's per diem rate includes providing assistance with, and supplies for, daily oral hygiene. Dental supplies include, but are not limited to:

- Dental floss
- Mouthwash
- Mouthwash cups
- Denture adhesive
- Denture cleaner
- Denture cups
- Toothbrushes
- Toothpaste

Routine and emergency dental services are an ancillary service and are not included in the facility's per diem rate.

9.7 Dietary Services and Food

Residents must be provided nourishing, palatable, well-balanced meals that meet their daily nutrition and special dietary needs. Dietary services must also meet the preferences of residents and offer substitutes of similar nutritional value.

Nutrition appropriate for each resident's condition is included in the facility's per diem rate. This includes, but is not limited to:

- Daily nutritious meals and snacks
- Reasonable food substitutes of a similar nutritive value
- Dietary supplements
- Enteral formulas, supplies, equipment, and associated nursing services
- Infant formulas
- Nursing services associated with total parenteral nutrition (TPN) *
- Special diets
- Therapeutic diets
- Water solutions

Medicaid reimburses non-profit nursing facilities that incur costs resulting from the purchase of raw food and food preparation associated with special dietary needs for religious reasons. (Refer to the Cost Reporting and Reimbursement Appendix of this chapter for more information.)

9.8 Durable Medical Equipment

9.8.A. Standard Equipment

Standard, non-customized durable medical equipment is included in the facility's per diem rate. The durable medical equipment supplier and the nursing facility must make arrangements for purchasing or renting required equipment. Standard durable medical equipment includes, but is not limited to:

* The formula, equipment, and supplies required for the TPN feedings are an ancillary service and are not included in the facility's per diem rate.

- Adaptive ADL equipment
- Air mattresses
- Autoclaves
- Bed boards
- Bed cradles
- Bed pans
- Bed rails
- Beds (including hospital beds)
- Bedside safety rails
- Bedside stands
- Blood pressure apparatus
- Canes
- Comfortable cushioned chair
- Commodes
- Crutches
- Emesis basins
- Food pumps
- Foot boards
- Foot rails
- Foot stools
- Freestanding trays for meals
- Geriatric chairs
- Infrared lamps
- Lifts
- Oxygen equipment and supplies
- Positioning pillows
- Reading lights
- Sitz baths
- Splints
- Suction machines
- Traction equipment
- Trapeze equipment
- Tub lifts
- Urinals
- Walkers
- Wash basins
- Wheelchairs

Such equipment must be available for all the residents demonstrating need. Previously acquired equipment should be adapted to meet the beneficiary's needs, if appropriate.

The facility is required to repair/maintain standard, non-customized equipment, and this expense is included in the per diem rate. This may not be billed separately to Medicaid, the beneficiary, his family, or representative.

Replacement, repair and maintenance of standard equipment owned or rented by the beneficiary is not a Medicaid-covered benefit.

9.8.B. Customized Equipment

For customized equipment, the durable medical equipment provider must request prior authorization. Once purchase or rental of the equipment is authorized, the DME/Medical Supply provider may provide the service and bill Medicaid directly.

Prior authorization is approved if the following conditions are met:

- The attending physician (M.D. or D.O.) must order the equipment in writing. These orders must be signed by the attending physician and retained in the beneficiary's medical record. The orders must include the estimated period of months that the beneficiary will need such equipment, the medical/functional need, and an explanation of why standard, non-customized equipment is not suitable. A copy of the physician's orders must be attached to the durable medical equipment provider's prior authorization request.
- The equipment is medically necessary and specifically customized for the exclusive use of the beneficiary.
- The equipment offers physical/restorative function to the beneficiary.
- The facility is not the direct supplier of durable medical equipment.

Repairs to customized equipment by the durable medical equipment provider are covered only when it is necessary to make the equipment serviceable. Extensive repairs and maintenance by authorized technicians are covered if the warranty has expired. The durable medical equipment provider may bill for authorized repairs. Routine periodic servicing, such as cleaning, testing, regulating, and checking of the equipment, is not separately reimbursable.

9.9 End of Life Care

Facilities are expected to have systems and policies in place to address appropriate advance care planning and end of life care. Facilities must notify residents at admission of their policies regarding the implementation of advance directives and the availability of hospice care. Residents are entitled to adequate and appropriate pain and symptom management as a basic and essential part of their medical treatment. Best Practice Information for end-of life care and pain management for nursing facilities and hospital LTC units is available on the MDCH website. (Refer to the Directory Appendix for website information.)

9.10 Enrichment Programs

Facilities are required to provide or arrange for an ongoing program of activities designed to meet the interests and physical, mental and social well-being of each resident. An individualized program may be developed as part of the person-centered care planning process. Programs designed to maintain the resident's quality of life are included in the facility's per diem rate. Such services include, but are not limited to:

- Social services;
- Books;
- Current periodicals (e.g., newspapers, magazines) [If the beneficiary personally subscribes to a periodical (e.g., newspaper, magazine) for his own use, he is responsible for payment of that subscription.];
- Diversional programs;
- Motivational programs;

- Reality-oriented programs; and
- Recreational programs.

9.11 Family Planning Services

Family planning services are an ancillary service and are not included in the facility's per diem rate.

9.12 Hearing Services

Hearing evaluations are an ancillary service and are not included in the facility's per diem rate.

A Medicaid co-payment is not required for nursing facility beneficiaries.

9.13 Hospice Services

Upon admission to a nursing facility, residents must be advised of the facility's policies regarding the availability of hospice care.

Nursing facility beneficiaries [including Memorandum of Understanding (MOU) Special Agreements for Complex Care cases] are eligible for Medicaid hospice services if determined by a hospice provider to meet hospice level of care. Additionally, in certain situations (such as lack of a caregiver in the home), a hospice beneficiary, in consultation with the hospice provider, may elect to enter a nursing facility to receive end of life care. Medicare beneficiaries receiving or eligible for the 100-day skilled nursing benefit have the right to choose hospice instead. This decision should not be influenced by differences between hospice and Medicare skilled nursing facility reimbursement rates.

If the beneficiary is enrolled in a MHP and is admitted to the nursing facility with the hospice benefit, the MHP is responsible for reimbursement of hospice services.

For nursing facilities that elect to contract with hospice providers, MDCH encourages a written contract between the hospice provider and the nursing facility that specifically outlines the responsibilities of each. Additionally, the contract must specify how the hospice provider will reimburse the nursing facility for room and board.

Nursing facilities **cannot** bill Medicaid directly for room and board or any other services for hospice beneficiaries. A hospice is responsible for all costs for a person receiving hospice care. The hospice bills Medicaid for room and board, then reimburses the nursing facility at the rate specified in the contract between the providers.

MDCH reimburses the hospice for its daily rate and for room and board for beneficiaries in Medicaid or Medicaid/Medicare certified beds. The room and board rate is 95% of the facility's Medicaid per diem rate, which is the minimum established by Centers for Medicare and Medicaid Services (CMS). Although the rate paid to the hospice by Medicaid is set, it is not necessarily the rate that the hospice must pay the facility. It is expected that some services may be purchased or traded between the facility and the hospice, so the negotiated room and board rate must be stipulated in the contract.

Because Medicaid is making a payment for room and board (even though it is paid to the hospice), beneficiaries must be treated as all other Medicaid beneficiaries. For example, the facility cannot seek or accept additional or supplemental payment from the beneficiary, his family, or representative in addition to the amount paid for the covered service, even when a beneficiary has signed an agreement to do so.

9.13.A. Nursing Facility Responsibilities

Nursing facilities must adhere to all State licensure requirements, even though some of the components of care are provided by the hospice rather than the nursing facility. An example of a licensure component completed by the hospice is that, upon admission, the hospice provides the facility with copies of the beneficiary's history and physical, interdisciplinary assessment, and plan of care. For purposes of licensure, these copies are accepted as appropriate.

If a beneficiary is already receiving hospice services and elects admission to a nursing facility, the nursing facility should note that the beneficiary has elected hospice on the Facility Admission Notice (MSA-2565-C) sent to the local MDHS office. This should result in a Level of Care 16 on the beneficiary's **mihealth card**. If the **mihealth card** does not indicate a Level of Care 16, the beneficiary or their designated representative should contact the local MDHS office to request a correction.

Hospice staff cannot be utilized to meet staffing patterns required for licensure (i.e., the facility cannot include hospice staff on staffing reports).

Although the hospice is responsible for developing the coordinated plan of care, the nursing facility, as well as the beneficiary, must be an active participant in its development.

If the hospice beneficiary in a nursing facility has a patient-pay amount, it is the hospice's responsibility to collect that amount from the beneficiary. The nursing facility cannot collect the patient-pay amount from a hospice beneficiary unless the contract with the hospice specifically delegates that responsibility to the facility.

Services that must be provided by the nursing facility include:

- Room and board;
- Laundry (including facility items as well as personal items); and
- All other non-terminal illness-related services afforded other Medicaid beneficiaries (e.g., services included in the per diem rate).

Hospice covered beneficiaries residing in the nursing facility must not experience any lack of nursing facility services or personal care due to their status as a hospice beneficiary. Facilities must offer the same drugs, services, medical supplies and equipment to all beneficiaries who have elected the hospice benefit in the same manner that services are provided to other beneficiaries in the facility who have not elected hospice care. If a service is normally furnished as part of the facility's per diem rate, the service must also be provided to hospice beneficiaries. If services are provided for needs associated with a non-terminal illness and are normally furnished and billed by another provider, that practice would continue.

9.13.B. Hospice Responsibilities

Hospice must certify/re-certify the beneficiary's need for hospice care.

If a beneficiary already living in a nursing facility elects the hospice benefit, it is the responsibility of the hospice to submit to MDCH, Enrollment Services Section, a Hospice Membership Notice form (DCH-1074). MDCH will assign a Level of Care code 16 on the Eligibility Verification System (EVS).

The hospice, in collaboration with the beneficiary and/or family and nursing facility, will establish a coordinated plan of care for the beneficiary. The plan must specify the overall care to be provided and indicate, in detail, which services will be provided by the hospice and which will be provided by the facility.

If the hospice beneficiary has a patient-pay amount, it is the hospice's responsibility to collect that amount from the beneficiary. The nursing facility cannot collect the patient-pay amount from a hospice beneficiary unless the contract with the hospice specifically delegates that responsibility to the facility.

9.13.C. Service Provision

The following is intended for use as a guideline only. It identifies services for which the hospice is responsible, services that the hospice may arrange, and services that are "negotiable."

9.13.C.1. Services That Hospice Must Provide (Related to the Terminal Illness)

- A coordinated plan of care outlining the responsibilities of each provider;
- Intermittent (i.e., less than eight hours per day) nursing care of the hospice beneficiary;
- Counseling (defined as bereavement, nutritional, and spiritual); and
- Social work services.

9.13.C.2. Services That Hospice May Arrange (Related to the Terminal Illness)

- Spiritual care; and
- Home health aide/homemaker services. This applies only for services not provided during the facility's normal provision of care. For example, if the facility normally provides baths five times a week but the hospice plan of care calls for a bath each day, the hospice aide would provide baths on the days the facility does not.

9.13.C.3. NEGOTIABLE SERVICES

Services that must be available for hospice beneficiaries but appropriate contracted providers may render, as related to the terminal illness and as included in the patient plan of care, include the following. These services are the responsibility of the hospice, and **cannot** be billed to Medicaid by the contracted provider.

- Inpatient care for acute episodes of pain and symptom control;
- Inpatient respite care (not available for beneficiaries residing in a nursing facility);
- Laboratory;
- Pharmacy;
- Durable medical equipment;
- Radiology;
- Medical;
- Up to 24 hours of continuous care (at least eight hours of which must be nursing care) during periods of crisis;
- Physical therapy;
- Occupational therapy;
- Speech/language pathology; and
- Emergency ambulance transportation (if the service is included as part of the hospice plan of care).

9.14 HOSPITAL SERVICES

A nursing facility must have in effect a transfer agreement with one or more hospitals.

9.14.A. Planned Inpatient Hospital Admission

When a hospital admission is planned, the beneficiary must be discharged from the nursing facility. The nursing facility must not count the day of discharge as reimbursable by Medicaid. This day is included on the hospital's claim when billing. The facility may not bill Medicaid for hospital leave days for a planned admission. (Refer to Holding a Bed [Hospital Leave and Therapeutic Leave] subsection of this chapter for more information.)

9.14.B. Emergency Inpatient Hospital Admission

When a resident is admitted to the hospital on an emergency basis, the nursing facility may receive Medicaid reimbursement for holding their bed. (Refer to Holding a Bed [Hospital Leave and Therapeutic Leave] subsection of this chapter for more information.)

9.14.C. Outpatient and Emergency Room

Outpatient and emergency room services are an ancillary service and are not included in the facility's per diem rate.

A beneficiary who goes to the hospital for outpatient or emergency room services is not discharged from the nursing facility because the beneficiary is not admitted to the inpatient hospital. The beneficiary should be included in the census of the nursing facility, even if the beneficiary was being treated at midnight in the hospital outpatient or emergency room.

9.15 Housekeeping and Maintenance

Facility and room/bed maintenance necessary to maintain a sanitary, orderly, and comfortable environment are a required service and included in the nursing facility's per diem rate.

9.16 Intravenous Therapy

Intravenous therapy nursing services, supplies and equipment (including all pumps) are included in the facility's per diem rate.

Pharmaceuticals used in IV therapy are an ancillary service and are not included in the facility's per diem rate.

9.17 Laboratory Services

Any nursing facility that performs laboratory services must be certified/accredited under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Laboratory tests that are listed as waived tests under CLIA are included in the facility's per diem rate (e.g., Testrip). A list of these tests and the instrumentation needed to perform them can be found on the FDA website. (Refer to the Directory Appendix for website information.)

Laboratory services that can only be performed with special laboratory equipment by professional laboratory staff may be provided and billed by the appropriate enrolled ancillary provider (e.g., independent laboratory, outpatient hospital). Such services are not included in the facility's per diem rate.

Drawing, collecting and delivery of laboratory specimens are routine nursing services. As such, they are included in the facility's per diem rate regardless of who actually performs the service (i.e., nursing facility or ancillary provider).

9.18 Laundry Services

Facilities are responsible for general laundry services (e.g., bedding) and the beneficiary's personal laundry (e.g., clothing). Such services are included in the facility's per diem rate.

Dry cleaning services may be billed to the beneficiary if the beneficiary requests the service in writing, he has prior knowledge that the service is not covered by Medicaid, and he agrees to accept the cost. A beneficiary's patient-pay amount may not be used to cover these costs.

9.19 Medically-Related Social Services

Nursing facilities must provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. These services may include,

for example, information and referral, resident and family support, discharge planning, and are included in the facility's per diem rate.

9.20 Mental Health Services

Nursing facilities are required to have a written agreement with the local CMHSP outlining their working relationship to provide screening, evaluation and specialized services to nursing facility residents. The agreement must include a description of the process to be used to ensure the annual review of residents previously identified as mentally ill or mentally retarded. The agreement must also specify the means through which the facility and the CMHSP will deliver mental health services for nursing facility residents.

Completion of required Pre-admission Screening and Annual Resident Review is included in the facility's per diem rate. Prior to admission to a nursing facility, all individuals, regardless of payment source, must receive the Level I Pre-admission Screening (PAS) to identify the need for mental health and specialized services. Additional screening for mental health and specialized services is done as an Annual Resident Review (ARR), or more frequently in response to a change in a beneficiary's condition. (Refer to PASARR Process section of this chapter for more information.)

Mental health services provided by the nursing facility staff, as specified in the resident's plan of care, are included in the facility's per diem rate. Nursing facilities must provide mental health and/or mental retardation services that are of lesser intensity than specialized services to all residents who need such services.

9.20.A. Specialized Services

Specialized services are those identified by the PASARR Level II and are provided or arranged by the CMHSP. These services must be available to nursing facility individuals regardless of whether they are identified and required by the PASARR process, or whether the individual is determined to require additional services to be provided or arranged for by the State as specialized services. Individuals with a primary diagnosis of dementia are also covered by this requirement, even though the PASARR process exempts individuals with a primary diagnosis of dementia.

The PASARR Level II evaluation may provide recommendations regarding the specialized services and programs needed by the resident. Recommendations are based on evaluation of the resident's impairment in functional skills and the severity of those deficits. Nursing facilities must meet the responsibilities as outlined in this section for providing specialized services.

"Specialized Services" are defined as those mental health services for residents who are mentally ill or mentally retarded which are:

- Of greater intensity than those normally required from a nursing facility;
- Provided in conjunction with usual nursing facility services;
- Determined through the PASARR process;
- Provided or arranged for by the local CMHSP acting on behalf of the State; or
- Result in the continuous and aggressive implementation of an individualized plan of care.

Specialized services for residents with **mental illness** may include, for example, individual, group and family psychotherapy, crisis intervention services, and formal behavior modification programs.

Specialized services for residents with **mental retardation** include specialized professional involvement because the service need is related to the resident's mental retardation. Evaluators must carefully distinguish between those service needs that require the involvement of a mental retardation professional, and those which are "generic" and do not require specifically-trained professionals. For example, administering medication is a "generic" service, while teaching a resident to self-administer may be a "specialized service" because it requires the involvement of a mental retardation professional to design and monitor the program.

For residents with **multiple diagnoses**, such as mental retardation and mental illness or mental retardation and dementia, evaluators may recommend either specialized services or other mental health services, depending on the interrelationship of the two diagnoses.

9.20.B. Nursing Facility Responsibilities

Responsibilities of the nursing facility include:

- Providing all of the usual and customary services (refer to the Medicaid Covered Services subsection) and as required by licensing and certification. This includes specialized mental health rehabilitation services as defined in 42 CFR 483.120.
- Monitoring the need for PASARR evaluations and ensuring that they are completed on time (refer to the PASARR Process section). The nursing facility must notify the CMHSP when a Level II evaluation is indicated.
- Collaborating with the resident or his legal representative and the CMHSP to develop an individualized plan of care for specialized services based on the needs identified during the PASARR Level II evaluation. The plan of care must outline the responsibilities of each provider for the specialized services.
- Coordinating the identified services (which may be obtained from the local CMHSP) and implementing and monitoring the services recommended in the individualized plan of care. Nursing facilities must also provide interventions which complement, reinforce and are consistent with any specialized services the individual is receiving or is required to receive by the State through the CMHSP. The individualized plan of care must specify how the facility will integrate relevant activities throughout all hours of the day at the facility to achieve consistency and enhancement of the goals identified in the individualized plan of care.

9.20.C. CMHSP Responsibilities

Responsibilities of the CMHSP include:

- Performing the comprehensive evaluation (Level II evaluation) when required by the PASARR Screening.

- Collaborating with the resident or his legal representative and the nursing facility to develop an individualized plan of care for specialized services based on the needs identified during the PASARR Level II evaluation. The plan of care must outline the responsibilities of each provider for the specialized services.
- Providing specialized services to nursing facility residents who have been determined to need them through the PASARR process. MDCH has allocated funds to local CMHSPs for this purpose.
- Providing training to nursing facility direct care staff to implement and monitor the programs as designed, and participating in the evaluation and modification of the plan of care as needed.
- Providing services to nursing facility residents on the same basis as to all other persons in the region. A nursing facility may use the local CMHSP as a mental health service provider in order to fulfill the nursing facility's obligation to provide specialized mental health rehabilitation services. Services for residents with a primary diagnosis of dementia are also available from a local CMHSP on the same basis.

In 1991, funds were made available to local CMHSPs to provide specialized services and other mental health services to individuals residing in nursing facilities. Priority for use of these funds is for individuals with the most severe mental health problems who need specialized services. To the extent there are funds remaining after this priority group is served, MDCH has given local CMHSPs authorization to serve individuals who need mental health services other than specialized services.

Ancillary providers of mental health services may bill Medicaid directly.

9.21 NURSING CARE

Nursing facilities must have nursing staff sufficient to provide nursing and other related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Nursing care includes the responsibility for development, implementation and oversight of a plan of care that remains consistent with on-going observation, assessment and intervention by licensed nurses. The following are examples of custodial and rehabilitative nursing care that may be performed by, or under the supervision of, licensed nurses and are included in the per diem rate. Nursing services include, but are not limited to:

- Observing vital signs and recording the findings in the beneficiary's medical record;
- Administration of topical, oral, or injectable medications, including monitoring for proper dosage, frequency, or method of administration, including observation for adverse reactions;
- Treatment of skin irritations or small superficial or deep skin lesions requiring application of medication, irrigation, or sterile dressings;
- Routine changing of dressings in chronic, non-infected skin conditions and uncomplicated postoperative incisions;
- Nursing observation and care of beneficiaries with unstable or complex medical conditions which can only be provided by, or under the immediate direction of, licensed nursing personnel;

- Proper positioning in bed, wheelchair, or other accommodation to prevent deformity and pressure sores;
- Provision of bed baths;
- Routine prophylactic and palliative skin care (e.g., application of creams and lotions) for the prevention of skin irritation and pressure sores;
- Administration of intravenous solutions on a regular and continuing basis;
- Administration of tube feedings;
- Nasopharyngeal aspiration required for maintenance of a clear airway;
- Care of a colostomy or iliostomy during early postoperative period, on an on-going basis, and conducting colostomy training;
- Use of protective restraints, bed rails, binders, and supports (if ordered by a physician and in compliance with state and federal regulations) provided in accordance with written patient-care policies and procedures;
- Use of intermittent positive pressure breathing equipment and nebulizers;
- Care of catheters;
- Care of tracheostomies, gastrostomies, and other indwelling tubes;
- Administration of oxygen or other medicinal gases on a regular and continuing basis in the presence of an unstable medical condition or when nursing assessment is required to determine frequency and necessity of administration;
- Identifying the need for, and insuring arrangements for, prompt and convenient clinical, laboratory, x-ray, and other diagnostic services;
- Use of heat as a palliative and comfort measure, such as whirlpool and hydrocolator;
- Training and assistance in transfer techniques (bed to wheelchair, wheelchair to commode, etc.);
- Training, assistance, and encouragement of self-care as required for feeding, grooming, toileting activities (including toilet routine to encourage continence), and other activities of daily living;
- Normal range-of-motion exercises as part of routine maintenance nursing care; and
- Pain assessment and management.

9.22 Orthotics

Orthotics are an ancillary service and are not included in the facility's per diem rate.

9.23 Oxygen

The administration of oxygen and the related nursing services are included in the per diem rate.

Oxygen gas, equipment, and supplies for intermittent and infrequent use are included in the facility's per diem rate.

If a beneficiary requires frequent or prolonged oxygen on a daily basis (i.e., at least 8 hours per day):

- As a resident in the Nursing Facility (Provider Type 60), the oxygen gas, equipment, and supplies must be billed by an enrolled medical supplier, not the nursing facility.
- As a resident in a County Medical Care Facility (Provider Type 61) or a Hospital Long Term Care Unit (Provider Type 62), the oxygen gas, equipment, and supplies are billable by the facility.

(Refer to the Billing & Reimbursement for Institutional Providers Chapter in this manual for billing instructions.)

Oxygen services (i.e., gas, equipment, and supplies) are not covered by Medicaid if Medicare is paying for the stay. Medicare's per diem reimbursement rate includes the oxygen services.

9.24 Personal Comfort Items

Medicaid does not cover individual personal comfort items (e.g., telephone, television, radio, guest trays). Such services are not included in the facility's per diem rate. Beneficiaries may purchase individualized services with personal funds. A beneficiary's patient-pay amount may not be used to cover these services.

If the facility provides personal comfort items to all its beneficiaries (e.g., a television in the recreation room), the service is included in the facility's per diem rate.

9.25 Personal Hygiene Items

Items needed for personal hygiene are included in the facility's per diem rate. Such items include, but are not limited to, the following:

- Bacteriostatic soaps
- Body lotions
- Combs and brushes
- Cotton swabs
- Deodorant/antiperspirant
- Facial tissues
- Hair conditioners (as appropriate)
- Incontinence supplies
- Medicine cups
- Oral hygiene supplies
- Patient gowns
- Personal hygiene preparations
- Safety razors
- Sanitary napkins
- Shampoo
- Shaving cream
- Soaps

9.26 Pharmacy

Nursing facilities must provide pharmaceutical services to meet the needs of each resident.

Prescriptions must be ordered and documented, in writing, in the beneficiary's medical record by the attending physician.

A Medicaid co-payment is not required for prescription pharmaceuticals for nursing facility beneficiaries.

The Michigan Pharmaceutical Product List (MPPL) contains the over-the-counter and prescription pharmaceutical products covered by Medicaid and any restrictions placed on those products, including when prior authorization is required. The prior authorization process is outlined in the MPPL and may be obtained by the physician or their designee. The Michigan Pharmaceutical Products List is available online. (Refer to the Directory Appendix for website information.)

Pharmaceuticals dispensed in nursing facilities must be billed through a pharmacy (unless pharmacy is included in the per diem rate, i.e., ICF/MR).

9.26.A. Over-the-Counter Products (OTC's)

- The MPPL designates when an OTC drug is included in the facility's per diem rate. It is the responsibility of the facility to provide these products. Examples of OTCs in the per diem include mouthwash, topical antiseptics, analgesics, cough and cold preparations, ointments (both generic and brand name [e.g., Vaseline, Gold Bond]), and vitamins and minerals. The pharmacy or supplier must make arrangements with the nursing facility for reimbursement.
- OTCs not included in the per diem rate that may be billed to Medicaid, as outlined in the MPPL, are reimbursable to Pharmacy (Provider Type 50) for nursing facility beneficiaries. Examples include Diphenhydramine and Insulin.

9.26.B. Medication Reviews

Medication reviews, as required by federal regulations, are the responsibility of the facility and are included in the per diem rate. The pharmacist must make arrangements with the facility for reimbursement of such services.

9.27 Physician Services

Physician services must be provided and are an ancillary service. Such services are not included in the facility's per diem rate. In accordance with federal requirements, residents have the right to choose an attending physician.

A physician must initially examine a resident within 48 hours of admission to the nursing facility, unless the resident has been examined by a licensed physician within five days before admission and a copy of that examination is available in the facility at the time of the resident's admission. If the admission occurs on a Friday, the exam must be completed within 72 hours.

A physician must evaluate a beneficiary every 30 days for the first 90 days after admission. The resident must then be evaluated every 60 days unless otherwise justified and documented by the physician. At a minimum, the resident must be evaluated at least once every 90 days on an ongoing basis.

A physician visit is considered timely if it occurs no later than ten days after the required visit. After the initial visit, the physician may alternate personal visits between the physician and a physician assistant or nurse practitioner.

9.28 Podiatry Services

Palliative treatment and routine foot care (e.g., trimming of the nails, removal of corns and calluses) are included in the facility's per diem rate.

Medically necessary podiatry physician services are an ancillary service and are not included in the facility's per diem rate.

9.29 Private Duty Nursing

Private duty nurses are not covered in a nursing facility by the Medicaid Program nor are they included in the facility's per diem rate. The beneficiary may use personal funds to purchase private duty nursing services. A beneficiary's patient-pay amount may not be used to cover the cost of private duty nursing.

9.30 Private Room

When a Medicaid beneficiary requires a private room due to medical necessity, the nursing facility is reimbursed at the usual per diem rate. Private rooms required for medical necessity are included in the facility's per diem rate. Written documentation of medical necessity must be part of the beneficiary's medical record.

Medical necessity is defined as a documented medical condition that creates the need to isolate the resident for his safety and/or the safety of others (i.e., infection control). This also includes behavioral conditions related to a medical condition (i.e., aggression related to dementia). The medical necessity must be documented, as well as addressed, in care planning and treatment.

If a beneficiary requests a private room and there is no medical necessity, the beneficiary may elect to pay privately. The nursing facility must advise the beneficiary that a private room is not a Medicaid-covered service unless it is medically necessary, and that the beneficiary or family is responsible for paying the difference between the cost of a semi-private and private room. The facility may only charge the difference between what it would normally charge a private-pay resident for a semi-private and a private room. Facilities may not charge beneficiaries the difference between the Medicaid per diem rate and the rate charged a private-pay resident for a private room. For example, if the facility charges $98.00/day for semi-private room and $112.00/day for a standard private room, the charge is $14.00/day. The beneficiary's patient-pay amount may not be used for this purpose.

If the beneficiary agrees to pay the difference between the semi-private and private room rate, the beneficiary or family member must request permission, in writing, from the MDCH. The Request for Authorization of Private Room Supplemental Payment for Nursing Facility form (MSA-1580) is used to obtain the permission. The MSA-1580 is completed by the beneficiary or family member. (Refer to the Directory Appendix for downloading the MSA-1580 and other contact information.) Requests to supplement the cost of a private room are reviewed for cost and reason for request on a case-by-case basis. A response will be sent to the requestor, the beneficiary (if different), and the facility within ten working days.

This response must be retained as part of the beneficiary's medical record. Subsequently, these charges are subject to audit by MDCH, CMS or designated representatives of either of those entities. These charges must be reported by the nursing facility as revenue received. This response, however, does not

guarantee that the beneficiary will be provided a private room. The agreement to provide a private room is given by the nursing facility.

9.31 Prosthetics

Prosthetic services are an ancillary service and are not included in the facility's per diem rate.

9.32 Radiology

Radiology services are an ancillary service and are not included in the facility's per diem rate.

9.33 Substance Abuse Services and Treatment

Services rendered for the treatment of alcohol and drug abuse are an ancillary service and are not included in the facility's per diem rate.

9.34 Supplies, Accessories and Equipment

Supplies, accessories, and equipment necessary to achieve the goals of the beneficiary's plan of care are included in the facility's per diem rate and must be available to the beneficiary. Medical supplies, accessories, and equipment include, but are not limited to:

- Atomizers
- Bandage products
- Bed linens
- Bib or protective cover
- Catheters/accessories and irrigation solution
- Cloth diapers
- Cotton balls
- Cotton swabs
- Deodorizers
- Diagnostic agents (e.g., Testape, Kyotest)
- Disposable diapers
- Disposable gloves
- Dressings (e.g., surgical pads, cellulose wadding, tape)

  Note: Some supplies for complex wound care are not included in the per diem rate and must be obtained through a medical supplier or pharmacy (Provider Type 87 and 50). Supplies that must be billed by a medical supplier, including information for interpreting the list of supplies, are on the MDCH website. (Refer to the Directory Appendix for additional information.)
- Elastic hose
- Enema kits
- Finger cots

- First aid trays
- Flameproof cubicle curtains
- Foot soaks
- Hot water bottles
- Hypodermic needles/syringes
- Ice bags
- Incontinence pads, pants, and liners
- IV supplies and equipment; related supplies (including IV infusion pump)
- Minor medical/surgical supplies
- Miscellaneous applicators
- Nebulizers (hand-held or used with a compressor)
- Ostomy supplies
- Plastic waste bags
- Recreational/therapeutic equipment and supplies to conduct ongoing activities
- Safety pins
- Sheepskin, devices and solutions for preventing/treating decubiti
- Slings
- Stethoscopes
- Straws
- Syringes/needles
- Thermometers
- Tongue blades (depressors)
- Towels/washcloths
- Tracheostomy care kits and cleaning supplies
- Trochanter rolls
- Water carafes/glasses

Note: This list is not complete. Generic equivalents and products in the same family (i.e., same general use) are also included in the facility's per diem rate.

9.35 THERAPIES

Nursing facilities must provide or obtain specialized rehabilitative services if required by the beneficiary's plan of care.

Routine maintenance therapy consists of the repetitive services required to maintain function. The development of the therapy and treatment are included in the per diem rate. Such therapy does not require the therapist to perform the service, nor does it require complex and sophisticated procedures.

Non-routine occupational therapy (OT), physical therapy (PT) and speech/language/pathology (ST) are ancillary services that are covered if prior authorization is obtained and the following conditions are met:

- The therapy must be billed by the facility;
- There must be a written order by the attending physician for each calendar month of therapy; and
- The written orders must be signed by the attending physician and retained in the beneficiary's medical record.

Non-routine ancillary therapy is therapy that requires the skills of qualified technical or professional health personnel such as physical therapists, occupational therapists, speech pathologists or audiologists, and is directly provided by or under the general supervision of these skilled personnel to assure the safety of the beneficiary and achieve the medically desired results as ordered by the beneficiary's physician.

Federal regulations require the facility to have a valid contract with the OT, PT, or ST provider. A valid contract allows the facility to retain professional and administrative control over the services provided. Therefore, an agreement that stipulates only the use of facility space does not constitute a valid contract.

If Medicaid funds have inappropriately been paid to a facility for OT, PT, or ST services when a facility did not possess a valid contract, the funds may be recovered by gross adjustment or at the time of cost settlement, as appropriate.

The following clarifies the professional responsibilities of the nursing facility, the physician, and the therapist in the provision of OT, PT or ST services for Medicaid beneficiaries.

- The facility has administrative and professional responsibility for the management of the total health care needs of the beneficiary as outlined in the plan of care. The facility must assure that appropriate OT, PT, or ST services are available to the beneficiary as needed. In situations where the therapist is not an employee of the facility, the facility must establish a valid contract with a therapist/speech pathologist who meets applicable licensure/certification/accreditation requirements.
- The attending physician is responsible for determining the medical necessity and appropriateness for services and preparing the written orders for OT, PT or ST evaluation and treatment. These are reviewed and approved/disapproved by the MDCH Prior Authorization Division.
- The therapists are responsible for evaluating the beneficiary's needs; developing a written plan of treatment, including goals and objectives; and providing or overseeing the appropriate services. A copy of the treatment plan must be retained in the beneficiary's medical record.

The facility's responsibilities, as described above, are not meant to conflict in any way with the professional responsibilities of OTs, PTs or STs in the evaluation and treatment of the beneficiary.

The cost of supplies and equipment (e.g., plate guards) used as part of the therapy program is included in the reimbursement for the therapy/speech pathology.

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital. ST may also be provided by a hearing and speech center. Prior authorization must be obtained by the facility regardless of where the service is to be provided.

Note: Therapy provided by a physician (M.D. or D.O.) is not a covered benefit for beneficiaries in a nursing facility.

9.35.A. Occupational Therapy (OT)

Occupational therapy (OT) must be active and restorative. A registered occupational therapist or a certified occupational therapy assistant must render the services. If the assistant renders the service, the assistant must be under the supervision of the therapist.

The following are examples of occupational therapy services that may be covered by Medicaid:

- Training in activities of daily living;
- Fabrication of adaptive equipment;
- Perceptual motor training;
- Splinting;
- Testing;
- Therapeutic exercises; and
- Prosthetic and orthotic training.

OT services that are provided and billed simultaneous with PT are not covered. Also, diversional OT, reality orientation, and restorative nursing functions are considered part of the per diem rate, and are not separately reimbursable.

9.35.B. Physical Therapy (PT)

Active, restorative, or specialized maintenance physical therapy (PT) programs, as explained below, are benefits of the Medicaid Program. There must be the expectation that the beneficiary's condition will improve significantly in a reasonable and generally predictable period of time.

A licensed physical therapist (temporary permit is acceptable), physical therapy assistant, or physical therapy aide must provide the services. If the assistant or aide renders the service, they must be under the supervision of the therapist.

The following are examples of restorative PT services which may be covered by Medicaid:

- Hot pack, ice pack, infrared treatment, or whirlpool bath is covered when provided as a prerequisite to a skilled physical therapy procedure;
- Gait training is covered when provided to a beneficiary whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;
- Prosthetic and orthotic training is covered when instructing the beneficiary in using the prosthetic or orthotic device; and
- Range of motion exercises are covered when provided as part of the treatment of a specific disability which has resulted in a loss or restriction of mobility.

For specialized maintenance physical therapy, the therapist's initial evaluation of the beneficiary's needs and designing of the program are covered. The program must be appropriate to the beneficiary's capacity, tolerance, and treatment objectives. The instructions to the beneficiary or to other members of the health team (e.g., nursing personnel) in carrying out such an individualized treatment plan and infrequent re-evaluations, as may be required, are also covered.

9.35.C. Speech Pathology/Therapy (ST)

The services must be for active, restorative treatment and must be rendered by a speech pathologist certified by, or possessing a "Letter of Equivalency" from, the American Speech and Hearing Association. For speech pathology evaluations, a copy of the speech pathologist's certification or "Letter of Equivalency" must accompany the first prior authorization request for that pathologist.

The following are examples of conditions that may warrant speech pathology services:

- Cerebral vascular accident (CVA) or trauma;
- Neurological disease, such as Parkinsonism or multiple sclerosis;
- Laryngectomy;
- Voice disorders caused by conditions such as nodules, polyps, papilloma, ulcers, cysts, or cord damage (the exact diagnosis must be included in the physician's order); or
- Maxillofacial abnormalities with traumatic or surgical excision of the tongue, lips, or hard or soft palate.

When properly documented, other diagnoses and conditions may be covered if they meet the above requirements and are prior authorized.

Since the purpose of speech pathology services is restorative rather than habilitative, these services are not covered for:

- Speech problems due to symptoms of organic brain syndrome or chronic brain syndrome; or
- Speech problems due to mental retardation.

Medicaid does not cover ST when another public agency (e.g., local or intermediate school district special education program) can assume the responsibility of services for the beneficiary.

9.35.D. Prior Approval for Therapies

The Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization (MSA-115) is used to request prior authorization. The MSA-115 must be reviewed and signed by the attending physician. When making the initial request for therapy, the facility must attach a copy of the initial evaluation and written treatment plan.

The initial evaluation does not require prior authorization and cannot be provided more often than twice in a 12-month period (and at least six months apart).

Exception: Evaluation of oral pharyngeal swallowing cannot be provided more than four times in a 12-month period.

Prior authorization may be requested for up to two calendar months per request.

The therapist or speech pathologist must keep appropriate notes that include the date of treatment, the name of the therapist, the type and length of treatment, and the resident's response to treatment. These notes must be maintained in the beneficiary's medical record.

Prior authorization requests for group therapy require documentation that group therapy is in the best interest of the beneficiary's treatment.

9.35.D.1. INITIAL REQUEST

When making the initial request for prior authorization of therapy, the facility must attach a copy of the initial evaluation and the written treatment plan. The initial evaluation and treatment plan must include the following information:

- Statement of the problem (i.e., the specific physical entity and functional incapacity involved or the specific speech and/or language diagnosis based upon results of formal/informal testing);
- Baseline condition at initial evaluation, measured in units appropriate to the problem (for speech pathology, this would include the baseline description of clinical and functional performance in all language modalities);
- Short-term goals appropriate to the beneficiary's diagnosis, level of severity, prognosis, and functional needs;
- Proposed technique for reaching goals, including the planned progression from the baseline condition to the goal; and
- Method by which progress will be measured.

This and any other supplemental documentation must include the beneficiary's name and Medicaid ID Number, the date, and the facility's name and ID Number.

The MSA–115 is used to obtain authorization for therapy prior to the provision of the service.

9.35.D.2. CONTINUED REQUEST

Authorization of the initial service does not guarantee authorization of continued service. The therapist must submit the MSA-115 for continued therapy with documentation of the most recent progress. The progress summary must be concise and refer to the baseline established in the initial evaluation. Progress must be objective and measurable.

9.35.D.3. DISTRIBUTION OF FORM

The prior authorization form is a four-part, snap-out form. The original, first, and second copies of the form must be submitted to the MDCH Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

The facility should retain a copy for its records until the approved or disapproved form is returned by the MDCH. If the facility does not receive a response regarding the original prior authorization form within 15 days of the date of its submission, a new request should be submitted. (The reason a second prior authorization form is being submitted should be included, i.e., no response to the first request.) The facility must not bill until authorization is received and the services are rendered.

9.35.D.4. PROCESS

The MDCH consultant will make a determination and assign a prior authorization number to approved requests. The originals will be returned to the facility. If a portion of the request is denied, Medicaid will only reimburse for the authorized services. The nine-digit Prior Authorization Number must be entered on the claim when billing. The facility must retain a copy of the approved request as part of the beneficiary's medical record.

Approval of the request confirms that a beneficiary is in need of services that can be covered by the Program. It does not verify beneficiary eligibility, level of care, nor guarantee the fee charged. The facility is responsible for verifying the beneficiary's Medicaid eligibility prior to providing the service.

Whenever a beneficiary is admitted to the facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, the name of that facility and the date of discharge from that facility should be included on the prior authorization request. In order to assure continuity of the treatment regimen in such instances, retroactive authorization may be requested if the request is filed within ten days following admission. Retroactive authorization may be granted when the service is rendered within Program guidelines for coverage (e.g., is restorative in nature).

Facilities participating in Medicare are not required to obtain prior authorization for the deductible and/or coinsurance amounts when Medicare approves the services.

9.35.D.5. BILLING

The Invoice Processing System is programmed to match the services authorized with the services billed. Services billed must not exceed the services authorized.

Completion Instructions

The following instructions pertain to the completion of the MSA-115. All prior authorization forms must be typewritten to facilitate processing.

Item 1 - Control Number

The control number is used by MDCH for identification purposes. The facility must **NOT** mark in this item.

Item 2 through Item 4 - Consultant's Use Only

These items are for the MDCH Consultant's use only. These items are not to be completed by the facility.

Item 5 - Prior Authorization Number

If all or part of the service is authorized, a nine-digit Prior Authorization Number will be entered in this item. The facility must enter this number on the claim when billing.

Note: In the event the facility is approved for both an MOU and therapy services, one prior authorization number will be issued for both the MOU and therapy.

If the service is disapproved, no number will be assigned.

Item 6 through Item 8 - Facility Identification Data

The facility's name, provider type code, and seven-digit identification number must be entered as they appear on the Medical Assistance Provider Enrollment Turn-around Form, page 2.

Item 9 - Facility Reference Number

The facility may enter a reference number or the beneficiary's name, not to exceed 10 alpha and/or numeric characters, to comply with its individual filing system.

Item 10 through Item 11 - Facility Identification Data

The facility's mailing address (including an attention line if appropriate) and telephone number (including area code) assists the Consultant in resolving inquiries and returning the prior authorization form to the facility.

Item 12 through Item 15 - Client Identification Data

The beneficiary's name (last, first, and middle initial), sex (M or F), ID Number, and birth date (in the six-digit format: month, day, year) must be entered exactly as they appear on the **mihealth** card.

Item 16 - Admission Date

This is the date the beneficiary was most recently admitted to the facility.

Item 17 through Item 18 - Diagnosis and Onset Date

The diagnosis for which the beneficiary requires the services and the onset date of the diagnosis indicate the primary reason the beneficiary requires the requested services must be entered.

If the beneficiary has a chronic disease (e.g., arthritis) and recently suffered an exacerbation, the approximate date of such exacerbation must be cited.

Item 19 through Item 21 - Therapist Identification Data

The therapist's/pathologist's name, office telephone number (including area code), address, and certificate number identifying the therapist/pathologist must be entered. (Speech pathologists must attach a copy of the Certificate of Clinical Competency or Letter of Equivalency to the first prior authorization involving an individual speech pathologist.)

The therapist/pathologist wishing to add any comments may do so by attaching a separate sheet which must contain the beneficiary's name and identification number, date, and the facility's name and identification number.

Item 22 - Treatment Authorization Request

The Treatment Authorization Request must be checked to indicate whether this is the initial prior authorization request for this beneficiary for this treatment plan, a continuing request for an additional calendar month of service, or a revision of a previously authorized treatment plan.

Item 23 - Service Given By

This indicates who is to provide the service: therapist/pathologist, assistant, or aide (this does not refer to a nurse's aide).

Item 24 - Treatment Month

The calendar month(s) in which treatment is to be rendered must be shown in a two-digit format (e.g., April should be shown as 04).

Item 25 - Date Started

The date treatment was started for the given diagnosis must be entered.

Item 26 - Last Authorized

The date the MDCH Consultant signed the last approved prior authorization request for the given diagnosis must be entered.

Item 27 - Number Sessions

This is the number of sessions rendered up to the date the form was completed for the given diagnosis. The facility must **not** indicate the number of sessions previously authorized for a different diagnosis.

Item 28 - Rehabilitation Potential

This is a brief assessment of the beneficiary's rehabilitative potential and factors that contribute to this determination (e.g., "good potential"; "patient's attitude is positive and persistent"; "progress depends upon the reduction of pain").

Item 29 - Line Number

The line number is to be used as a reference.

Note: A separate Line Number must be used for each different CPT/HCPCS Code that is used.

Item 30 - Number per Month

This is the number of times the service is to be provided. Services may be prior authorized on a weekly basis.

Item 31 - Procedure Code

This is the CPT/HCPCS code(s) as listed in the Medicaid Provider Manual, Billing & Reimbursement for Institutional Providers Chapter, Nursing Facility Section which describes the service(s).

Note: For each different CPT/HCPCS code, a separate Line Number must be used.

Item 32 - Consultant Use Only

The facility is not to complete this item. The MDCH Consultant will use this area to indicate any amendments on approved services. The facility should always review this area to see if any changes are necessary for delivery of services and/or accurate billing.

Item 33 - Goals

The **expectations** for the beneficiary's ultimate achievement and the length of time it will take must be stated (e.g., ambulation unassisted for 20 feet, able to dress self within 15 minutes, oral expression using 4-5 word phrases to express daily need).

Item 34 - Progress Note/Discharge Plan

This is the documentation of the beneficiary's progress from the prior month to the current time in reference to the measurable and functional goals stated in the treatment plan. Documentation of beneficiary nursing and family education may be included. The final month of anticipated treatment should include the discharge plan for the carry-over of achieved goals to supportive personnel.

Item 35 - Complications Causing Extension of Treatment

Any condition or complication that might require an extension of services (e.g., decubiti, urological complications, or fractures) should be fully described.

Item 36 - Physician Certification

The attending physician must indicate if this is an initial certification or a recertification and sign and date the prior authorization form. The attending physician's signature is required each time a request is made.

Item 37 - Provider Certification

The facility's certification is required to validate the form. This is accomplished by the facility's authorized representative's signature on the form and the form must be dated. All unsigned requests will be returned to the facility for signature.

Item 38 through Item 43 - Consultant Use Only

These items will be completed by the consultant. The consultant will indicate that the service is approved as presented, approved as amended, or disapproved. If all or part of the plan is authorized, the consultant will assign a nine-digit Prior Authorization Number in Item 5.

The therapist/speech pathologist must keep progress notes. Such notes include the:

- date of treatment,
- name of the individual who rendered treatment,
- type and length of treatment, and
- beneficiary's response to the treatment.

The progress notes must be included in the beneficiary's medical record.

The cost of supplies and equipment (e.g., plate guards) used as part of the therapy/speech pathology program is included in the reimbursement for the therapy/speech pathology.

The following illustrates an MSA-115 as it might be completed in a usual situation.

OCCUPATIONAL/PHYSICAL THERAPY – SPEECH PATHOLOGY PRIOR APPROVAL – REQUEST/AUTHORIZATION

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

1. CONTROL NUMBER

NOTE: FOR INITIAL AND REVISED REPORTS ONLY, YOU **MUST** ATTACH A COPY OF THE INITIAL EVALUATION AND TREATMENT PLAN.

CONSULTANT USE ONLY 2. 3. 4.

5. PRIOR AUTHORIZATION NUMBER

6. TREATMENT SITE	7. TYPE	8. I.D. NUMBER	9. PROVIDER'S USE ONLY
Hills Nursing Home	**60**	**6143500**	**Good**

10. ADDRESS (NUMBER, STREET, CITY STATE, ZIP)	11. PHONE NUMBER
5 Main Street, Ada, Michigan 49441	**(616) 243-9170**

12. RECIPIENT NAME (LAST, FIRST, MIDDLE INITIAL)	13. SEX	14. I.D. NUMBER	15. BIRTH DATE	16. ADM. DATE
Good, Sam				

17. DIAGNOSIS TO BE TREATED/EVALUATED	18. ONSET DATE
CVA with resultant left hemiparesis	

19. THERAPIST / PATHOLOGIST NAME (LAST, FIRST, MIDDLE INITIAL)	20. OFFICE PHONE NUMBER	21. LICENSE / CERTIFICATION NUMBER
O'Malley, Sue R.	**(616) 432-7620**	**843714**

22. TREATMENT AUTHORIZATION REQUEST	23. SERVICE GIVEN BY	24. TREATMENT MO..	25. DATE STARTED	26. LAST AUTH.	27. NO. SESSIONS
☐ INITIAL ☐ CONTINUING ☒ REVISED	☒ THERAPIST/ PATHOLOGIST ☐ ASST ☐ AIDE	**08**	**12/01/02**	**11/24/02**	**1**

28. REHABILITATION POTENTIAL

33. GOALS

Gait Training

ESTIMATED TIME

34. PROGRESS NOTES/ DISCHARGE PLAN

Patient is exhibiting some hesitation in moving outside the Parallel bars. Does two lengths with standby assistance before rest. Trying to get outside of the bars within next week.

29. LINE NO.	30. NUMBER PER MONTH	31. PROCEDURE CODE	32. CONSULTANT USE ONLY
01	**20**	**97116**	
02			
03			
04			
05			
06			

35. COMPLICATIONS CAUSING EXTENSION OF TREATMENT

36. PHYSICIAN CERTIFICATION

I certify, ☐ re-certify ☒ that I have examined the above named patient and have determined that therapy is necessary; that service will be furnished on an in/out-patient basis while the patient is under my care; that I approve the above treatment plan or evaluation and will review it every 30 days or more often if the patient's condition requires.

James P. Pike, M.D. (PHYSICIAN NAME (TYPE OR PRINT)) — JAMES P. PIKE, M.D. (PHYSICIAN SIGNATURE) — 01/03/02 (DATE)

37 PROVIDER CERTIFICATION

The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and if approved, and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements, documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

SUSAN MICHAELS (PROVDIER SIGNATURE) — 08/03/02 (DATE)

CONSULTANT USE ONLY

38. CONSULTANT REMARKS

39. APPROVED AS PRESENTED ☐ AMENDED ☐	40. DISAPPROVED ☐	41. CONSULTANT SIGNATURE	42. DATE	43. MONTH

MSA-115 (02-03) AUTHORITY: Title XIX of the Social Security Act. COMPLETION: Is voluntary, but is required if payment from applicable programs is sought. The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

9.36 TRANSPORTATION

9.36.A. Non-emergency Transportation

The nursing facility is responsible for all non-emergency transportation for all Medicaid beneficiaries, including Medicare/Medicaid beneficiaries when Medicare is covering the cost of the care. Non-emergency transportation includes transport to medical appointments/treatment not available in the facility (i.e., dialysis treatment). The facility must either arrange or provide transportation. Reimbursement for non-emergency transportation is included in the facility per diem rate. The per diem rate also includes transportation for newly-admitted beneficiaries from a hospital or another residence.

Travel to out-of-state medical providers (other than Michigan Medicaid-enrolled "borderland" providers as defined in the General Information for Providers chapter of this manual) is not the responsibility of the facility and must be prior authorized by MDCH.

The facility must select the most appropriate, cost-effective mode of transportation. Whenever possible, a facility-owned vehicle should be used. This vehicle must comply with the Americans with Disabilities Act (ADA).

In rare situations, the condition of a beneficiary needing non-emergency transport requires an attendant in addition to the driver. In such cases, it is appropriate for a nurse aide to accompany the beneficiary and this cost should be reflected in the annual cost report as "staffing costs associated with providing needed medical care." Sending a nurse aide or other staff member with the beneficiary being transported must not negatively impact the care of residents remaining in the facility.

The need for a nurse aide to accompany a beneficiary must not be confused with the responsibility of the family or legal guardian "to attend the beneficiary if escort is needed to sign consent forms, decide treatment options, sign insurance forms, provide histories, etc." A nurse aide is not to be responsible for these legal and medical decisions and knowledge.

9.36.B. Emergency Ambulance

Nursing facilities must have contractual arrangements for ambulance services for emergencies. When there is an emergency, an ambulance provider renders the service and bills Medicaid.

9.36.C. Non-emergency Ambulance

When a physician issues a written order for non-emergency ambulance transportation, usually due to the need for a stretcher or other emergency equipment, the ambulance provider may bill Medicaid directly and must maintain the physician's order as documentation of medical necessity. If non-emergency ambulance transport is not ordered by the beneficiary's physician, arrangements for payment must be between the facility and the ambulance provider, and cannot be charged to the beneficiary, beneficiary's family or used to offset the patient-pay amount.

9.37 Vaccines

Reimbursement for any vaccination ordered by the attending physician and administered in the nursing facility is included in the per diem rate. The invoiced purchase cost of the vaccine should be included as an allowable medical supply expense on the facility's cost report.

9.38 Vision

Vision services (examinations and glasses) are ancillary services and are not included in the facility's per diem.

A Medicaid copayment is not required for nursing facility beneficiaries.

SECTION 10 – SPECIAL PLACEMENTS AND AGREEMENTS

10.1 DEMENTIA UNITS

A nursing facility may elect to designate beds or units to address the special needs of beneficiaries with Alzheimer's disease or other dementing illnesses. Care for Medicaid beneficiaries in dementia specialty beds is reimbursed as defined for any other nursing facility bed.

10.2 HOLDING A BED (HOSPITAL LEAVE AND THERAPEUTIC LEAVE)

Medicaid reimburses the nursing facility for holding a bed while the beneficiary is admitted to a hospital for emergency medical treatment (hospital leave) or takes a therapeutic leave from the facility for non-medical reasons.

Prior to therapeutic leave or transfer to a hospital, providers must give written notice of the facility's bed hold and readmission policy to the beneficiary and a family member or legal representative. This must include information about Medicaid coverage for therapeutic and hospital leave. In an emergency, notice must be given to the beneficiary and family or legal representative within 24 hours. If the beneficiary refuses to have a family member notified, this must be documented in the beneficiary's record.

The written notice must specify:

- The Medicaid bed hold policy under which the beneficiary is permitted to return and resume residence in the facility; and
- The facility's written policy under which a beneficiary is readmitted to the facility when their absence is in excess of the Medicaid-reimbursed leave days.

The beneficiary must be readmitted immediately to the first available bed if the beneficiary still requires nursing facility services and is still Medicaid eligible.

10.2.A. Hospital Leave Days

Medicaid reimburses a nursing facility to hold a bed for up to ten days during a beneficiary's temporary absence from the facility due to admission to the hospital for emergency medical treatment only when the facility's total available bed occupancy is at 98 percent or more on the day the beneficiary leaves the facility. "On the day" is defined as the facility's census at midnight (i.e., 12:01 a.m.) on the day that the beneficiary leaves. Note that calculation of available bed occupancy for purposes of Medicaid reimbursement for hospital leave days is different than calculation of occupancy for cost reporting purposes.

Facilities at 97.50 percent occupancy or more may round up to 98 percent. Facilities may not round up 97.45 percent – 97.49 percent to 98 percent.

Occupancy includes all licensed beds (e.g., Medicaid-certified, dual Medicare/Medicaid certified, licensed only). The 98 percent or more occupancy does not include beds held open for hospital or therapeutic leave day(s).

In cases where a facility's available bed occupancy is below 98 percent on the day the beneficiary leaves for an emergency admission to the hospital, but rises to 98 percent or more during his hospital stay, no hospital leave days can be billed for the beneficiary. Hospital leave days are only billable for a beneficiary if the occupancy rate is 98 percent or more on the day the beneficiary leaves the hospital.

In cases where the available bed occupancy is at 98 percent on the day the beneficiary leaves and drops below 98 percent during his hospital stay, the facility may bill up to 10 hospital leave days.

In instances where a facility is enrolled with Medicaid and has more than one Provider ID number, the available bed occupancy must be calculated separately for each Provider ID number.

Examples of Worksheet for Determining % of Occupancy

		Example 1	Example 2
A.	Total Licensed Beds (excluding beds in an approved non-available bed plan and/or beds disapproved by MDCH for occupancy)	179	140
B.	Number of Total Licensed Beds Not Occupied (unoccupied beds available for a new resident)	2	7
C.	Beds for Residents on Hospital Leave (Medicaid or private pay is paying to hold the bed)	6	8
D.	Beds for Residents on Overnight Therapeutic Leave	0	10
E.	Total Residents on Leave (C + D = E)	6	18
F.	Adjusted Licensed Beds (A – E = F)	173	122
G.	Number of Residents Physically in Facility (total occupancy minus total residents on leave) (A – B – E = G)	171	115
H.	Occupancy (number of residents physically in facility divided by adjusted bed capacity) (G / F = H)	171 / 173 = 99%	115 / 122 = 94%

Facilities billing for Hospital Leave Days, must document in the beneficiary's medical (clinical) record what the facility's census was at the time the beneficiary left the facility for a hospital leave.

The facility must hold the bed and may bill Medicaid if there is reasonable expectation by the attending physician at the point of admission to the hospital that the beneficiary will return to the nursing facility by the end of the tenth day. The hospital admission must be for emergency medical treatment, as documented by the attending physician in the beneficiary's medical record.

An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the beneficiary (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The beneficiary must return to the nursing facility in ten or fewer days in order for the nursing facility to bill Medicaid for hospital leave days.

If the beneficiary is in the hospital for more than ten days, the nursing facility is released from its obligation to hold the bed and cannot bill Medicaid for **any** hospital leave days. The resident may be charged to hold the bed for those days if they agree in advance. (See Medicaid Non-Covered Leave Days subsection.) The facility is encouraged to monitor the resident during the hospital stay to determine the likely length of hospitalization.

If the resident is expected to be in the hospital for ten days or fewer and dies while in the hospital, the nursing facility may bill Medicaid for the hospital leave days up to the day before the resident died.

If the resident returns to the nursing facility under Medicare coverage, and was Medicaid eligible prior to the emergency admission, the facility may bill Medicaid for the hospital leave days if the emergency hospitalization was for ten days or fewer.

A resident is counted in the facility census if they are in the facility at midnight. If the resident is out of the facility on hospital leave at midnight, that day must be counted as a hospital leave day. If the resident returns to the nursing facility from the hospital, then is re-admitted to the hospital for the same condition that they were hospitalized for previously, the 10-day period of Medicaid reimbursed hospital leave days continues if the resident was not counted in the facility census for that day. If, given the circumstances above, the resident was counted in the facility census, a new 10-day period of Medicaid reimbursed hospital leave days may begin.

The resident need not be shown on the Medicaid claim as discharged from the nursing facility unless the hospital admission was a planned admission (not an emergency) or was longer than 10 days.

Patient-pay amounts and billing methods are not affected by this hospital leave day policy. The nursing facility should continue to collect any patient-pay amount, typically on the first day of the month, and indicate the amount collected on the Medicaid claim. The Medicaid Claims Processing System automatically deducts the patient-pay amount and reimburses the provider for the balance. If the facility bills Medicaid for hospital leave days that occur at the beginning of the month, then the nursing home should collect the patient-pay amounts as usual. The facility should charge the amount against the patient-pay that Medicaid will pay for that day. For example, if a resident has a patient-pay of $200 and is in the hospital for an emergency condition for the first five days of the month (the stay is 10 days or fewer), the nursing facility should collect the patient-pay amount from the resident, then submit a Medicaid claim. Medicaid would reimburse the facility the hospital leave day per diem rate, minus the patient-pay amount. Using 2002 figures, the facility reimbursement would be $150.30 [($70.06 x 5)-$200].

There is no limit to the number of hospital leave days per resident that may be billed to Medicaid annually as long as there are no more than 10 consecutive leave days per hospital stay.

Hospital leave days are not included in the Medicaid census statistics.

10.2.B. Therapeutic Leave Days

If the beneficiary has a temporary absence from the nursing facility for therapeutic reasons as approved by a physician, Medicaid reimburses the facility to hold the bed open for up to a total of 18 days during a 365-day period. Therapeutic leave is for non-medical reasons, such as overnight stays with friends or relatives. A resident is counted in the facility census if they are in the facility at midnight. If the beneficiary is out of the facility on therapeutic leave at midnight, that day must be counted as a therapeutic leave day.

The Medicaid Program covers up to 18 therapeutic leave days in a 365-day period for each beneficiary if:

- The facility reserves the bed for the beneficiary during his absence; and
- The beneficiary's written plan of care provides for out-of-facility visits; and
- The beneficiary returns to the facility.

There is no limit to the number of therapeutic leave days that may be reimbursed at one time as long as the total does not exceed 18 days in a 365-day period (not the calendar year). For example, if a resident goes on a 5-day family vacation beginning April 10, 2003, that resident has 13 therapeutic leave days remaining until April 9, 2004.

If a beneficiary does not return from a therapeutic leave, the beneficiary must be discharged on the date he left the facility. The date of admission and the date of discharge may not be billed as therapeutic leave days.

Therapeutic leave days must be included in the Medicaid census statistics if the therapeutic leave day is being paid by the beneficiary or Medicaid.

10.2.C. Medicaid Non-Covered Leave Days

Medicaid does not reimburse providers to hold a bed for reasons other than emergency transfer to a hospital (10-day maximum per hospital admission), or therapeutic leave (18-day maximum per 365-day period). However, the facility may hold the beneficiary's bed for other reasons and for leave days not covered by Medicaid, and bill the beneficiary if the beneficiary:

- Has prior knowledge that the service is not a Medicaid benefit; and
- Desires to have the bed reserved; and
- Agrees, in writing, to pay the facility to hold the bed at a specified rate. (The beneficiary's patient-pay amount may not be used for this purpose.)

If the beneficiary elects to not pay privately, the beneficiary has the option to return to the next available, equivalent bed. A beneficiary cannot be involuntarily transferred/discharged after a temporary absence, including discharge to obtain acute care in an inpatient hospital, unless the appropriate criteria are met and the appropriate regulations, policies, and procedures are followed.

Except for Medicaid-covered leave days and when beneficiaries have paid to hold a bed, the beneficiary must be discharged from the facility, then readmitted upon return to the first available bed.

All bed hold days (excluding hospital leave days) must be included in the Medicaid census statistics.

10.3 Involuntary Transfer or Discharge

10.3.A. Conditions

A nursing facility must not involuntarily transfer or discharge a beneficiary unless:

- It is necessary for the welfare of the beneficiary, and the beneficiary's needs cannot be met in the facility; *
- The beneficiary's health has improved sufficiently so the beneficiary no longer needs the services provided by the facility; *
- It is necessary to protect the safety of individuals in the facility;
- It is necessary to protect the health of individuals in the facility; *

* Items require documentation of medical necessity by the attending physician.

- The beneficiary has failed, after reasonable and appropriate notice, to pay (or to initiate payment under Medicaid) for a stay at the facility; or
- The facility ceases to operate.

The facility must include documentation in the beneficiary's clinical record for any of the above circumstances.

10.3.B. Transfer Trauma

For certain residents (defined below), transfer trauma must be considered when that resident may be moved due to a change in the level of nursing need.

Transfer trauma is defined as "any adverse psychological and/or physical effects occasioned by the transfer of a nursing home patient that would be materially detrimental to the physical or mental health of the patient."

Residents for whom transfer trauma must be considered include all those who have resided in the current nursing facility for at least one year, or who have been involuntarily transferred within the previous year. (A discharge to obtain acute care in an inpatient hospital, followed by an immediate readmission within three weeks to the same nursing facility, does not interrupt the continuity of a resident's stay).

The State Survey Agency evaluates transfer trauma. This evaluation considers the social, mental and emotional adjustment of the resident, including the length of time that the resident has been in the nursing facility and the relationships that the resident has formed in the facility. This evaluation may also consider the resident's age, history and success of previous placements, and history of adapting to change. Consideration must also be given to the opinion of the attending physician regarding the resident's social and emotional adjustment and the physical effects of the proposed transfer.

Transfer trauma must be considered before the resident is notified of a nursing level of care change. When Medicaid is the payer source, Medicaid payment at the current level continues while transfer trauma is being considered.

If Medicaid was not the payer source immediately prior to the transfer trauma issue being raised, then Medicaid payment is not made until a decision is reached.

If the transfer trauma decision upholds the beneficiary' s medical need to remain in a bed not certified for his present level of care, then the beneficiary's prior level of care will be retained to provide for continued Medicaid coverage.

If it is determined that there is no issue of transfer trauma, the beneficiary must be transferred to a bed or setting appropriate for the new level of care. MDCH will change the level of care code. The beneficiary or representative can appeal the level of care decision.

Concerns about involuntary transfer and/or transfer trauma should be reported to the Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)

10.3.C. Beneficiary Notification

Nursing facilities must give beneficiaries a 30-day written notice regarding transfer unless:

- The transfer or discharge is a health care emergency;
- The safety or health of beneficiaries or staff is endangered;
- The beneficiary agrees to the transfer/discharge;
- The beneficiary's health has improved sufficiently so the beneficiary no longer needs the services provided by the facility; or
- The facility ceases to operate.

The notice must include:

- The reason for the transfer or discharge;
- The effective date of the transfer or discharge;
- The location to which the beneficiary will be transferred or discharged;
- The name, address, and (toll-free) telephone number of the State Long Term Care Ombudsman;
- For beneficiaries with developmental disabilities (DD), the mailing address and telephone number of the agency responsible for the protection and advocacy of DD individuals, established under the Developmental Disabilities Assistance and Bill of Rights Act;
- For nursing facility beneficiaries with mental illness (MI), the mailing address and telephone number of the agency responsible for the protection and advocacy of MI individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act; and
- Appeal rights.

The facility must also provide:

- Sufficient preparation and orientation to beneficiaries to ensure safe and orderly transfer or discharge from the facility, as required by state and federal regulations; and
- Notice of the facility's bed-hold and re-admission policy, including the Medicaid bed-hold policy.

If a nursing facility elects to discontinue operations (voluntary closure) or withdraw from the Medicaid program, the facility must provide notice to the beneficiary as outlined above not less than 30 days before the closure or withdrawal. The notice must be sufficient to allow for suitable relocation arrangements.

10.4 Married Couples

When married beneficiaries or blood relatives live in the same Medicaid nursing facility, they may share a room if both spouses or their relatives consent. (This policy applies only to beneficiaries who both require nursing facility services. It does not apply when one beneficiary does not require nursing facility services. For example, if a husband and wife wish to share a room in a nursing facility, in order for Medicaid to cover both of them in the facility, they must both require nursing facility services. If only one of them requires nursing facility services, Medicaid only covers services for that person.)

10.5 Memorandums of Understanding (MOU) - Special Agreements for Complex Care

The Request for Prior Authorization for a Complex Care Memorandum of Understanding form (MSA-1576) is used to request prior approval (PA) for the placement of a Medicaid beneficiary for whom placement from a hospital has been, or could be, hindered due to the cost and/or complexity of nursing care or special needs. The PA covers an individually negotiated reimbursement rate for the placement. Special individualized placement requests and payment arrangements are based on medical necessity and/or service/supply needs exceeding those covered by Medicaid reimbursement for routine nursing facility care.

Examples include, but are not limited to:

- Ventilator dependent care (for nursing facilities not contracted with MDCH to provide ventilator dependent care)
- Multiple skin decubiti utilizing several treatment modalities
- Tracheostomy with frequent suctioning needs
- Beneficiaries who require intensive nursing care or treatment.

Program requirements:

- Referrals may come from either the acute care hospital or the nursing facility.
- Hospitals must document that at least ten (10) Medicaid certified nursing facilities within a 50 mile radius of the hospital refused to admit the beneficiary due to the complexity of the patient's care needs.
- Nursing facilities may request a MOU after admitting a beneficiary if the hospital failed to accurately document the beneficiary's condition and needs prior to transfer to the nursing facility. The nursing facility must request the MOU within 30 days from the date of admission to the nursing facility.

The following information must be submitted:

- A completed MSA-1576, including any requests for additional nursing, CENA, supplies or equipment. An electronic copy of the form is available on the MDCH website. (Refer to the Directory Appendix for website information.) (Refer to the Medicaid Service Descriptions Section of this chapter for information regarding what services are to be provided by the NF as part of the daily per diem reimbursement.)

- The beneficiary's medical background, including current medical status, treatment/nursing care plan, and justification for any additional nursing hours and/or special equipment requested. (This information should be included on the MSA-1576).
- Recent (within the past 30 days) lab, x-ray, and diagnostic/therapeutic test results and/or reports.
- A list of nursing facilities within a fifty (50) mile radius that have denied admission due to the complexity of care the beneficiary required, including:
  - Name and address of the nursing facility
  - Contact person's name and title
  - Date of contact
  - Reason for denial
- Documentation of the financial resources available to the beneficiary, including:
  - Medicaid coverage
  - Medicare Parts A and B
  - Other commercial insurance coverage.
  - Name and telephone number of a contact person at the nursing facility requesting the MOU.

It may take up to three weeks for the MOU to be processed. If it appears that a beneficiary, upon discharge, will require intensive nursing care, the hospital's discharge planning coordinator should initiate the prior authorization process for the MOU as early in the beneficiary's hospital stay as possible to ensure a smooth transition to the nursing facility. (Refer to the Directory Appendix for contact information.)

The hospital or nursing facility will be contacted by telephone regarding Medicaid's ability to assist with the beneficiary's placement. If approved, the NF will receive a prior authorization number to be used when billing. (Refer to the Directory Appendix for contact information.)

10.6 One-Day Stay

A nursing facility is reimbursed for a one-day stay if a Medicaid beneficiary is admitted to the facility and, the same day, is discharged from the facility due to death, return home, or transfer to another institution that is not a Medicaid-enrolled provider. The one-day stay does not apply to a beneficiary admitted to a nursing facility if, later that day, the beneficiary is discharged and transferred to another nursing facility or an inpatient hospital and, at midnight, the second facility or hospital claims the beneficiary in its daily census.

A one-day stay must be included in the Medicaid census statistics.

10.7 Religious Non-medical Health Care Center

Religious Non-medical Health Care Centers may be licensed as nursing facilities and certified for Medicaid. Beneficiaries in Medicaid-certified facilities, under the care of a practitioner, may be determined to be in need of nursing care and, therefore, covered by Medicaid.

SECTION 11 – SPECIAL PROVIDER TYPE COVERAGES AND LIMITATIONS

11.1 HOSPITAL SWING BEDS (PROVIDER TYPE 63)

In order to address the shortage of rural nursing facility beds, federal requirements allow rural hospitals to provide post-hospital extended care services. Such a hospital, known as a swing bed hospital, can "swing" beds between hospital and nursing facility levels of care on an as-needed basis. In order to receive Medicaid reimbursement, hospital swing beds must meet all applicable state and federal requirements and provide all required services.

Providers of hospital swing bed services may bill Medicaid for hospital swing bed days only when the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid inpatient diagnosis related group (DRG) of the admission. Hospitals that are exempt from the DRG reimbursement system may bill for Medicaid-covered swing bed days beginning the day of admission to the swing bed.

The total number of Medicaid-reimbursed hospital swing bed days is limited to 100 days per beneficiary per calendar year.

Providers of swing bed hospital services must transfer a beneficiary to a nursing facility, located within a 50-mile radius of the beneficiary's residence, within five business days after the hospital has been notified, either orally or in writing, that a bed has become available.

Medicaid does not require the MDS for clinical assessment purposes or reimbursement for beneficiaries in hospital swing beds. The PASARR process must be completed, as outlined earlier in this chapter, prior to placement in a nursing facility.

(Refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual for additional swing bed billing instructions.)

11.2 NURSING FACILITIES FOR MENTAL ILLNESS (NF/MI) (PROVIDER TYPE 72)

Medicaid reimburses NF/MI for services provided to qualified beneficiaries age 65 and older.

In order to be admitted to a NF/MI, a beneficiary must require specialized nursing care, in addition to having a psychiatric diagnosis requiring care.

In order to receive Medicaid reimbursement, NF/MI providers must meet all applicable state and federal requirements and provide all defined services.

Medicaid reimburses NF/MI providers at a per diem rate, which includes all of the usual covered nursing facility services as outlined in this chapter. In addition, ancillary services are also included in the per diem rate for NF/MI providers, e.g., laboratory, x-rays, medical surgical supplies (including incontinent supplies), hospital emergency room, clinics, optometrists, dentists, physicians, pharmacy. Therapy/speech pathology provided to these beneficiaries is included in the facility's per diem rate.

11.3 VENTILATOR-DEPENDENT CARE UNITS

There may be occasions when a beneficiary no longer requires acute hospital care but requires specialized care in a Ventilator Dependent Care Unit (VDCU). Medicaid authorizes admission of ventilator dependent Medicaid beneficiaries to hospital and nursing facility ventilator units with which it has agreements to provide VDCU services.

11.3.A. Placement Criteria

A request for placement must show that the:

- Beneficiary is dependent on life-supporting mechanical ventilating equipment for at least six hours per day.
- Beneficiary stay normally meets or exceeds the hospital high-day outlier threshold for DRG 475.

Approval for admission to a VDCU will **not** be given for a beneficiary who is only on CPAP or BiPAP. If a beneficiary has weaning potential or requires other rehabilitative services (in addition to the respiratory care) and is enrolled in a Medicaid Health Plan (MHP), the MHP is responsible for the first 45 days reimbursement in the post acute setting. If there is no weaning potential and the beneficiary requires only custodial care, disenrollment from the MHP may occur at the time the beneficiary is discharged from the hospital.

In situations where a beneficiary cannot immediately be placed in a nursing facility or hospital VDCU, Medicaid will cover nursing days in the inpatient hospital. When the beneficiary is in a hospital setting because a nursing facility placement is not available, Medicaid will cover the ancillary services provided by the hospital.

The hospital cannot charge a beneficiary the difference between the hospital's charge and MDCH's payment for nursing days.

If a beneficiary refuses an appropriate placement to a VDCU, the beneficiary is responsible for all hospital charges incurred after the date of referral.

11.3.B. Authorization for VDCU Placement

To begin the prior authorization process, the hospital discharge planner, case manager, or social worker must complete and submit a MSA-1634 (Medicaid Ventilator Dependent Care Assessment) form and a MSA-1635 (Medicaid Ventilator Dependent Care Authorization) form. The forms are available on the MDCH website.

The beneficiary's physician must sign the MSA-1635 and, by doing so, attests to the medical necessity of the patient transfer from an acute care setting to a nursing facility setting. Physician assistant, medical assistant, or nurse practitioner signatures may not be substituted for the physician's signature.

MSA-1634 and MSA-1635 forms must only be submitted when the resident has exhausted other resources of reimbursement. If services are authorized, MDCH will assign a nine-digit prior authorization number on the MSA-1635. The facility must enter this number on the claim when billing.

(Refer to the Directory Appendix for contact information.)

Certification, Survey & Enforcement Appendix

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SECTION 1 - INTRODUCTION

Michigan Department of Community Health (MDCH), under an approved State Plan as required by the Social Security Act, is responsible for annual Medicaid certification of all nursing facilities (other than State-owned facilities). MDCH is also responsible to ensure all Medicaid-certified nursing facilities are in compliance with Health Survey and Life Safety Code Survey requirements.

As required by federal law, the State Medicaid Agency (MDCH, Medical Services Administration) has entered into an interagency agreement with the State Survey Agency (MDCH, Bureau of Health Systems) to conduct surveys of Medicaid providers and applicants. The State Medicaid Agency (SMA) accepts the State Survey Agency's (SSA) certification decisions as final, but exercises its own determination whether to enter into agreements with providers.

For the purposes of this appendix, a Medicaid-certified nursing facility (NF) is defined as a nonstate-owned nursing home, county medical care facility, or hospital long term care unit with Medicaid certification. This appendix includes information regarding Medicaid certification of nursing facilities, staff certification, the survey process, and enforcement remedies when facilities are not in compliance with applicable requirements.

SECTION 2 - MEDICAID CERTIFICATION AND DE-CERTIFICATION OF NURSING FACILITY BEDS AND MEDICAID PROVIDER ENROLLMENT

This Section describes Medicaid certification requirements for nursing facilities, certification and de-certification of nursing facility beds, and how nursing facility providers enroll in Medicaid.

The State Medicaid Agency (SMA) is responsible for initial certification and annual certification of beds for nursing facilities seeking Medicaid reimbursement. In order for a provider to receive Medicaid reimbursement for nursing care, the nursing facility beds must be Medicaid certified by the SMA and the provider must be enrolled with Medicaid. The State Survey Agency (SSA) is responsible for conducting any required certification surveys for the SMA.

2.1 DUAL CERTIFICATION

MDCH requires all new Medicaid-certified nursing facility beds to also be certified for Medicare. Requests for certification of new Medicaid beds that are not Medicare-certified will be denied. Requests for initial Medicare certification may be made to the provider's SSA Licensing Officer. Facilities must meet state and federal regulations for certification.

Providers may seek annual certification of nursing facility beds currently certified as Medicaid-only. Beds that were certified as Medicaid-only as of August 1, 2004 are not required to become Medicare-certified. This exception also applies to Medicaid-only certified beds that were designated as unavailable for occupancy on August 1, 2004. However, MDCH strongly encourages Medicare and Medicaid (dual) certification of all nursing facility beds in order to maximize access for beneficiaries.

A nursing facility that has certified beds that were granted an exception under this policy, and that is subsequently involved in circumstances that would require it to enroll with Medicaid (such as a change in ownership), must secure Medicare certification for Medicaid beds within one year. A provider's failure to secure dual certification for all Medicaid-certified beds will result in denial of Medicaid certification and termination of the Medical Assistance Provider Enrollment & Trading Partner Agreement.

A provider that requests new Medicaid certification for some beds in a nursing facility must dually certify all Medicaid beds in the facility before any new Medicaid bed certifications will be approved for the facility, even if the existing Medicaid-certified beds were granted an exception under this policy. For example, a nursing facility has a distinct part or unit that is certified as Medicaid-only and is granted an exception under this policy. The provider adds a new wing and requests Medicaid certification for the new beds. The new beds will be approved for Medicaid certification only if all Medicaid beds in the nursing facility are also certified for Medicare, including the beds in the historically Medicaid-only unit.

A licensed nursing facility entity that becomes a provider as a result of the purchase of a previously closed or currently operating Medicaid-only nursing facility must receive Medicare certification for all Medicaid-certified beds in that nursing facility within one year from the date of purchase of an operating nursing facility or the date of reopening of a previously closed nursing facility. The provider will receive a provisional Medicaid provider agreement while pursuing Medicare certification of the Medicaid-certified beds. This provisional agreement is time limited and holds the provider to the loss of Medicaid certification and disenrollment without appeal if Medicare certification is denied. If warranted, the SMA may grant an additional grace period contingent upon evidence that substantial progress has been made toward Medicare certification. Failure to meet this requirement will result in de-certification of the

Medicaid beds and termination of the Medical Assistance Provider Enrollment & Trading Partner Agreement.

A nursing facility that currently has Medicare certification of its Medicaid beds must maintain the dual certification. A nursing facility that voluntarily disenrolls or decertifies beds from Medicare will lose Medicaid certification of those beds. A nursing facility that loses its Medicare certification through the Centers for Medicare and Medicaid Services (CMS) regulatory enforcement actions will automatically lose its Medicaid certification. An exception or exemption to this dual certification may be made pursuant to the provisions contained in Section 21718 of P.A. 368 of 1978 (MCLA 333.21718). Any exception or exemption granted to a nursing facility under Section 21718 of P.A. 368 of 1978 prior to August 1, 2004 will be recognized.

Facilities granted a Certificate of Need (CON) for special population beds, as defined in the Certificate of Need Review Standards for Nursing Home and Hospital Long-Term Care Unit Beds, are also required to dually certify some types of special population beds (e.g., ventilator dependent care beds). ICF/MR or MI beds need not be dually certified.

A provider must request and receive dual Medicaid and Medicare certification for new Medicaid beds acquired through the CON process, e.g. new construction or the redistribution of certified beds.

2.2 Medicaid Bed Certification Limits

Individual facilities seeking to enroll in the Medicaid program or seeking to increase the number of Medicaid-certified beds must apply as outlined in the Medicaid Nursing Facility Bed Certification Process subsection of this appendix. Requests to the SMA will be reviewed in date order and must be received 45 days before the first of the month beginning the next quarter of the provider's cost reporting year. MDCH will authorize Medicaid-certified beds, limited by the aggregate Upper Bed Limit (set in 1996 at 47,542), based on the criteria outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests subsection. Preference will be given to facilities that are requesting Medicaid certification in order to dually certify beds, to facilities that are creating innovative living environments for beneficiaries who choose nursing facility care, and to facilities in geographic areas with limited Medicaid accessibility. Changes in bed certifications will take place after approval is granted effective on the first of the month beginning the next quarter of the provider's cost reporting year. Changes in bed certifications will not be approved on a retroactive basis.

2.3 Criteria for Evaluation of Medicaid Bed Certification Requests

The SMA will collaborate with the SSA when making a determination regarding the approval or denial of any application for Medicaid bed certification and provider enrollment. Approval or denial of an application to MDCH for Medicaid bed certifications will be based on the following criteria:

- Verification from the SSA that the beds are also Medicare-certified.
- The nursing facility's historical and current survey performance demonstrates no regulatory deficiencies or only deficiencies with minimal impact on residents. The nursing facility has not been subject to one of the following actions or concerns within three years (or as noted) of the filing of an application for Medicaid bed certification:

- A state enforcement action involving license revocation, a limited or total Ban on Admissions, reduced license capacity, selective transfer of residents, receivership, or appointment of a clinical/administrative advisor or temporary manager.
- Termination of a Medical Assistance Provider Enrollment & Trading Partner Agreement initiated by MDCH.
- A state rule violation showing failure to comply with state minimum staffing requirements and/or a federal citation documenting potentially harmful resident care deficits resulting from insufficient staff.
- A state or federal finding of Immediate Jeopardy.
- Repeat citations at the harm or substandard quality of care level. "Repeat citation" is defined as two citations of the same federal deficiency, or two or more citations within the same regulatory grouping, at the substandard quality of care, harm, or Immediate Jeopardy levels, issued within the last three years or three standard survey cycles.
- A number of citations at Level Two or above on the scope and severity grid on three consecutive standard surveys that exceeds twice the statewide average number of citations. (The time frame for this criterion may exceed three years.)
- A number of citations resulting from abbreviated surveys at Level Two or above on the scope and severity grid during any calendar year that exceeds twice the statewide average of abbreviated survey citations.
- A federal or state termination or decertification action.
- A federal or state action to deny payment for new or all admissions.
- A filing of bankruptcy or failure to meet financial obligations that threatens the ability of the nursing facility to achieve or maintain compliance with state and federal requirements.
- An outstanding debt to MDCH (i.e., cost settlement, civil money penalty [CMP] fine, provider bed tax, licensing fees). This does not include financial issues that are in the appeal process.
- Failure to comply with a state correction notice order.
- Enforcement action against the administrator's license in current or previously administered nursing facilities.
- Any other concerns reasonably related to the ability of the nursing facility to maintain compliance with Medicare and Medicaid Requirements for Long Term Care Facilities or to provide appropriate care to residents.

- If currently enrolled as a Medicaid provider, in addition to the criteria above, must be a provider in good standing, defined as:
  - The nursing facility, owner(s), administrator, or other staff are not sanctioned or excluded by Medicare or Medicaid;
  - The nursing facility is in compliance with the Medicare and Medicaid Requirements for Long Term Care Facilities.

Medicaid may enter into a provisional Medical Assistance Provider Enrollment & Trading Partner Agreement with a provider (or the owner or management company) that does not meet the above criteria if:

- The applicant and the owner or management company take actions acceptable to MDCH to correct, improve or remedy any conditions or concerns that would result in denial of the application; and
- The applicant and the owner or management company attains and maintains compliance with the criteria above during the period of the provisional Medical Assistance Provider Enrollment & Trading Partner Agreement. Failure of the provider to comply with the terms of the conditional agreement will result in termination without appeal of the provisional Medical Assistance Provider Enrollment & Trading Partner Agreement.

2.4 Medicaid Nursing Facility Bed Certification Process

Current providers who wish to change their Medicaid-certified beds (increase, decrease, relocate) and providers who wish to enroll in the Medicaid Program may do so as outlined in this subsection. A written request to change Medicaid-certified beds must contain the following:

- Number and location of facility beds
- Current certification designation of all facility beds by unit or wing
- Requested number and proposed location of increased, decreased, or relocated Medicaid beds, with an attached layout of the facility showing the current and proposed distribution of beds.

A provider may request a change in Medicaid bed certifications at the time of annual survey and any time throughout the year up to once per quarter.

The change in bed certifications will take place after approval is granted effective on the first of the month beginning the next quarter of the provider's cost reporting year. Changes in bed certifications will not be approved on a retroactive basis.

In addition to the process outlined below, nursing facilities must abide by the procedures outlined in the State Operations Manual, Section 3202.

MDCH will respond to Medicaid bed certification requests with a determination within 45 days of receipt of all requested information.

2.4.A. Bed Certification Process for Medicaid Enrolled Providers

Nursing facilities that are currently enrolled with Medicaid and want to change their number of Medicaid-certified beds must file a written request with their SSA Licensing Officer and with the SMA. The SMA and the SSA will coordinate regarding the consideration and disposition of requests for additional Medicaid beds. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests and the Dual Certification subsections of this appendix.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and the MDCH LTC Reimbursement and Rate Setting Section (RARSS) will be notified, in writing, by the SMA. If the request is denied, the provider will be notified of their appeal rights in writing. If the request is approved, the SSA will be given approval to issue a new Notice of Licensure/Certification Action (LC-180) reflecting the change.

2.4.B. Bed Certification Process for Nursing Facilities Not Enrolled in Medicaid

This subsection applies to providers operating existing facilities that have not previously participated in the Medicaid Program, or providers seeking to certify Medicaid beds following the loss of certification due to a regulatory action.

Non-Medicaid providers seeking to receive Medicaid certification for nursing facility beds and receive Medicaid payment must file a written request with their SSA Licensing Officer and with the SMA. The SMA and the SSA will coordinate regarding the consideration and disposition of the request for Medicaid bed certifications. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests subsection of this appendix.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and RARSS will be notified, in writing, by the SMA. If the request is denied, the SMA will notify the provider of their appeal rights in writing. If the request is approved, the SMA will authorize the SSA to issue a new LC-180 reflecting the change.

The provider must also enroll in Medicaid as outlined in the Medicaid Provider Enrollment subsection of this appendix.

2.4.C. Bed Certification Process During a Change in Ownership (CHOW)

A provider seeking a change in ownership of a nursing facility must first receive approval through the CON process within MDCH. The new provider can avoid a delay in payment and address any potential certification issues by submitting a written 90-day advance notice, plus a copy of the sale and/or lease agreement, to the SSA Licensing Officer, the SMA/LTC Services Section and RARSS. (Refer to the Directory Appendix for contact information.)

The following are changes in ownership that must be reported to the SMA and SSA, regardless of whether a CON is required:

- A change from sole proprietorship to partnership or corporation,
- A change from partnership to sole proprietorship or corporation,
- A change from corporation to sole proprietorship, partnership or corporation,
- Sale or lease of a nursing facility,

- Transfer or sale of stock resulting in a change of the controlling interest in a privately held company,
- Consolidation or merger of two or more corporations that results in the creation of a new corporation.

If the new owner does not want to make any changes in bed certifications, no additional action regarding certifications is required and the certifications continue as they were under the previous owner. However, if the facility has beds designated as Medicaid-only, the new owner must dually certify all Medicaid beds within one year as outlined in the Dual Certification subsection. As part of the CHOW approval process, the SMA may deny bed certifications and recommend against Medicaid enrollment based on the criteria in the Criteria for Evaluation of Medicaid Bed Certification Requests subsection. In addition, dual certification requirements apply as outlined in the Dual Certification subsection.

If the new owner wants to change the bed certifications, a written request must be filed with the SSA Licensing Officer and with the SMA Long Term Care Services Section. The SMA and the SSA will coordinate regarding the consideration and disposition of the request for additional Medicaid bed certifications. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests subsection.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and the RARSS will be notified, in writing, by the SMA. If the request is denied, the SMA will notify the provider of appeal rights in writing. If the request is approved, the SMA will authorize the SSA to issue a new LC-180 reflecting the change.

A new owner is considered a new provider and must enroll in Medicaid as outlined in the Medicaid Provider Enrollment subsection, regardless of whether any bed certification changes are made.

2.4.D. Bed Certification Process for a New Nursing Facility or Newly Licensed Nursing Facility Beds

A provider seeking to build a new nursing facility, build a new section of a nursing facility, significantly remodel, or newly license nursing facility beds must first receive approval through the CON process within MDCH.

Providers seeking to receive Medicaid certification for the new nursing facility beds and receive Medicaid payment must file written requests with the SSA Licensing Officer and with the SMA. The SMA and the SSA will coordinate regarding the consideration and disposition of the request for Medicaid bed certifications. Medicaid approval or denial of the application will be based on the Criteria for Evaluation of Medicaid Bed Certification Requests.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and RARSS will be notified in writing. If the request is denied, the SMA will notify the provider of appeal rights in writing. If the request is approved, the SMA will authorize the SSA to issue a new LC-180 reflecting the change.

If not already enrolled, the provider must enroll in Medicaid as outlined in the Medicaid Provider Enrollment subsection.

2.5 MEDICAID PROVIDER ENROLLMENT

To enroll with Medicaid, a nursing facility must:

- Receive written notice from the SMA approving the Medicaid bed certifications.
- Receive an LC-180 from the SSA authorizing the Medicaid bed certifications. This document must indicate Medicare certification of the new Medicaid certified beds.
- Complete a New Provider Information Packet to establish data with the RARSS. (A New Provider Information Packet may be obtained from RARSS or the MDCH website. Refer to the Directory Appendix for contact and website information.)
- Complete a Medical Assistance Provider Enrollment & Trading Partner Agreement. (Requests for an application may be made to MDCH Provider Enrollment. Refer to the Directory Appendix for contact information.)
- Nursing facilities are required to enroll with the State of Michigan Vendor and Contractor Payment System. Providers can enroll on-line or call the Payee Registration Helpline. (Refer to the Directory Appendix for contact information.)

A provider will not be enrolled with Medicaid, which includes issuance of provider ID number for billing, until MDCH Provider Enrollment has received:

- A copy of the letter from MDCH authorizing the CON (for new providers and CHOW).
- Written notice from the SMA that the nursing facility has been approved for Medicaid bed certifications. This will include a copy of the LC-180 indicating dual certification (Medicare) for the new Medicaid-certified beds.
- Notice from the RARSS that the provider has the required data on file.
- A completed Medical Assistance Provider Enrollment & Trading Partner Agreement.
- A copy of the nursing facility license.

NOTE: The provider's Federal Employer ID number registered with the Vendor and Contractor Payment System must agree with the Federal Employer ID on file with the RARSS and in the nursing facility enrollment file with MDCH Provider Enrollment.

2.6 Notification Process for Regulatory Actions

MDCH or CMS may make decisions that result in the loss or reduction of a provider's Medicaid-certified beds. Loss of certification, or de-certification, means that Medicaid will no longer pay for any service in the nursing facility related to the de-certified beds.

MDCH or its designee notifies the following entities, in writing, of the loss of Medicaid certification at least 30 days prior to the effective date of payment termination:

- The affected nursing facility,
- The local Michigan Department of Human Services (MDHS) office, and
- The public by means of public notice in a local newspaper.

This notification of the nursing facility's loss of certification will state that residents must either:

- Make other arrangements for payment to the nursing facility; or
- Relocate to a setting that is Medicaid certified.

The provider may request assistance from MDHS to coordinate relocation for those beneficiaries who wish to transfer. MDCH may choose to apply the Nursing Facility Closure Protocol described in the Nursing Facility Closure Protocol subsection to protect the best interests of residents faced with transfer.

2.7 Nursing Facility Closure Protocol

An interagency agreement exists, including the SMA, the Office of Services to the Aging (OSA), the SSA, and MDHS, to delineate the roles and responsibilities of the respective agencies when residents of licensed/certified nursing facilities must be relocated due to nursing facility involuntary or voluntary closure. The agreement applies to all nursing facilities, including those that are county medical care facilities or hospital long-term care units. At the time of a closure, the nursing facility will be provided with a copy of this agreement and contact information for the agency representatives who will be involved in the closure.

2.8 Voluntary Withdrawal From Participation in the Medicaid Program or Voluntary Nursing Facility Closure

A provider may choose to close voluntarily, not as a result of regulatory action. A provider may also choose to continue operating as a nursing facility, but withdraw from participation in the Medicaid Program. In both situations, the nursing facility must follow established guidelines to assure safe and appropriate care of residents.

When a provider decides to close voluntarily, it must provide written notice at least 30 days in advance to residents and, if known, a family member or legal representative of the resident. In order to allow time for appropriate relocation, facilities are encouraged to provide residents with as much notice as possible in excess of the 30 days required by law. The provider is responsible for the safe and appropriate relocation of all residents.

Actual notice of closure must be given, which means that the notice must be given to the resident and a family member or legal representative in a form that they can understand and must be explained to them as needed. The notice must include contact information for the LTC Ombudsman. Facilities are encouraged to include the following information:

- The timeline for voluntary closure or withdrawal from Medicaid
- The process for relocation
- The long term care options available to residents, including community-based care
- Contact information for assistance, e.g. the Area Agency on Aging.

The provider must submit written notification of termination at least 60 calendar days prior to the termination to MDCH Provider Enrollment, RARSS, the SSA Licensing Officer, the SMA/LTC Services Section, and the local MDHS office. (Refer to the Directory Appendix for contact information.)

In the event of a voluntary closure, the nursing facility remains Medicaid-certified until all residents are relocated.

If the nursing facility chooses to withdraw from Medicaid but remain open as a licensed nursing facility, residents who are Medicaid eligible at the time of facility disenrollment may remain in the facility and receive Medicaid payment. The nursing facility's Medicaid enrollment will continue for purposes of payment for state plan services as long as Medicaid residents remain in the facility.

The interagency agreement referenced in the Nursing Facility Closure Protocol subsection of this appendix addresses voluntary closures as well as regulatory closures, and outlines the responsibilities of the state agencies involved. The SSA monitors the withdrawal or closure of a nursing facility. The provider may request MDHS assistance with resident relocation if needed.

If the provider does not fulfill their responsibilities for the safe and appropriate relocation of residents, as reported by the SSA, the State Closure Team may change the closure into a regulatory action. At that point, the closure becomes non-voluntary and the State Closure Team may request the assistance of a closure agent or take other measures to insure a safe and orderly transfer of residents. The interagency agreement referenced in the Nursing Facility Closure Protocol subsection of this appendix would apply.

2.9 Nursing Facility Filing of Bankruptcy

Medicaid-enrolled providers are required to notify the MDCH Long Term Care Services Section Manager and the RARSS Manager immediately upon filing for bankruptcy. (Refer to the Directory Appendix for contact information.)

2.10 Re-entry After De-certification

A nursing facility may re-enter the Medicaid Program after decertification (whether voluntary or involuntary) if the following conditions are met:

- Submission of a request to the SSA for re-entry, including documentation indicating that the factors leading to a regulatory termination no longer exist.
- Evidence that all of the applicable statutory and regulatory requirements have been met.

- There is reasonable assurance that the deficiencies that caused the regulatory termination will not reoccur.
- The facility is concurrently pursuing Medicare certification.
- The facility meets all enrollment criteria outlined in this section.

Upon re-entry into the Medicaid Program, all Medicaid beds must also be Medicare certified.

The process for re-entering the Medicaid Program includes:

ACTION	DESCRIPTION OF PROCESS
Application	The nursing facility must make application for program re-entry to the SSA. The SSA forwards the completed application and evidentiary confirmation to CMS and the SMA for review and processing. A nursing facility may apply for re-certification at any time; however, the Criteria for Evaluation of Medicaid Bed Certification Requests apply as outlined in this section.
Departmental Review	The SMA makes a formal review of the nursing facility's financial status and requests confirmation of compliance with all civil rights requirements from the Office of Civil Rights (OCR). If financial responsibility and compliance with the civil rights requirements are confirmed, a reasonable assurance period (not subject to appeal) is set and the SSA is asked to conduct an initial survey.
Survey Activity	There will be at least two surveys during the reasonable assurance period. ▪ **Initial Survey** - A survey is conducted at the beginning of the reasonable assurance period to document compliance with previously cited deficiencies. The initial survey may be a partial or full survey at the discretion of MDCH. A finding of substantial compliance at this survey will allow the nursing facility to begin the reasonable assurance period. If the nursing facility is found to not be in substantial compliance, then it must re-apply. ▪ **Second Survey** - A full survey must be conducted and the nursing facility must be in substantial compliance in order for the reasonable assurance period to end. The SSA will schedule the survey to coincide with the end of the established reasonable assurance period. If the nursing facility has maintained compliance during the reasonable assurance period, it may be approved for Medicaid enrollment. If the nursing facility is not in substantial compliance at the second survey, it must enter another reasonable assurance period if it continues to seek re-entry into Medicaid. ▪ **General Survey Protocol** - Facilities are afforded the same rights for challenging survey results as in the standard certification process, which is through the administrative review process within the SSA. During the reasonable assurance period, the SSA may conduct as many surveys as approved by Medicaid to document compliance with state and federal requirements. Surveys are unannounced; therefore, the nursing facility will only receive acknowledgement of receipt of the approved application and that Medicaid enrollment is based on the outcomes of the surveys conducted. All survey reports (CMS-2567L) are forwarded to the SMA within 10 working days to determine the significance of any findings and the resultant action plan. The results of each survey are evaluated to ensure that the reasons for

ACTION	DESCRIPTION OF PROCESS
	the termination no longer exist or are at the level of substantial compliance (Level One – Cells A, B or C). Facilities are notified of the determination, in writing, by the SMA. If the SSA determines that the conditions for re-entry are met, Medicaid enrollment will be approved. If the SSA determines that the conditions for re-entry have not been met, the SSA will send the provider a denial letter. The nursing facility may correct the deficiencies and re-apply for certification, resulting in another reasonable assurance period.
Reasonable Assurance Period	The reasonable assurance period is designed to assure that a nursing facility can operate for a certain period of time without the re-occurrence of the deficiencies that led to termination from participation in the program(s). The SMA contacts the SSA to conduct surveys during the reasonable assurance period. The reasonable assurance period begins when the initial survey is completed, which assures MDCH that the nursing facility is complying with requirements for which they were originally de-certified. The SMA will establish a reasonable assurance period, typically from one to six months duration. The length of the reasonable assurance period is not subject to appeal. The time frame for reasonable assurance is based upon criteria, which may include: ▪ A history of maintaining compliance ▪ Absence of a pattern of repeat citations ▪ Timely submission of plans of correction and implementation of approved plans of correction when needed ▪ Number of adverse actions initiated in the past three years ▪ History of termination and re-admission to the program ▪ Current compliance status ▪ Existence of other factors that may affect compliance, e.g., staffing concerns, turnover of key personnel, pay scale The SMA will not approve Medicaid enrollment until the reasonable assurance period has been satisfied. During the reasonable assurance period, the nursing facility must: ▪ Employ adequate management and care staff to provide care in accordance with all applicable federal, state and local regulations.Limit admissions to two residents per day or four residents in a seven-day period, regardless of payment source. ▪ Develop an admissions informed consent document that is acceptable to the SMA and that explains the re-entry process. The document should further explain to the resident (or authorized representative) that his residency in the nursing facility could be temporary and a transfer to another setting may be necessary if the nursing facility fails to meet all of the requirements for certification. This notice must be explained to, and signed by, the resident or his authorized representative. A signed copy of this document must be placed in the resident's record.

ACTION	DESCRIPTION OF PROCESS
Appeals Procedure	An applicant may appeal a denial of Medicaid enrollment by submitting a written request within 60 days of the date of the denial decision. The appeal should be addressed to the MDCH Administrative Tribunal and Appeals Division. (Refer to the Directory Appendix for contact information.) The written appeal must include documentation to support the appeal. If the applicant fails to submit documentation within the 60 days, then the denial decision remains in effect.
Payment	Providers are eligible for Medicaid reimbursement when the nursing facility has been found to meet the conditions for re-entry and is an enrolled Medicaid provider. Under extraordinary circumstances, the SMA may elect to enter into a provisional Medicaid provider agreement during the reasonable assurance period. In most cases, Medicaid reimbursement is not available until the facility has met all required conditions.

2.11 NON-AVAILABLE BEDS

Any nursing facility bed is considered available for occupancy if the bed is licensed and Medicaid certified, unless it is removed from service due to a regulatory ban on admissions or removed voluntarily using the SMA's non-available bed policy.

The SMA allows nursing facilities to designate beds as non-available, thereby removing them from the occupancy and rate setting calculations. For more information on this policy, refer to the Cost Reporting & Reimbursement Appendix of this chapter.

SECTION 3 - STAFF CERTIFICATION

All health care professionals performing duties within Medicaid-certified nursing facilities must possess the licensure and certification credentials required for their individual disciplines.

3.1 NURSE AIDE CERTIFICATION AND TRAINING

A nurse aide employed in a Medicaid-certified nursing facility must be a Certified Nursing Assistant (CNA). Medicaid reimburses facilities through the annual cost settlement process for the Medicaid share of documented costs directly related to meeting the nurse aide training and testing requirements. Training programs and testing sites must be approved by the SSA in order for those costs to be reimbursed by Medicaid**.** A nursing facility may not charge its employed aides for training, testing, and registry costs related to meeting these requirements. (Refer to the Cost Reporting & Reimbursement Appendix of this chapter for additional information.)

The SSA is responsible for approval of programs that train and certify nurse aides for employment in all Medicaid-certified nursing facilities.

- For information about training requirements, programs or facilities, or concerns regarding the testing program or information placed on the Nurse Aide Registry, contact the MDCH, Bureau of Health Professionals.
- For testing registration information or assistance, or test site concerns, contact the Michigan Nurse Aide Customer Service.
- To inquire about a nurse aide's listing on the Registry, name and good standing, contact the Michigan Nurse Aide Registry.

(Refer to the Directory Appendix for contact information.)

3.2 EMPLOYEE SCREENING (CRIMINAL BACKGROUND CHECKS)

Nursing facilities are prohibited from employing, independently contracting with, or granting clinical privileges to any individual making application or being offered privileges who has been convicted of certain crimes. Public Act 303 of 2002 requires nursing facilities to facilitate and bear the cost of criminal background checks, either through the Michigan State Police or the Federal Bureau of Investigation (depending on defined criteria), on all individuals seeking to perform direct services to residents. The law also provides for the sharing of criminal background information with other member agencies of the provider community for the purpose of applicant screening.

An overview of Public Act 303 of 2002 and template forms for use by nursing facilities conducting criminal history checks on applicants are available on the MDCH website. (Refer to the Directory Appendix for website information.)

SECTION 4 - NURSING FACILITY SURVEY

The purpose of surveying nursing facilities in the State of Michigan is to ensure quality of life and quality of care for residents. In order to fully comply with the applicable federal and state statutes, the State Medicaid Agency has contracted with the State Survey Agency to conduct nursing facility certification surveys. This contract represents the intent and purpose of both agencies to promote high quality health care and services for beneficiaries under the Medicaid Program to:

- comply with state and federal statutes, regulations and guidelines requiring the proper expenditure of public funds for the administration of the Medicaid Program and certification of health care providers;
- assure that the services provided under Title XIX and Title V of the Social Security Act are consistent with the needs of beneficiaries and the programs' objectives and requirements.

Reports generated as a function of this process are used by MDCH to assure proper payment of claims submitted, to facilitate enforcement actions, and to assess continued certification under the current Medical Assistance Provider Enrollment & Trading Partner Agreement.

4.1 SURVEY PROCESS

The basic survey protocol, including criteria and procedures, is the same for participation in both the Medicaid and Medicare Programs. The State Survey Agency (SSA):

- At appropriate intervals as prescribed by federal and state regulations, conducts on-site surveys, re-surveys and other necessary monitoring of the providers applying to or already participating in the Medicaid Program to determine compliance with program requirements.
- Recommends to the SMA certification of those providers that meet applicable federal and state statutes and regulations. The methodology of survey, evaluation and certification complies with applicable statutes, regulations, the provisions of the intraagency agreement and is subject to review and comment by the SMA.
- Notifies the SMA and the individual provider within five working days of a certification determination and 30 calendar days prior to the expiration or automatic cancellation date of a time limited certification. Such notifications shall be made by a document process mutually agreed upon by both agencies and shall include information sufficient in detail to allow Medicaid to carry out appropriate provider agreement action. This document process shall also allow for extensions of existing certifications as provided for in federal regulations.
- Annually provides to Medicaid a complete listing of all certifications in effect on January 1st of that year.
- Determines and authorizes any waiver of provider requirements granted, the conditions of the waiver, and the time period such waiver will be in effect.

4.2 Survey Review

The SSA sends all survey reports with enforcement recommendations to the SMA for review. Reports and subsequent enforcement recommendations include information sufficient in detail to allow the SMA to carry out appropriate provider agreement action. Following review and authorization by the SMA, the SSA may be designated to generate any or all of the necessary certification and enforcement documentation pertaining to a participating provider.

SECTION 5 - NURSING FACILITY ENFORCEMENT

This enforcement policy applies when the State Survey Agency (SSA) or the Centers for Medicare and Medicaid Services (CMS) determines, on the basis of a standard, abbreviated, extended, or partial extended survey, that a provider is or was out of compliance with the federal certification requirements as stated in 42 CFR Part 488, Survey, Certification and Enforcement Procedures. In Michigan, the Michigan Department of Community Health, Bureau of Health Systems functions as the State Survey Agency.

5.1 AUTHORITY

The Omnibus Budget Reconciliation Act (OBRA) of 1987, as amended, incorporated specific provisions for nursing home reform into the Social Security Act, including revised requirements for survey, certification, and enforcement of providers participating in the Medicare and Medicaid programs. Applicable regulations are found at 42 CFR Part 488.

5.2 GUIDING PRINCIPLES OF ENFORCEMENT

5.2.A. Philosophy

- All long term care providers have the **responsibility** to provide person-centered quality care and services appropriate to the needs of the residents they serve.
- Long term care providers are an essential **resource** for communities, providing health care services, education, and employment.
- MDCH, as the licensing and certification authority, must insure that all Michigan long term care providers fulfill their responsibility to provide **quality** services.

5.2.B. Purpose

To develop, implement, and support an enforcement system that:

- **Promotes** continuous provision of quality care and the highest practicable physical, mental and psychosocial functioning of each resident.
- **Protects** the health, welfare, rights, and choices of long term care residents, as defined by law and regulation, without infringing upon the rights of the resident.
- **Promptly corrects** noncompliance through effective application of appropriate regulatory remedies.

5.3 ENFORCEMENT PRINCIPLES

- The enforcement system must reflect a philosophy of serving resident needs by providing quality care.
- The SSA and the SMA must both strive for consistency in identifying deficiencies and in decision-making for selection and application of remedies. This enforcement principle is consistent with the intent of federal enforcement regulations, the State Operations Manual, and the CMS evaluation process for State Survey Agency performance.

- The SMA's enforcement plan contains a range of remedies. This allows an appropriate remedy scheme tailored to the facility and the cited deficiencies.
- Repeat noncompliance or failure to obtain compliance will result in the application of progressively stronger remedies.
- Remedies that displace residents from their homes will only be used as a last resort; such remedies include facility closure, termination of Medicaid or Medicare provider agreements, or transfer of residents. These remedies will not be used unless the health, safety and/or welfare of the residents is seriously affected, other remedies have not resulted in the facility's ability to achieve and maintain substantial compliance, and/or the physical plant is not a viable setting for quality care and services.
- State enforcement remedies for nursing facilities must include, at a minimum, statutorily specified remedies for skilled nursing facilities and may include additional or alternative remedies approved by CMS.

5.4 Facility Compliance and Deficient Practice

The SSA or CMS, on the basis of a standard, abbreviated, extended or partial extended survey, will determine whether a participating provider is in compliance with the federal regulations governing Medicaid certification. Based on this determination, one or more remedies (corrective actions) may be selected based on the seriousness of the deficiency, facility history, welfare of the residents, and the likelihood that the remedy will promote prompt and sustained compliance. Enforcement remedies include both federal and state enforcement options. Criteria have been designed to minimize the time between identification of the deficiencies and application of remedies. Repeated or uncorrected deficiencies will be assessed progressively stronger remedies. If the SSA finds that a provider currently meets the requirements, but previously was noncompliant, the SSA may impose a remedy for the days it finds that the facility was not in compliance. Nothing in this paragraph shall be construed as restricting the remedies available to the MDCH to address a nursing facility's deficiencies.

5.5 Determining the Seriousness of Deficiencies

To determine the seriousness of deficiencies for the purpose of selecting enforcement remedies, MDCH will consider the factors of scope and severity. **Scope** represents how much of the facility, or how many residents, are or may be affected by a specific deficient practice. **Severity** represents the potential for harm, or the level of harm that has occurred. Scope and severity are assigned an alphabetic and numeric level on the remedy determination grid. The most serious deficiency cited (based on level of scope and severity) determines the category or categories of remedies to be applied. Other factors in the selection of remedies include:

- whether the deficiencies immediately jeopardize the health, safety, or welfare of the facility's residents;
- the relationship of one deficiency to other deficiencies;
- the facility's compliance history;

- the likelihood that the selected remedy will promote correction and continued compliance;
- the provider's culpability, i.e., whether noncompliance is the result of neglect, indifference or disregard;
- the relationship of one remedy to other remedies.

5.5.A. Severity

LEVEL OF SEVERITY	DEFINITION
No actual harm with a potential for minimal harm	The deficiency has the potential for causing no more than a minor negative impact on the resident(s).
No actual harm with a potential for more than minimal harm, but not Immediate Jeopardy	Noncompliance that results in minimal physical, mental, and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his highest practicable physical, mental and psychosocial well being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
Actual harm that is not Immediate Jeopardy	Noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his highest practicable physical, mental, and psychosocial well being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
Immediate jeopardy to resident health or safety	A situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, serious harm, impairment, or death to a resident receiving care in the facility.

5.5.B. Scope

SCOPE OF IMPACT	DEFINITION
Isolated	Scope is isolated when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations.
Pattern	Scope is a pattern when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) has been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the facility.

SCOPE OF IMPACT	DEFINITION
Widespread	Scope is widespread when the problems causing the deficiencies are pervasive in the facility or represent systemic failure.

5.6 ENFORCEMENT REMEDIES

A remedy is a corrective action. Remedies available to MDCH are specified in federal and state law. When the scope and severity increase, the deficiencies repeat, or the facility fails to maintain substantial compliance, selected remedies may also increase.

5.6.A. Federal Enforcement Remedies

Each federal remedy listed below is described in rules as stated in 42 CFR Part 488 et. seq., and further discussed in the CMS State Operations Manual for Medicaid and/or Medicare certified facilities. Federal remedies available to MDCH or CMS include, but are not limited to:

- Denial of payment for new Medicare and/or Medicaid admissions
- State monitoring
- Temporary management
- Directed plan of correction
- Directed inservice training
- Civil money penalties
- Transfer of residents
- Closure of facility with transfer of residents
- Termination of Medical Assistance Provider Enrollment & Trading Partner Agreement
- Denial of payment for all Medicare and/or Medicaid residents imposed by CMS
- Alternative or specified state remedies approved by CMS
- Administrative/Clinical Advisor

5.6.B. State Enforcement Remedies

The SSA has the option of imposing any state or federal remedy based on the facility's failure to maintain compliance, deficiencies cited within the same regulatory grouping that repeat within the last 24 months (or two standard survey cycles), and the degree of culpability of the facility. In addition to federal remedies, the SMA may accept one or more of the following enforcement actions taken by the SSA under state licensure authority. Also see Michigan Enforcement Rules for Long Term Care Facilities at R 330.11001-330.11017.

- Emergency Order Limiting, Suspending or Revoking a License

- Notice of Intent to Revoke Licensure
- Correction Notice to Ban Admissions or Readmissions
- Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific Requirements
- Appointment of a Temporary Manager or Clinical/Administrative Advisor
- State Patient Rights Penalties, if applicable

5.7 Denial of Payment for New Admissions (DPNA)

Denial of payment for new admissions may be imposed at any time a provider is not in substantial compliance and must be imposed when a provider is not in substantial compliance within three months of being found out of compliance.

The DPNA enforcement remedy stops Medicaid payment for any new residents admitted to the facility after the effective date of the DPNA. The resident's status on the effective date of the denial of payment is the controlling factor in determining whether readmitted residents are subject to the denial of payment.

Guidelines for the definition of new admission are:

- Medicaid residents admitted to the facility on or after the effective date of the denial of payment for new admissions are considered new admissions. If Medicaid residents are discharged and readmitted to the facility, they continue to be considered new admissions, and are subject to the denial of payment.
- Medicaid residents admitted to the facility and discharged before the effective date of the DPNA are considered new admissions if they are readmitted to the facility on or after the effective date of the DPNA. Therefore, they are subject to the denial of payment.
- Medicaid residents admitted before the DPNA and discharged on or after the effective date of the DPNA are not considered new admissions if subsequently readmitted. Therefore, they are not subject to the denial of payment.
- Medicaid residents admitted before the effective date of the DPNA who take temporary leave before, on, or after the effective date of the DPNA are not considered new admissions upon return and, therefore, are not subject to the denial of payment.
- Medicaid residents admitted on or after the effective date of the DPNA who take temporary leave (e.g., hospital or therapeutic leave) are not considered new admissions when they return. If they were subject to the DPNA before their leave, they continue to be subject to it after their return.
- Private pay residents admitted to the facility after the effective date of the DPNA who then become eligible for Medicaid are subject to the denial of payment.
- Private pay residents in the facility prior to the effective date of the DPNA who then become eligible for Medicaid after the effective date of the DPNA are not subject to the denial of payment.

5.8 Recovery of Medicaid Funds for Admissions During DPNA

Under federal regulations, no federal funds will be paid to a nursing facility or to a state for any resident admitted when the facility is under a Denial of Payment for New Admissions sanction. Nursing facilities will be subject to Medicaid post-payment review to determine if any new residents were admitted during a period of time when the facility was under a DPNA sanction and, if so, Medicaid funds will be recovered from the facility. Facilities will be notified in advance of any recovery action and given the opportunity to produce documentation indicating that the admission was not a new resident and/or to appeal MDCH's determination.

5.9 Minimum Data Set - Resident Assessment Instrument

On a monthly basis, a nursing facility is required to electronically submit to the SSA resident assessments completed in the past month. Failure to comply will result in citations and imposition of remedies, including requirement of a plan of correction. Continued failure to comply will result in increasingly severe remedies up to and including termination of the Medical Assistance Provider Enrollment & Trading Partner Agreement.

An individual who willfully and knowingly certifies a material and false statement in a resident assessment will be subject to civil money penalty fines as outlined in 42 CFR § 483.20(f)(5)(j)(1).

5.10 Termination

This remedy may be imposed at any time when appropriate, but must be imposed when a provider has been out of substantial compliance for six months.

5.11 Purpose of Remedies

TYPE OF REMEDY	PURPOSE
Directed Plan of Correction	The purpose of the directed plan of correction is to achieve correction and continued compliance with federal requirements. It is used when specific corrective action is required or the corrective action must be accomplished within a specified time, e.g., when a facility's heating system fails and specific repairs or replacement must be made within a specific period of time; when a provider has had difficulty attaining compliance after a revisit; or when assistance with a plan of correction is needed to ensure an effective revisit prior to imposition of a denial of payment or termination of provider status.
Directed In-Service Training	The purpose of directed in-service training is to provide basic knowledge to achieve compliance and remain in compliance with federal requirements. Directed in-service training is used when education is likely to correct deficiencies and help the provider achieve substantial compliance.

TYPE OF REMEDY	PURPOSE
State Monitoring	The purpose of state monitoring is to oversee correction of cited deficiencies as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred. State monitoring is appropriate if the provider has had three consecutive standard surveys with substandard quality of care; poor compliance history, pattern of poor quality of care, and/or many complaints; immediate jeopardy without a temporary manager appointment; concern that conditions in a facility have potential to worsen; the provider refuses to accept appointment of a temporary manager; the provider is unwilling or unable to take corrective action for cited substandard quality of care. MDCH may impose state monitoring without notice.
Denial of Payment for New Admissions	The purpose of Denial of Payment for New Admissions (DPNA) is to encourage prompt and sustained compliance. DPNA may be imposed any time the provider is found out of substantial compliance and must be imposed when a provider is out of compliance three months after a determination of noncompliance. DPNA may be imposed alone or in combination with other remedies.
Denial of Payment for All Medicare and Medicaid Residents	The purpose of Denial of Payment for All Medicare and Medicaid Residents is to encourage prompt and sustained compliance. This remedy may be imposed any time the provider is out of substantial compliance, but only by CMS. Factors considered in imposing this remedy include the seriousness of current survey findings, noncompliance history of the facility, and failure of other remedies to achieve or sustain compliance.
Temporary Management	The purpose of a temporary manager is to oversee correction of deficiencies and ensure the health and safety of the facility's residents while corrections are being made. A temporary manager may be imposed as a federal remedy any time a provider is not in substantial compliance; when a facility's deficiencies constitute immediate jeopardy or widespread actual harm and is imposed as an alternative to termination; or to oversee the orderly closure of a facility. The authority and qualifications of the temporary manager are described in the State Operations Manual at Section 7550.
Temporary Administrative and/or Clinical Advisor	The purpose of a Temporary Administrative and/or Clinical Advisor is to monitor and mentor the facility administrative and/or clinical staff through the period of corrective action. This is an additional federal Category 2 enforcement remedy defined in the State Plan and Michigan Department of Community Health Rule 330.11007(6). Authority for this remedy is found at §488.303(e) and §488.406(a)(8)&(9).

5.12 Revisit Policy

Revisits are not assured and, depending on the circumstances of any given situation, termination can occur any time for any level of facility noncompliance without regard to revisits. Facilities have the responsibility to correct their deficiencies and notify the SSA when corrections will be completed. It is expected that revisit requests will be made prudently so that the likelihood of additional revisits is reduced. If correction is not achieved at the expected time, the facility should notify the SSA that correction has been delayed so that the revisit can be delayed. MDCH's expectation is that the facility has achieved compliance status as alleged in the Plan of Correction. Revisits may be conducted for any level of noncompliance. Remedies may be imposed for any level of noncompliance. Revisits are not assured before imposition of denial of payment for new admissions or termination.

The SSA is authorized, at its discretion, to perform up to three revisits to verify compliance. A fourth revisit may be conducted by the SSA only with the authorization of the SMA. An approved Plan of Correction must be received by the SSA with each revisit request. A fourth revisit requires justification.

5.13 Choosing the Compliance Date

MDCH follows CMS policy related to revisits. On a first revisit, the compliance date is the accepted Plan of Correction completion date if it is determined at the time of the revisit that the deficiencies were corrected and the facility is in substantial compliance. If a revisit survey identifies that the facility had a deficiency after the completion date that was corrected before the revisit date, the actual correction date is used.

On the second revisit, the compliance date is the revisit date, unless there is specific evidence of earlier compliance. In this case, observation of compliance is relevant, as is evidence indicating a specific date of correction.

On third or subsequent revisits, the compliance date is the revisit date, without exception.

5.14 Evidence of Compliance in Lieu of a Revisit

Revisits may be conducted at any time for any level of noncompliance. Revisits are required whenever a survey finds noncompliance at Level F (Substandard Quality of Care), Harm, or Immediate Jeopardy (IJ) and must continue for all citations at that level until compliance is achieved with F (SQC), Harm, or IJ citations. In other cases, appropriate to the type of deficiency, acceptable evidence of compliance may be allowed in lieu of a revisit at the SSA's discretion. Evidence of compliance is not acceptable after a second revisit has been conducted within an enforcement cycle. When a facility is allowed to present acceptable evidence in lieu of a revisit, the compliance date is the date the evidence indicates the facility was in substantial compliance.

5.15 Setting the Mandatory Three- and Six-Month Remedy Time Frames

The three-month mandatory denial of payment for new admissions and the six-month mandatory termination dates will be set based on full months rather than on a number of days. With few exceptions, these dates will coincide with the same numerical date of the month of survey exit that identified the noncompliance. For example, if a survey ended on 1/15, the three-month effective date for mandatory denial of payment for new admissions is 4/15, and the six-month termination date is 7/15. Exceptions involve those cases for which a three-month or six-month numerical date is not on the calendar. In these cases, the effective date of the remedy will be the next calendar day.

Immediate Jeopardy situations generally have 23-day termination cycles.

5.16 Failure to Readmit a Qualified Medicaid Resident

A daily civil money penalty (CMP) of $400 will be imposed when an enrolled Medicaid facility refuses to readmit a qualified Medicaid resident (as defined by CMS) following hospitalization. An opportunity to correct will not be provided. This daily CMP will start on the date validated by MDCH that nursing home readmission should have occurred. The daily $400 CMP continues until the resident is offered the next qualifying available Medicaid bed at the refusing facility, or the resident is placed in another suitable facility. The refusing facility will be notified by the SSA when an allegation of failure to readmit a qualified Medicaid resident is being investigated.

5.17 Definitions

TERM	DEFINITION
Administrative and/or Clinical Advisor	An alternative federal Category 2 remedy imposed upon a facility for the purpose of mentoring facility administrative and/or clinical staff through the period of corrective action.
Ban on Admissions	Admissions to the facility are suspended on the date specified in the MDCH Correction Notice Order. Includes readmissions if stated in the order.
CMS	The Centers for Medicare and Medicaid Services.
Culpability	The extent to which the facility is responsible for the cited deficient practice. This is often related to occasions when the noncompliance is determined by the State Survey Agency to be intentional, or a product of neglect, indifference, or disregard.
Deficiency	A facility's failure to meet any participation requirement specified in the Social Security Act or in 42 CFR, Subpart B, 483.5 - 485.75.
Failure to Maintain Compliance	Inability of the facility to maintain substantial compliance for at least three months, or a facility having three or more survey cycles in a 12-consecutive month period.

TERM	DEFINITION
Immediate Jeopardy	Immediate Jeopardy to resident health or safety means a situation in which immediate corrective action is necessary because the nursing facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, serious harm, impairment, or death to a resident receiving care in the facility. Such a finding is made in accordance with the criteria and definitions in the CMS State Operations Manual Appendix Q - Guidelines For Determining Immediate Jeopardy.
Noncompliance	Any deficiency that causes a facility to not be in substantial compliance.
No Opportunity to Correct	The facility will have remedies imposed immediately after a determination of noncompliance has been made.
Opportunity to Correct	The facility is allowed an opportunity to correct identified deficiencies before remedies are imposed.
Past Noncompliance	Past noncompliance is noncompliance that occurred between two certifications of compliance, against which a civil money penalty is imposed. If past noncompliance is cited, a civil money penalty must be imposed.
Plan of Correction (POC)	Mandatory for all deficiencies of scope and severity levels B through L on the remedy determination grid. A POC must be provided to the SSA within 10 days of the receipt of the survey report (CMS-2567). The POC must be approved by the SSA; if disapproved, remedies may be imposed immediately.
Remedy	A corrective action. Some remedies are specified in federal law; others are specified in state law.
Repeat Deficiency	When deficiencies in the same regulatory grouping of requirements are found more than once within 24 months or two standard survey cycles.
Repeated Noncompliance	For purposes of enforcement action, this term refers to findings of Substandard Quality of Care on three (3) consecutive standard surveys, but does not refer to citations in which the substance of a deficiency or the exact tag number of a deficiency is repeated.
Substandard Quality of Care	Deficiencies at 42 CFR 483.13 (Resident Behavior and Facility Practices, F tags 221-226); 483.15 (Quality of Life, F tags 240-258); or 483.25 (Quality of Care, F tags 309-333) on the remedy determination grid in cells F, H, I, J, K, or L.
Substantial Compliance	Survey findings or acceptable evidence of compliance in lieu of revisit indicate that no actual harm has occurred and there is a potential for no more than minimal harm.

5.18 Substandard Quality of Care (SQC)

When a standard or abbreviated survey identifies substandard quality of care (SQC), an extended or partial extended survey is conducted. In addition to the imposition of remedies, the SSA takes the following actions:

- Notifies the attending physicians of residents identified during the survey process as having been affected by the substandard quality of care.
- Notifies the state licensure board responsible for licensing the facility's administrator of all findings of substandard quality of care.
- Prohibits the facility from providing nurse aide training and competency evaluation programs for two years.

If a facility has been found to have provided SQC on the last three (3) consecutive standard surveys, along with other remedies, the MDCH will impose:

- Mandatory denial of payment for new admissions;
- State monitoring.

5.19 Immediate Jeopardy

When the SSA identifies that Immediate Jeopardy to resident health or safety exists, the provider is notified and directed to submit as soon as possible an allegation that the Immediate Jeopardy has been removed. Within two calendar days of the last day of the survey during which Immediate Jeopardy was identified, the SSA will notify the provider that the SMA must terminate the Medical Assistance Provider Enrollment & Trading Partner Agreement within 23 calendar days of the last day of survey if the Immediate Jeopardy has not been removed. At its discretion, the SMA may appoint a temporary manager who must remove the Immediate Jeopardy within 23 days to avoid termination.

In order for a 23-day termination timeclock to be stopped, the provider must submit an acceptable Plan of Correction to the SSA. A subsequent revisit must then be conducted to verify removal of the Immediate Jeopardy, even if the underlying deficiencies have not been fully corrected.

Civil Money Penalties (CMP) of $3,050 to $10,000 per day will be imposed for each day an Immediate Jeopardy was identified before removal. Following removal of the Immediate Jeopardy, CMPs will continue until the facility is found to be in substantial compliance, but will be selected from a lower fine range of $50 to $3,000 per day. The upper range of CMPs will apply for a minimum of one day, even if the Immediate Jeopardy is removed immediately after identification and notification. No CMP will apply on the day the facility is determined to be in substantial compliance.

The SSA may consider using a Per Instance Civil Money Penalty of $1,000 to $10,000 when the beginning date of the deficiency cannot be determined, or when a Civil Money Penalty is combined with other enforcement actions, e.g., a discretionary denial of payment for new admissions, directed plan of correction, or directed in-service training.

5.20 No Opportunity to Correct

Providers will not be given an opportunity to correct deficiencies before remedies are imposed when they have deficiencies of actual harm (or higher) on the current survey event, as well as on the previous standard survey or any intervening survey. The previous harm (or higher) level deficiency must have been in a completed survey cycle with compliance verified. The MDCH will impose either a Civil Money Penalty or Denial of Payment for New Admissions, or both. The MDCH may impose other optional federal remedies.

5.21 Opportunity to Correct

An opportunity to correct deficiencies before remedies are imposed is not assured. The SSA has no obligation to give a provider an opportunity to correct deficiencies prior to imposing remedies and must only meet the minimum notice requirements that are applicable to the imposition of remedies. At the SSA's discretion, it may provide facilities an opportunity to correct deficiencies before remedies are imposed when they do not meet the criteria for "No Opportunity to Correct."

When an opportunity to correct deficiencies before remedies are imposed is offered, the SSA will request an acceptable plan of correction, provide initial notice of possible enforcement action, conduct a revisit (if applicable), and provide formal notice of other remedies if noncompliance continues at revisit. While formal notice of denial of payment for new admissions is generally provided in the first revisit letter, the SSA may provide it to the facility in the initial deficiency notice.

The MDCH must impose DPNA no later than three months after the last day of the survey that identified the noncompliance if substantial compliance is not achieved.

The MDCH may impose either a per day or per instance Civil Money Penalty for past noncompliance, for days of noncompliance after the finding is made, or a combination thereof. Amounts will be determined by the MDCH based on facility history, repeating deficiencies, high numbers of deficiencies, culpability of the provider, failure to achieve or maintain substantial compliance, and for increasing noncompliance.

5.22 Prohibition of Approval of Nurse Aide Training and Competency Evaluation Programs

Federal law, as specified in the Social Security Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a Section 1819(b)(4)(C)(ii)(II) or Section 1919(b)(4)(C)(ii) waiver; has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities. Exceptions to this, as specified in Public Law 105-15, Permitting Waiver of Prohibition of Offering Nurse Aide Training and Competency Evaluation Programs in Certain Facilities, will apply.

5.23 New Owner

A new owner may apply to the SSA to have approval of the facility's nurse aide training and competency evaluation program restored before a two-year lockout period has expired.

5.24 Notice of CMP Assessment

Prior notice is not required before the imposition of CMPs. A penalty equivalent to a one-day penalty will apply in all circumstances even if the violation(s) is immediately corrected. The daily penalty will end on the day prior to the determination of substantial compliance, or on the day prior to the determination that a civil money penalty is no longer warranted. The SSA determines compliance. CMP amounts may be increased to reflect changes in levels of noncompliance at revisit. CMP amounts may increase for repeat deficiencies.

The SSA has developed a CMP schedule for Immediate Jeopardy and Harm or Potential Harm occurrences to promote a consistent application of penalties. The CMP schedule conforms to 42 CFR 488.408 and is intended to cover the majority of cases of CMP imposition. Situations may occur that justify exception to the guidelines. The CMP schedule is subject to change without notice. For further information, contact the Enforcement Unit, Division of Operations, Bureau of Health Systems. (Refer to the Directory Appendix for contact information.)

Accrual of CMPs ceases when one of the following situations occurs:

- the facility is determined by the SSA to have achieved substantial compliance
- the appointment of a receiver by a circuit court
- closure of a facility
- appointment of a temporary manager for the purpose of overseeing the orderly closure of the facility
- termination of a provider agreement

5.25 Use of CMP Funds

Money collected by the SMA as a result of civil money penalties is held in a special fund to be applied to the protection of the health or property of residents of any nursing facility that MDCH finds deficient. Money recovered by the SMA from funds due a facility (because of lack of payment of civil money penalties by the facility) is also deposited into this fund.

5.26 Cost Reporting for Remediation Expenses

Temporary manager and (limited) other remediation expenses incurred by the provider as a result of an enforcement action are a Medicaid allowable routine nursing care cost as part of the owner/administrator cost classification. Total owner/administrator compensation is subject to established program cost limitations and allowable cost principles. Civil money penalties are not allowable Medicaid costs. (Refer to the Cost Reporting & Reimbursement Appendix of this chapter for additional information.)

5.27 Appeal Rights

The provider is notified of appeal rights at the time of remedy imposition. Providers may only appeal the existence of a deficiency and/or the number of days considered in violation. The established daily amount of the CMP is not subject to appeal. Appeals are through MDCH. (Refer to the Directory Appendix for contact information.)

MDCH has developed an informal review process for resolution of disputes regarding deficiencies cited by surveyors. Information regarding this process can be found on the MDCH website. (Refer to the Directory Appendix for website information).

The provider is also notified of waiver rights at the time of remedy imposition. Within 60 calendar days of the notice of appeal rights, the provider may elect to waive the right to appeal. The waiver must be in writing and be received by the SSA Enforcement Unit and by the MDCH Administrative Tribunal and Appeals Division within 60 days of the notice of appeal rights. Waiver of the right to appeal will reduce the total CMP amount by 35%.

5.28 Penalty Collection

Collection of civil money penalties will be made by voluntary transmittal, in a check payable to the State of Michigan, within 30 calendar days of notice of penalty amount due or within 15 days of issuance of appeal results. If voluntary transmittal does not occur, the CMP will be recovered by gross adjustment against the next available Medicaid warrant or as a component of final cost settlement in a change of ownership. No repayment schedules will be allowed for any penalty assessments. Civil money penalties are not allowable Medicaid costs.

Cost Reporting & Reimbursement Appendix

TABLE OF CONTENTS

SECTION 1 - INTRODUCTION

This appendix outlines Medicaid policy pertaining to nursing facility ownership, nursing facility reimbursement, nursing facility costs, and nursing facility financial reporting. Cost reporting, rate determination, financial settlement, audit, and appeal processes are addressed in this appendix. Costs classifications (such as plant, variable, allowable and non-allowable, add-ons) used to determine nursing facility reimbursement are defined.

Throughout the appendix references will be made to the State Medicaid Agency (SMA) and the State Survey Agency (SSA). The Michigan Department of Community Health (MDCH), Medical Services Administration, is the designated SMA, and is responsible for administration of the Medicaid program. The MDCH Bureau of Health Systems is the designated SSA.

1.1 REIMBURSEMENT RATE METHODOLOGY – GENERAL

The Medicaid nursing facility reimbursement rate is prospectively determined based on the nursing facility's historical or acquisition costs, which are subject to limitations put forth in policy. Participating Medicaid providers' nursing facility resident days and cost information are reported to the SMA on an annual cost report submitted by the nursing facility. The nursing facility industry aggregate cost data is used to analyze and determine facility class reimbursement limits and related cost levels necessary for calculating nursing facility per diem rates and other analysis. The facility's routine nursing care per diem rate includes plant and variable cost based on the facility's audited allowable costs, measured against class wide rate limitations. Additional reimbursement for specific services outside of the routine nursing care per diem rate are also analyzed and determined from the facility's annual cost report and included in the Medicaid annual reimbursement settlement.

The intent of the Medicaid nursing facility reimbursement system is to:

- Assure high quality services at reasonable costs.
- Encourage the efficient use of nursing care resources.
- Provide reimbursement for allowable costs incurred by prudent, cost-conscious facility managers.
- Provide a review and appeal mechanism to assure that nursing facility providers receive fair and equitable treatment.

Reductions may be implemented to the variable cost portion of the NF rate due to Executive Order, legislative mandate, or cost savings initiatives. Notice of a reduction, or continuation of a reduction, will be issued via a policy bulletin. A record of recent NF variable rate reductions will be maintained on the MDCH website. (Refer to the Directory Appendix for website information.)

1.2 MEDICARE PRINCIPLES OF REIMBURSEMENT

Unless stated otherwise in this appendix, Medicaid reimbursement rates are determined for nursing facilities in accordance with the federal Principles of Reimbursement established for the Medicare Program. Nursing facility providers are expected to comply with applicable provisions in these Principles, with policies published by the SMA, and with all relevant federal and state statutes, rules and regulations. When reviewing the Principles of Reimbursement, any references to "intermediary" should be interpreted as referring to the SMA.

Medicare Principles of Reimbursement appear in the Code of Federal Regulations (CFR), at Title 42, Part 413, and in manuals published by the federal Centers for Medicare and Medicaid Services (CMS). The Provider Reimbursement Manual, also referred to as PRM-15 and Pub. 15, may be obtained from CMS electronically or by contacting CMS. (Refer to the Directory Appendix for website and contact information.)

SECTION 2 - OWNERSHIP CHANGES AND MEDICAID TERMINATION

2.1 PREREQUISITE

When an ownership change is anticipated, the Certificate of Need (CON) requirement must be satisfied before Medicaid enrollment can occur. The Department of Community Health, Bureau of Health Systems office, administers the CON Program. Contact information and subject matters pertaining to the CON may be found on-line on the MDCH website. (Refer to the Directory Appendix for website information.)

2.2 OWNERSHIP CHANGES

When an ownership change is anticipated, the proposed Seller(s) and the proposed Purchaser(s) must provide written notice to both the State Medicaid Agency (SMA) and the State Survey Agency (SSA) at least 90 calendar days prior to the anticipated ownership change. The written notice to the SMA must be sent to the MDCH LTC Reimbursement and Rate Setting Section (RARSS) and to the Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.) The written notice to the SSA must be sent to the nursing facility's licensing officer. Failure to provide written notice to either agency could result in payment and settlement delays.

Prior to the ownership change date, the new ownership must complete a New Provider Information Packet to provide RARSS with the necessary information for the rate setting and reimbursement process. Failure to provide this information prior to or immediately upon completion of the purchase will delay the rate setting and reimbursement processing for the new ownership. For New Facility/Owner Requirements, refer to the Cost Reporting Section of this appendix.

Depending on the circumstances of the change in ownership, the new owner may be required to complete a new Medical Assistance Provider Enrollment & Trading Partner Agreement, and obtain a new provider number. The new owner must not use the prior owner's Medicaid provider number for reporting and billing Medicaid services. Failure of the new ownership to secure a new provider number for billing subjects the new owner to financial responsibility for the prior owner's claim liability. Refer to the Provider Enrollment Section of the General Information for Providers Chapter for provider agreement requirements.

The Seller(s) and the Purchaser(s) will be notified by RARSS and advised of any requirements related to cost reporting and rate setting, including final settlement for the former owner. For information regarding reimbursement settlement, refer to the Cost Report Reimbursement Settlement Section of this appendix.

2.3 NURSING FACILITY SALE BETWEEN FAMILY MEMBERS

The sale of a family owned nursing facility between family members is allowable and recognized as a transfer of ownership and a recognized sale transaction for Medicaid reimbursement within allowable cost and reimbursement limits if **all** of the following requirements are met. However, if it is subsequently determined control is not relinquished by the prior entity or interested parties, asset values will revert back to the values prior to the recognized sale and any additional reimbursement paid will be recovered.

- A purchase contract or agreement must be present. The transaction must terminate the seller's interest in the business. The seller must not have any recourse or ownership protection to retain

or have a security interest in obtaining future ownership of that nursing facility in the event of the termination of the new ownership (purchaser) at a later date.

- Borrowing or financing for the sale transaction must be between the purchaser and a non–related third party (i.e., a financial institution). Financial loans from the family-related seller individual or entity to the family-related purchaser are not allowable for reimbursement. The finance instrument must not be a land contract from the seller.
- Total dollar amount of allowable borrowings cannot exceed the purchase price (allowable asset value). The Capital Asset Value (CAV) limit applicable to the nursing facility immediately prior to the sale, appropriately adjusted for nursing facility asset items that are excluded from the sale transaction, is the maximum reimbursable borrowing balance applicable to the asset transaction.
- The nursing facility property appraisal must be obtained. The facility appraisal value must support the purchase price negotiated between the sales parties. Refer to the Appraisal Guidelines Section of this appendix for additional information.
- The new ownership operation must be a different legal entity in which the family-related seller is not an officer or board member exercising control over the new operation. The nursing facility entity may remain as an ongoing business entity in a situation where the real estate sale does not involve the licensed nursing facility operator. This occurs where a related party lease exists between the nursing facility entity prior to the real estate transaction, and the real estate transaction of the leased nursing facility is between the family-related parties. The requirement that the family-related lessor/seller cannot exercise active interest or control in the management of the nursing facility after the sale must be met.

The following will be applied to a change in ownership as a result of a sale between family members:

- The allowable asset value to the purchaser is limited to the allowable historical capital asset cost of the seller party (or nursing facility entity owned by the family member) minus the dollar amount of depreciation expense allowed and reimbursed under the Medicaid Program. There is no increase in nursing facility asset values. MDCH considers Medicaid reimbursement to the nursing facility for depreciation expense was zero dollars during the time period that the seller provider was reimbursed by Medicaid for plant cost based upon capital asset value tenure reimbursement rate.
- The tenure factor for the nursing facility following the sale will revert to zero due to the capital asset transaction affecting a plant cost increase.
- The Medicaid program plant cost reimbursement limitations of the Deficit Reduction Act (DEFRA) of 1984 will not apply to the transaction as a result of the purchase limitation to the historical asset cost base of the seller.
- The seller may be subject to depreciation recapture dependent on the sale price of the assets and the depreciation reimbursement made to the seller during the time period in which the seller was reimbursed a plant cost component under the depreciation cost method. The reimbursement period of depreciation recapture is limited to Medicaid services reimbursed during the time period from October 1, 1984 through the date in which the nursing facility transferred to the tenure plant cost component reimbursement. The dollar amount of depreciation recapture may impact the asset acquisition allowable dollar amount for the purchaser.

2.4 Facility Asset Change of Ownership

In the event of a binding agreement and/or sale occurring on or after July 18, 1984, the Plant Cost Component for the nursing facility, attributable to the agreement and/or sale, is limited to the Medicaid Program policy provisions applying federal reimbursement limits of the DEFRA. Refer to the plant cost component rate determination provisions in the Rate Determination Section of this appendix for additional information.

At the time of the facility asset ownership change, the Provider must complete a Plant Cost Certification and submit a copy of the purchase and/or lease agreement, along with plant cost information, to the LTC Reimbursement and Rate Setting Section. The information is necessary to establish the reimbursement rate for the Plant Cost Component due to the asset ownership change. For Plant Cost Certification requirements and timeframes for filing the data, refer to the Plant Cost Certification Section of this appendix.

For an explanation of the effect of the sale of assets on the Tenure Factor, refer to the Rate Determination Section of this appendix.

In the event of a sale after March 31, 1985, Medicaid will recapture from the selling provider any reimbursement received in the form of depreciation expense, through the date of either the sale and transfer of assets or, for a Class I facility, that provider's conversion to a "Return on Current Asset Value Component" reimbursement, whichever is earlier. This reimbursement provision does not apply to Class I nursing facility providers whose ownership began after March 31, 1985. For information regarding depreciation reimbursement adjustment, refer to the Cost Report Reimbursement Settlements Section of this appendix.

2.5 Termination of Medicaid Participation

A nursing facility that loses its Medicaid certification as a result of regulatory action, irrespective of whether that action requires facility closure, or a nursing facility that chooses to terminate its participation in the Medicaid program without closing must comply with notice and cost reporting requirements. Refer to the Cost Reporting Section in this appendix and to the Nursing Facility Closure Section in the Survey, Certification and Enforcement Appendix of this chapter for relevant information.

When Medicaid participation is terminated voluntarily or involuntarily, payment for at least one month of services rendered is retained for Final Settlement.

SECTION 3 – DEFINITIONS

General definitions are provided in this section. More detailed explanations are provided in relevant sections related to cost, audit or rate setting.

Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
Acceptable Cost Report	A complete and accurate accounting of the financial and statistical activities of a nursing facility provider prepared in accordance with Medicaid policy and cost reporting instructions on the electronic format required by the State Medicaid Agency. The cost report must include the certification statement signed by an authorized representative of the nursing facility certifying the cost report as a true, correct and complete statement of facility financial and statistical activities prepared from the nursing facility provider's books and records.
Administrator	A nursing facility administrator is a person(s) who is on site and responsible for the professional administration, supervision and management of the nursing facility and operations as they relate to resident care. The nursing facility administrator must be licensed in accordance with the law in Michigan.
Allowable Costs	Costs incurred in the provision of nursing facility services subject to guidelines and limitations set forth in Medicare Principles of Reimbursement, as they appear in federal regulations and in manuals published by the federal Centers for Medicare and Medicaid Services, unless stated to the contrary in policies and procedures issued by the State Medicaid Agency.
Ancillary Services	Services for which charges are customarily made in addition to routine service charges. Services are defined in the Coverages portion of this chapter.
Asset Acquisition Cost	The cost or value for a nursing facility asset determined in accordance with Medicare Principles of Reimbursement. Medicaid further defines acquisition cost as the cost incurred by the present owner in acquiring the asset. For Class I, II, III and IV Nursing Facilities ▪ For depreciable assets acquired after July 31, 1970, the historical cost may not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of purchase, or the fair market value of the asset at the time of its purchase. For Class III and IV Nursing Facilities ▪ For depreciable assets acquired on or after December 1, 1997, the allowable historical cost of the asset may not exceed the historical cost less depreciation allowed to the owner of record as of August 5, 1997 or, if the asset did not exist as of August 5, 1997, the first owner of record after August 5, 1997.

Authorized Representative	An individual who has legal authority to obligate the nursing facility entity. The individual may be an officer, senior or majority partner, possess controlling ownership interest or an appropriate management employee of the licensed nursing home business entity. For purpose of signatures required for cost reporting and reimbursement request actions, individuals not included in these positions must have designated legal right to act on behalf of the subject business entity.
Available Bed	A bed considered available for occupancy. Beds are considered available except in the following situations: ▪ Unoccupied beds when the facility is under a regulatory Ban on Admissions (does not include beds unoccupied when the facility is under a Denial of Payment for New Admissions action). ▪ Beds covered under a State Medicaid Agency-approved Non-Available Bed Plan. ▪ Beds temporarily unoccupied due to renovation or construction where the State Survey Agency has deemed the beds unacceptable for occupancy.
Available Bed Days	The number of available bed days for a facility is the number of available beds in the facility multiplied by the number of days in the cost reporting period that they are available.
Average of Variable Costs	See Class Average of Variable Costs.
Ban on Admissions	A regulatory/enforcement sanction, imposed by the State Survey Agency (SSA), prohibiting the admission of any new resident(s) into the nursing facility, regardless of payment type, while the prohibition is in effect. Readmissions are allowed during this period on an individual case basis at the discretion of the SSA. A modified ban on admissions is a regulatory/enforcement sanction, imposed by the State Survey Agency, which may be imposed for a period of time after a ban on admissions has ended. The length of the modified ban on admissions is at the discretion of the SSA and may limit the number of new admissions for a designated period of time. **Note:** A Ban on Admissions is different from a Denial of Payment for New Admissions.
Base Costs	Costs that cover activities associated with direct patient care. Major items under these categories are payroll and payroll-related costs (salaries, wages, related payroll taxes, fringe benefits) for departments of nursing, nursing administration, dietary, laundry, diversional therapy, and social services; food; linen (does not include mattress and mattress support unit); workers compensation; utility costs; consultant costs from related party organizations for services relating to base cost activity, nursing pool agency contract service for direct patient care nursing staff, and medical and nursing supply costs included in the base cost departments. With the exception of nursing pool services, purchased services and contract labor from unrelated parties or from related organizations, incurred in lieu of base costs as previously defined, are separated into base and support costs using the industry-wide average base-to-variable cost ratio.
Base Costs Per Day	Facility base costs divided by the total number of resident days for the same period.

Base Cost Component, Indexed	See Indexed Base Cost Component.
Base Period	An interval of time for which cost data is obtained and used in the calculation of a prospective reimbursement rate.
Capital Expenditure	Expenditure not limited to cost of construction, engineering, and equipment, which, under Generally Accepted Accounting Principles, is not properly chargeable as an expense of operation.
Census	See Resident Days/Occupancy.
Census Day	A census day is counted when a resident is occupying a nursing facility bed at midnight. A census day is counted if the resident is away from the facility for therapeutic leave and the facility is paid to hold the bed (therapeutic leave days paid by the resident or Medicaid); the resident is on a one-day stay and the nursing facility is paid for the day; the resident is discharged due to death and the nursing facility is paid for the day. A resident is not counted for census purposes if the resident is admitted to the hospital, even if the facility is being reimbursed by any payer source to hold the bed. A resident is counted for census purposes on the day of admission, but not on the day of discharge except as noted above.
Chain Organization	A group of two or more nursing care facilities, or at least one nursing care facility and another business or entity, that is owned, leased, or through any other device controlled or operated by one organization. Chain nursing facility organizations include, but are not limited to proprietary organizations and various religious, charitable, and governmental organizations, any of which may be engaged in other activities not directly related to health care.
Change of Ownership	The exchange of real property, e.g., a sale of stock or real estate, including a sale of a building housing a nursing facility provider as a lessee; a change in corporate structure for a nursing facility, e.g., a change from a sole proprietorship to a corporation; or any other ownership change that affects the provider/licensed operator of a nursing facility.
Class I Facilities	Proprietary and nonprofit nursing facilities that do not fall under the Class II, Class III, Class IV or Class V definitions. The provider type assigned to this Class is 60.
Class II Facilities	Proprietary nursing facilities for the mentally ill or developmentally disabled (mentally retarded), with a different variable cost limit than Class I facilities. The provider type assigned to this Class is 72.
Class III Facilities	Proprietary nursing facilities, hospital long term care units, and nonprofit nursing facilities that are county-operated medical care facilities. The provider types assigned to this Class are 61 or 62, for the respective facility types.

Class IV Facilities	State-owned and operated institutions for the mentally retarded (developmentally disabled), Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and nonprofit nursing facilities for the mentally retarded. The provider type assigned to this Class is 65.
Class V Facilities	A distinct part of a special nursing facility for the care of ventilator-dependent residents. The provider type assigned to this Class is 63.
Class VI Facilities	Hospitals that provide a program of short-term nursing care (Swing Beds) not exceeding 100 days per stay. The provider type assigned to this Class is 63.
Class Average of Variable Costs (AVC)	The total *indexed* variable costs for all facilities in a class divided by the total resident days for all facilities in the class. An AVC is calculated for each nursing facility class. For example, the AVC for October 1, 2003, which is used for rate year October 1, 2003 to September 30, 2004, is based on variable costs reported in cost reports for facility fiscal years ending in 2002, indexed to October 1, 2002.
Class Variable Cost Limit (VCL)	A limit set at the 80th percentile of the Indexed Variable Costs (IVC) for facilities in a particular class during the current calendar year. The 80th percentile is determined by rank ordering facilities from the lowest to the highest IVC, then accumulating Medicaid resident days of the rank-ordered facilities, beginning with the lowest, until 80% of the total Medicaid resident days for the class are reached. The Variable Cost Limit for the class of facilities equals the IVC of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs. A VCL is calculated for Class I and Class III nursing facilities. For example, the VCL for October 1, 2003, which is used for rate year October 1, 2003 through September 30, 2004, is based on variable costs reported in cost reports for facility fiscal years ending in 2002, indexed to October 1, 2002.
Common Ownership	A situation in which more than one individual possesses significant (5% or greater) ownership or equity in a nursing facility or an organization serving the nursing facility provider.
Compensation	The total monetary, fringe, and/or benefits received by an employee or owner for services rendered to the nursing facility.
Control	A situation where an individual or organization has the power, directly or indirectly, to significantly influence and/or direct the actions or policies of a nursing facility or an organization serving the nursing facility provider.
Corporate Official or Employee	An individual representing an organization with the authority to exercise control over a nursing facility.
Cost Center	A division, department, or subdivision thereof; a group of services; or any other unit or type of activity into which functions of an organization or nursing facility are divided for purposes of cost assignment and allocation.

Cost Index	An indicator used to adjust nursing facility cost levels. The cost index used by Medicaid is Global Insight's Skilled Nursing Facility Market Basket Without Capital Index, which is published quarterly in the Global Insight DRI-WEFA Health Care Cost Review. The cost index is used to adjust reported costs from the facility's cost report period end date to October 1 of the year that is one year prior to the rate year being calculated. For example, cost report data used to set rates for the October 1, 2003 to September 30, 2004 nursing facility rate year are indexed to October 1, 2002.
Cost Report	A formal compilation of the nursing facility ownership, financial and statistical data in MDCH prescribed format, and required on an annual basis for the reporting period generally extending over a 12-month period based on the nursing facility's fiscal year. Each nursing facility provider's cost report must include an itemized list of all expenses as recorded in the formal and permanent accounting records of the facility.
Current Provider	The provider that operated the nursing facility during the time period of the last cost report on which normal rate setting would occur. Also see Provider.
DEFRA	Deficit Reduction Act of 1984
Denial of Payment for New Admissions (DPNA)	A regulatory/enforcement action, imposed by the CMS or the State Medicaid Agency, prohibiting payment for new Medicare and/or Medicaid admissions. Medicaid will not pay for services provided to a resident admitted during a DPNA. **Note:** A Denial of Payment for New Admissions is different from a Ban on Admissions.
Economic Inflation Rate	The annual economic inflation percentage for Class I and Class III nursing facilities established by the state legislature through the appropriations process.
Economic Inflation Update	The Economic Inflation Rate (EIR) for the facility class applied to the lesser of the Variable Rate Base for the facility or the class Variable Cost Limit.
Facility	An entire nursing facility or a distinct part thereof being considered for rate setting. The entire building may be considered a distinct part unit for rate setting purposes. A unit smaller than the entire building may also be considered a distinct part unit for rate setting purposes if the identified facility space area meets required certification requirements.
Fair Market Value	The price that an asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition, generally comparable to the price at which other sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition.
Fiscal Year - Facility	For purposes of cost reporting, a nursing facility provider's financial reporting year for tax purposes, normally a 12-month period unless approved for exception due to change in provider ownership or fiscal period end date change.
Fiscal Year – State	October 1 through September 30.

Fixed Equipment (Major)	Equipment that is affixed to or constitutes a structural component of the nursing facility as defined by the current version of the American Hospital Association Chart of Accounts.
Hold A Bed Day	See Leave Day.
Home Office	The central office of a chain organization (See Chain Organization.)
Hospital-Attached Long Term Care Unit (HLTCU)	A distinct part of a general hospital licensed as a nursing facility.
Hospital Leave Day	See Leave Day - Hospital.
Indexed Base Cost Component	A facility's total per resident day allowable base costs indexed to October 1 of the year that is one year prior to the rate year being calculated.
Indexed Support Cost Component	A facility's indexed base cost component multiplied by the lesser of the facility's support-to-base ratio or the support-to-base ratio limit for that facility's bed-size group.
Indexed Variable Costs	The sum of a facility's allowable base and support costs per resident day indexed to October 1 of the year that is one year prior to the rate year being calculated.
Leave Day – Hospital	A day where a facility may be reimbursed by any payor source to hold a resident's bed for his/her return. (Medicaid policy pertaining to reimbursement is contained in the coverages portion of this chapter. The day is not counted as a census day of care for resident occupancy on the nursing facility's cost report.
Leave Day – Therapeutic	A day where a facility may be reimbursed by any payor source to hold a resident's bed for his/her return. Medicaid policy pertaining to reimbursement is contained in the Coverages portion of this chapter. The day is counted as a census day of care for resident occupancy on the nursing facility's cost report.
Management Company	An entity contracted by a licensed and Medicaid-enrolled nursing facility provider to manage one or more of the daily operations of the facility.
Medical Care Facility (MCF)	A county-operated nursing facility.
Net Quality Assurance Supplement (Net QAS)	The Quality Assurance Supplement minus the bed fee assessment (fee per licensed bed per day.

New Facility (for rate-setting purposes)	A nursing facility provider that does not have a current Medicaid historical cost, including a newly constructed facility or an existing facility that has never before participated in the Medicaid program, or a facility that has participated in Medicaid in a different provider class, or an existing facility that qualified as a "No Medicaid" or "Low Medicaid" activity cost reporting provider for two consecutive fiscal years. A nursing facility that has made physical plant additions and/or renovations, including a total replacement or a facility that has been sold or resold is not considered a new facility.
New Provider in a Medicaid-Enrolled Facility	A person or business entity that has purchased or is purchasing a nursing facility that previously had Medicaid participation and whose new ownership individual(s) or business entity are not related through family or business ties to the owner's business entity of the previous owner. Under certain circumstances, a sale between family members may be approved by the State Medicaid Agency and the new owner may be considered a new provider.
Nursing Facility or Nursing Home	A facility (or distinct part of a facility) that is licensed by the State of Michigan to provide nursing care and related medical services for residents who require such care above the level of room and board.
OBRA	The federal Omnibus Budget Reconciliation Act, initially passed in 1987 as Public Law 100-203, with amendments in 1988, 1989, 1990 and 1994. This law incorporated specific provisions for nursing facility reform, including revised requirements for the survey and certification process and for the enforcement process.
Occupancy	See Resident Days/Occupancy.
Occupancy Rate	The total number of resident days in a given time period divided by the number of available bed days in the facility for the same time period.
Owner/Administrator	A person who is employed and functions as the administrator, assistant administrator, business manager, or in any other administrative capacity in the nursing facility, and who is also part or full owner of the nursing facility operating entity, i.e., the provider and/or the nursing facility's real property. If a Director of Nursing is an owner and acts occasionally in an administrator capacity, the time acting in an administrative capacity is allocated to the owner/administrator salary.

Ownership/Corporate Interest	A person, partnership, or corporation that: ▪ Has ownership interest totaling 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Has an indirect ownership interest equal to 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Has a combination of direct and indirect ownership interests equal to 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility, if that interest equals at least 5% of the value of the property or assets of the facility/disclosing entity; or ▪ Is an officer or director of a nursing facility, i.e., in the disclosing entity, that is organized as a corporation; or ▪ Is a partner in a nursing facility, i.e., in the disclosing entity, which is organized as a partnership. **Examples:** ▪ If Ms. C owns 10% of a note secured by 60% of the nursing facility provider's assets, Ms. C's interest in the provider's assets equates to 6% and must be reported. Conversely, if Mr. S owns 40% of a note secured by 10% of the provider's assets, Mr. S's interest in the provider's assets equates to 4% and need not be reported. ▪ If Mr. F owns 10% of the stock in a corporation that owns 80% of the nursing facility, Mr. F's interest equates to an 8% indirect ownership interest and must be reported. Conversely, if Ms. N owns 80% of the stock of a corporation that owns 5% of the stock of the nursing facility, Ms. N's interest equates to 4% indirect ownership interest and need not be reported.
Patient	See Resident.
Per Resident Day Cost	The total cost for a cost component divided by the total number of resident days. The number of resident days used is the greater of the number of resident days listed in the facility's cost report or 85% of the total number of available bed days for the cost reporting period.
Plant Costs	Plant costs include depreciation, interest expense (incurred for either working capital or capital indebtedness, mortgage discount points), property taxes, amortization costs associated with loan financing costs (e.g., letters of credit), letter of credit application or commitment fees, amortization of legal fees pertaining to acquisition, recording fees or other fees relating to the capital asset acquisition, and specific lease expenses.
Property Owner	A person, partnership, corporation, organization, or entity, other than the nursing facility provider, having the property rights to the building in which a nursing facility operates or to the land on which a nursing facility sits.

Proprietary Provider	A provider or organization that is organized and operated with the expectation of earning profit for its owner[s], as distinguished from providers organized and operated on a nonprofit basis. Proprietary providers may be sole proprietorships, partnerships, or corporations.
Provider	A legal entity (person, partnership, corporation, or organization) that has been approved to participate in the Michigan Medicaid Program and has signed a Medical Assistance Provider Enrollment & Trading Partner Agreement. Some conditions of provider participation continue after enrollment in Medicaid has ended, e.g., record retention.
Purchase Allowance	A deduction granted for damage, delay, shortage, imperfection, or other causes, excluding discount and return.
Purchase Discount	A reduction (off the original price for property, goods or services) granted for the settlement of debts (e.g., 5/10 days which means a 5% discount if paid within 10 days).
Purchase Price	The total price agreed upon between a buyer and a seller for property, goods or services.
Quality Assurance Assessment Factor (QAAF)	The percentage increase determined and implemented by Medicaid for a class of nursing facilities.
Quality Assurance Supplement (QAS)	The product of the QAAF for the class times the lesser of the Variable Rate Base for the facility or the class Variable Cost Limit.
Related Entity or Organization	An entity having a business relationship with a nursing facility provider that has 5% or greater beneficial interest or common ownership in or has control of the facility or the facility owner, whether such control has legal standing or is utilized. Also see Chain Organization and Ownership/Corporate Interest.
Related Party	An individual, group of individuals, or business entity that meets criteria similar to that defining a related entity or organization.
Resident Days/Occupancy	Resident days or occupancy for nursing facility Medicaid cost reporting is the sum of the census days in a specified period of time. To calculate the resident days for a particular day, total the census days for that day. (Residents who are hospitalized are not counted in the census). **Example:** Residents occupying beds in facility = 100 Residents on therapeutic leave = 5 Residents hospitalized = 3 Total resident days = 105

Routine Nursing Costs	Costs including, but not limited to, necessary medical, nursing, and mental health services, and all items of expense that nursing facility providers incur in the provision of routine nursing services. Costs must be included in the nursing facility provider's Medicaid cost reporting in accordance with established cost classifications.
Routine Nursing Services	Organized nursing care and activities for the resident, under the observation and assessment of licensed nurses, that enable the resident to attain or to maintain the highest practicable physical, mental, and psychosocial well being in accordance with a written plan of care.
State Medicaid Agency (SMA)	The Michigan Department of Community Health. The work unit within the Department with administrative responsibility for the Medical Assistance (Medicaid) Program is the Medical Services Administration.
State Survey Agency (SSA)	The Michigan Department of Community Health. The work unit within the Department with administrative responsibility for nursing facility survey and certification is the Bureau of Health Systems.
Support Costs	Costs that are payroll and benefit-related (salaries, wages, related payroll taxes, fringe benefits) for the departments of housekeeping, maintenance of plant operations, medical records, medical director, and administration; administrative costs; all consultant costs not specifically identified as base; all equipment maintenance and repair costs; purchased services; and contract labor not specified as base costs.
Support Costs Per Day	A facility's support costs divided by the total number of resident days for the same period.
Support Cost Component, Indexed	See Indexed Support Cost Component.
Support-to-Base Ratio	A facility's allowable support costs divided by allowable base costs. A facility's support-to-base ratio is limited to the 80th percentile support-to-base ratio for the facility's bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the facility. Group bed size is based on the number of licensed beds in a facility regardless of bed type or whether the bed is available. This includes all types of licensed nursing beds, Home for the Aged beds, or any other type of licensed bed where nursing care is provided. A facility's support-to-base ratio is rebased annually from the most recent audited base period, regardless of ownership.
Support-to-Base Ratio Limit for Bed Size Group	The support-to-base ratio limit for a bed-size group is set at the 80th percentile of the support-to-base ratios for facilities in the same bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the facility. The 80th percentile is determined by rank-ordering facilities within the same bed-size group from the lowest to the highest support-to-base ratio, then accumulating Medicaid resident days of the rank-ordered facilities, beginning with the lowest, until 80% of the total Medicaid resident days for the group are reached. The support-to-base ratio limit for the bed-size group equals the support-to-base ratio of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs.

Swing Beds	A program of short-term nursing care not exceeding 100 days, provided to patients in a hospital as defined in federal law and Michigan statute.
Therapeutic Leave Day	See Leave Day – Therapeutic.
Variable Costs	A facility's total allowable base and support costs for providing routine nursing services to residents, as determined in the Allowable Costs Section of this appendix. Also see definitions for Base Costs and Support Costs.
Variable Cost Component	The lesser of a facility's Variable Rate Base or the Class Variable Cost Limit, plus the Economic Inflation Update.
Variable Cost Limit	See Class Variable Cost Limit.
Variable Costs Per Day	A facility's variable costs (total base and support costs) divided by the total number of resident days for the same period.
Variable Costs, Indexed	See Indexed Variable Costs.
Variable Rate Base	The sum of a facility's indexed base cost component and indexed support cost component. For rate setting purposes, the figure used as the facility's Variable Rate Base is the lesser of the facility's calculated Variable Rate Base or the Class Variable Cost Limit.

SECTION 4 - COST REPORTING

A nursing facility participating in the Medicaid program must submit a Medicaid cost report to the MDCH annually as a condition of participation. An electronic copy of the cost report, the cost report completion instructions, completion and submission checklists, and related information are available on the MDCH website. (Refer to the Directory Appendix for website information.)

4.1 EXCEPTIONS

4.1.A. Exception for Hospice Provider Owned Nursing Facility

A hospice provider that owns and operates a nursing facility is not required to file an annual cost report to Medicaid. The nursing facility industry aggregate cost data is used in place of individual facility cost data to establish a Medicaid reimbursement rate for this type of nursing facility. Rate determination procedures are addressed in the Rate Determination Section of this appendix.

4.1.B. Exception for Swing Beds

Hospitals providing short term nursing services (swing beds) are not required to submit a Medicaid nursing facility cost report. Costs associated with swing beds are combined with those of the hospital and submitted on the hospital cost report. Refer to the Hospital Chapter of this manual for information regarding cost reporting requirements related to swing beds.

4.2 NURSING FACILITY COST REPORT [CHANGE MADE 4/1/06]

An annual cost report is required for the cost reporting period which is based on the nursing facility's fiscal reporting year end. Each cost report must include an itemized list of all expenses as recorded in the formal and permanent accounting records of the facility. These records must be maintained in a manner consistent with cost finding regulations in the Medicare Principles of Reimbursement except where modified by Medicaid reimbursement and cost reporting policy. Records must also be kept in a manner consistent with previous cost reporting periods. The accrual method of accounting is mandated for all providers. For any cost situation that is not covered by the Medicare Principles of Reimbursement guidelines or Medicaid policy, Generally Accepted Accounting Principles (GAAP) should be applied. Related organizations and costs to related organizations, as defined in federal regulations, must be disclosed on the nursing facility cost report. Related organization costs claimed for Medicaid reimbursement through the nursing facility's rate determination process must be documented to RARSS on a completed home office cost report or on alternative cost reporting schedules as defined in the Home Office, Chain Organization, or Related Party Cost Reporting subsection of this appendix. **(per bulletin MSA 06-10 effective 3/29/06)**

RARSS retains the filed nursing facility cost reports for a minimum of three years from the date of receipt. Nursing facilities are required to retain documentation supporting filed cost reports for a minimum of seven years from the end of the applicable cost reporting period, or beyond the seven year period if audit determinations have not been resolved.

4.3 Cost Report Requirements

The RARSS will mail a notice to the facility or business office as designated by the provider soon after the end date of the nursing facility's cost reporting period on record. The notice specifies the nursing facility's county and license number coding, fiscal reporting period end date, cost report due date, and other pertinent data necessary for the completion of the cost report. The provider will also receive a compact disk (CD) with the specific information required to file an acceptable Medicaid Cost Report package in an electronic format. The CD has the applicable electronic cost report template, completion instructions, Marshall Valuation Services Cost Multiplier index for asset acquisitions, and other pertinent information.

The completed cost report package submitted to RARSS must include:

- The standardized electronic cost report (ECR) data in accordance with specified formatting and software.
- A paper copy of the Certification Statement (Worksheet A), which has been prepared and printed from the completed ECR file, and signed by an authorized representative of the nursing facility certifying to the accuracy of the prepared cost report.
- A copy of the nursing facility's trial balance of revenues and expenses.
- A completed cost report submission checklist.

The completed cost report package must either be mailed or delivered to RARSS as indicated in the notice.

4.4 Cost Report Acceptance

Each cost report submitted to RARSS is verified prior to its acceptance. The cost report package will only be accepted if all of the following conditions are met:

- The package is complete.
- The cost report calculations are mathematically accurate, reasonable and consistent.
- The completed electronic cost report (ECR) data uses the required software and specified format.
- MDCH audit staff can generate a full cost report applicable to the cost year from the ECR file.
- The paper copy of the Certification Statement is completed and signed, and agrees with the submitted ECR file.
- The data meets a set of validation checks contained within the ECR plus the appropriate bed size and certification reporting requirements.
- The submitted ECR file includes proper reporting of costs and related cost report allocations in accordance with prior year(s) audit adjustment determinations for like costs or cost reporting issues.
- The cost report preparation complies with Medicaid policy and cost reporting instructions.

A cost report is considered not filed until it is accepted by RARSS. If the submitted cost report is determined to be unacceptable, RARSS will return the cost report to the nursing facility for correction and provide notice of the date the corrected cost report is due. The returned cost report will include information that indicates the reason(s) for the unacceptable report.

A corrected cost report – a revision of the most recently submitted cost report – may be submitted to RARSS for acceptance upon approval by RARSS. The provider should contact RARSS to obtain the acceptance status of that reporting period's most recent cost report ECR file prior to submission of a corrected cost report. A corrected cost report that is accepted by RARSS defaults as the original cost report.

4.5 Less Than Complete Cost Report

With written approval from the RARSS, a nursing facility may submit a less than complete cost report.

4.5.A. No Medicaid Utilization

A nursing facility that has not furnished any services to Medicaid beneficiaries during the entire cost reporting period does not need to submit a cost report to comply with Medicaid's cost reporting requirements. The nursing facility may replace the cost report with a letter signed by an authorized representative that identifies the cost reporting period to which the statement applies (includes the facility name and Medicaid provider ID number), and states that:

- No covered services were furnished during the reporting period.
- No claims for Medicaid reimbursement will be filed for this reporting period.

The signed statement must be submitted to the RARSS within 30 calendar days following the date of the nursing facility cost report filing notice.

4.5.B. Low Medicaid Utilization

RARSS may authorize a less than complete cost report for a nursing facility with low utilization of Medicaid services in a reporting period. "Low utilization" is defined as an average of five or fewer Medicaid residents per day in the facility for the cost year, i.e., fewer than 1,825 Medicaid nursing days. The nursing facility must submit a written request to RARSS for approval to file a less than complete cost report for the specific cost reporting period. The request must be signed by an authorized representative of the nursing facility, identify the reporting period the request applies to, include the facility's name and Medicaid provider ID number, and:

- Indicate the reason(s) for the request.
- Indicate Medicaid utilization and the approximate Medicaid dollar amount of payments received for the year.

The written request must be submitted to the RARSS within 30 calendar days following the date of the nursing facility cost report filing notice.

After RARSS reviews the filed utilization and payment information, RARSS will send a written response to approve or deny the facility's request to submit a less than complete cost report. If approved, the facility will be required to furnish the following information using the required formats (ECR file worksheets):

- Information and Certification page.
- Statistical and Fiscal Data page.
- Ownership Information and Questionnaire.

In addition, the facility must prepare and submit the following information for the cost reporting period:

- Balance Sheet, and
- Prepared Financial Statements.

The nursing facility must submit the data within the same time period required for complete cost reports. Medicaid reserves the right to require the facility to file a complete cost report.

4.6 Cost Report Due Date

The RARSS will notify the nursing facility of the cost report due date by letter mailed to the nursing facility or designated business office. An acceptable cost report must be received by RARSS within five months following the nursing facility's cost reporting period end date. Subsequent notice of the cost report due date is addressed in the Cost Report Delinquency subsection of this appendix.

A cost report is considered filed timely if the acceptable cost report is submitted to the RARSS on or before the last day of the fifth month following the cost report period end date. Late submission of an acceptable cost report may cause a delay in determination of the provider's annual reimbursement rate and the rate notice to the provider. Refer to the Rate Determination subsection of this appendix for additional information.

4.6.A. Corrected Cost Report Due Date

If the cost report is returned to the provider unaccepted, the provider is given 15 calendar days from the date that RARSS returned the cost report to resubmit a corrected cost report. A written request for an extension may be made to RARSS for additional days (not to exceed 30 calendar days from the return date). The RARSS will notify the provider in writing of the extension decision. If a corrected cost report is not received by the correction due date, the nursing facility is subject to cost report delinquency and payment termination notification. Refer to the Cost Report Delinquency subsection of this appendix for additional information.

4.6.B. Cost Report for Facility Closure or Change of Ownership

A nursing facility that has terminated its Medicaid program participation, either voluntarily or as the result of regulatory action, is required to submit a final cost report within five months following termination date.

The former owner of a nursing facility that has undergone a change of ownership is required to submit a final cost report within five months following the effective date of the ownership change.

4.7 New Facility/Owner Requirements

A new Medicaid provider (either a new owner or a new Medicaid participating provider) must notify RARSS of its fiscal year and cost reporting period, and other pertinent information regarding the nursing facility. In order for RARSS to establish the facility's Medicaid reimbursement rate, this notice must be submitted to MDCH at least 30 calendar days prior to the begin date of Medicaid participation. Untimely submission of the data will result in delaying Medicaid payment to the nursing facility.

The new provider information packet is available by request to the RARSS. An electronic copy of the packet may also be accessed on the MDCH website. (Refer to the Directory Appendix for contact and website information.)

The new provider information data must include the following items:

- Operations begin date.
- Fiscal year reporting period.
- Federal employer identification number.
- Facility business name.
- Corporate name (if different from business name).
- Facility address.
- Business mail address (if different from facility address).
- Affiliation to a home office chain or related nursing facility group, including corporate organization, address, fiscal reporting time period, federal employer identification number and contact person information.
- Nursing facility Medicare Program status.

The new provider information data packet must be signed and submitted by an authorized representative of the nursing facility.

4.8 Changing a Cost Reporting Period

An annual cost report is required for the reporting period based on the nursing facility's fiscal reporting year. A nursing facility must file an annual cost report in accordance with the cost reporting period established with RARSS. However, under certain circumstances, RARSS may authorize a change in the nursing facility cost reporting period. The new cost reporting period must concur with the time period of the nursing facility financial reporting year.

4.8.A. New Facility/New Ownership Initial Cost Report

A new Medicaid provider (either a new owner or a new Medicaid participating provider) must notify RARSS of its fiscal year and cost reporting period, and other pertinent information regarding the nursing facility. The initial cost report must cover a period of at least two months but may not exceed 13 months.

4.8.B. Written Request for Cost Reporting Period Change

A nursing facility owner interested in changing a cost reporting period must submit a written request to RARSS. The request for such a change must be filed at least two months prior to the first day of the new fiscal reporting period being requested. The request must include documentation supporting the change, such as a copy of an approval of Medicare Program reporting change or Internal Revenue Service reporting year change notice. If the reporting year change is not yet approved by these agencies, a copy of notice to Internal Revenue Service reporting or application for Medicare Program reporting change may be submitted. The request must also include a copy of the nursing facility director or governing board approval resolution or minutes adopting the fiscal reporting revision.

RARSS will notify the provider in writing of the approval or denial of the request and cost report time period requirements resulting from the request.

4.8.C. Approval for Transition Period Cost Reporting

If the change is approved, the nursing facility will be required to file a cost report for the period between the end date of the original cost reporting period and the beginning date of the new cost reporting period. This cost report must cover a time period not less than two months and not more than 13 months. Cost report periods that cover a period less than seven months may be used for Medicaid reimbursement for retrospective cost settlement determination for specific cost items, but are not used for prospective rate setting determinations affecting a subsequent rate setting year.

4.8.D. Extended Period Cost Report

A provider may submit a request for a cost report period of more than 13 months if the:

- Provider is terminating Medicaid Program participation.
- Facility is closing.

Written request must be made to the RARSS and must outline the exceptional circumstances. The provider will be notified in writing of approval or denial.

The RARSS may approve such requests if the Medicaid program or the nursing facility are not significantly adversely affected. Examples of not adversely affected include where:

- the request is not made for purpose to gain access to higher ceiling rates or economic inflation adjustors;
- the cost report data will have limited use for reimbursement determinations, i.e., not used for annual rate setting;
- the report is not used for subsequent time period rate determination; and
- it is used solely for retrospective settlement items.

4.9 Cost Report Delinquency

The nursing facility cost report is considered delinquent if:

- An accepted cost report has not been received by RARSS by the cost report due date and the cost report remains not filed with RARSS.
- A corrected cost report has not been received by RARSS by the cost report due date or correction period due date and the cost report remains not filed with RARSS.

If the nursing facility cost report is delinquent, RARSS will send a delinquency and Medicaid payment termination notice by certified mail to the nursing facility or the provider's designated business office. The notice will indicate the date (not less than ten business days from the notice date) on which Medicaid payment will be terminated unless a cost report is received by the RARSS.

If an acceptable cost report is received after payment termination, payments will be reinstated through the normal pay cycle(s) process. Medicaid will remove the payment termination entry pertaining to the cost report delinquency action allowing the release of all payments withheld for the cost report delinquency action.

4.10 Amended Cost Report

An amended cost report to adjust a previously accepted cost report may be permitted or required by Medicaid.

An amended cost report is accepted by Medicaid to:

- Correct material errors detected subsequent to the filing of the original cost report.
- Comply with health insurance policies or regulations.
- Reflect the settlement of a contested liability.

Before completing and submitting an amended cost report, the nursing facility should contact the RARSS by verbal or written communication to determine the appropriate mode for making the necessary amendment(s). Amended cost report data will be effective for reimbursement rate determination and payment for nursing facility services rendered beginning in the month following the receipt of the provider's notice to RARSS of the need to amend the cost report.

The provider must include a disclosure letter with the amended cost report identifying the reason for the amended report and citing the cost report Worksheet(s) and the data input cell(s) within the Worksheet(s) that have been revised.

The provider cannot amend an audited cost report. Amended cost reports will not be accepted by RARSS after the completion of an audit except in cases where the filed and audited cost report continues to be the basis for the nursing facility's current reimbursement rate. An amended cost report must properly reflect any audit adjustments made to the original cost report. Amended data will be used, as appropriate, to compute future rates but will not be used to retroactively change a previously paid prospective rate. Use of amended cost report data for retroactive application to prior services will only be made in cases related to fraud or failure to disclose required information in the cost reporting. Situations where retroactive changes are permissible are described in the Cost Report Reimbursement Settlements Section of this appendix.

4.11 Home Office, Chain Organization, or Related Party Cost Reporting [Renamed and Changes Made 4/1/06]

Nursing facilities that have costs applicable to services, facilities, and supplies furnished to the provider by organizations or entities related to the nursing facility by common ownership or control may include the costs in the nursing facility cost report. These costs may arise from arrangements involving a home office of a chain organization or services provided to the nursing facility or purchased by the nursing facility from related party businesses.

For facilities that are operated as part of a chain organization, home office costs claimed on the individual nursing facility's cost report must be reported using the Medicaid Nursing Facility Home Office Cost Statement (MSA-1578). **(per bulletin MSA 06-10 effective 3/29/06)**

For nursing facilities reporting costs of services provided by a related party organization, the MSA-1578 must be used for reporting costs. A CD containing an electronic copy of the MSA-1578 will be forwarded to providers at least 60 days prior to the provider's deadline for submission. **(per bulletin MSA 06-10 effective 3/29/06)** Alternative cost reporting worksheets or accounting schedules may be substituted for the Home Office Cost Statement if RARSS agrees that the alternative format provides supporting documentation to adequately identify expenses and the allocation of costs to the nursing facility. RARSS will approve the format as submitted, require additional data or revisions to the reporting format, or disapprove the alternative reporting.

When the fiscal year for the home office or related organization coincides with the nursing facility's fiscal year, the due date for the home office or related party organization cost report must coincide with the nursing facility's annual cost report due date. In cases where the fiscal years do not coincide, the nursing facility must submit the cost report of the home office or related party organization for the most recently completed fiscal year of that entity. If the report was previously submitted to RARSS, it must be resubmitted by the same due date as the nursing facility's cost report. **(modified per bulletin MSA 06-10 effective 3/29/06)** (Refer to the Related or Chain Organization Cost Allocation subsection in this appendix for additional information.)

If the facility does not provide the above referenced supporting documentation to support home office or related party organization costs, the facility must remove the costs from the nursing facility's cost report. The nursing facility's cost report will not be accepted if the provider does not remove the unsupported costs.

4.11.A. Home Office Costs - Chain Organization

For Medicaid purposes, a chain organization consists of a group of two or more nursing facilities, or at least one nursing facility and any other business or entity owned or operated and controlled by one organization.

For Medicaid policy regarding allowable costs, refer to the Cost Classification and Cost Finding Section of this appendix.

4.11.B. Related Party Business Transactions

The operating costs of a related ownership organization are allocated to the individual nursing facility as a purchased service. This cost must be identified within the appropriate cost center in the Medicaid cost report. Identification of the type of service determines if the costs qualify to be apportioned between base and support cost using the industry-wide base and support cost percentages. If the service does not qualify to be apportioned by this method, the allocated costs are classified as support costs in the individual nursing facility.

The related party organization cost reporting is required for the specific related party organization business entity in the following cases:

- If the dollar amount of routine nursing care costs to the individual nursing facility exceeds $10,000 in aggregate, regardless of the number or type of services provided.
- If the sum (total dollar amount) of routine nursing care costs to multiple nursing facilities exceeds $50,000 in aggregate, regardless of the number or type of services provided and number of nursing facilities served.

These dollar limits apply to related party business transactions whether they are routine or ancillary nursing services.

Facility lease arrangements between related parties must be separately reported in the cost report as described in the Allowable and Non-Allowable Cost Section of this appendix.

4.12 Cost Report Filed Under Protest

As part of the cost settlement and cost report audit process, a nursing facility provider may dispute a Medicaid regulatory or policy interpretation. (Refer to the Appeal Process Section of this appendix for additional information.) If the provider has a dispute regarding the annual cost report, the nursing facility must submit a separate cost report, referred to as a 'protest cost report' to establish their reporting of the dispute issue. In order to preserve the nursing facility cost report claim, this separate cost report must be identified as under protest for the disputed issues that remain under appeal or are subject to an appeal. The protest cost report filing must include an accompanying letter, signed by the nursing facility authorized representative, listing the disputed issue(s) and respective dollar amount(s) for the basis of the protest cost report filing. Protest cost reporting issues will be addressed in the cost report audit process dependent upon resolution of the disputed issues. The cost report filed under protest will not be used for rate determination, but will provide information for audit consideration

relative to disputed issues. The auditor will address necessary audit adjustments to the accepted cost report to reflect the appeal resolution.

Protest cost report filing is not for general disagreement with promulgated Medicaid policy. The RARSS will not accept protest cost reports filings that include items considered as disagreement or dissatisfaction with promulgated policy.

SECTION 5 - PLANT COST CERTIFICATION

Medicaid reimburses nursing facilities for costs associated with capital asset ownership. The costs are referred to as plant costs and are reimbursed as the Plant Cost Component of the per diem reimbursement rate. The Plant Cost Component is based on the cost report data submitted by the nursing facility for the previous calendar year. The Plant Cost Component includes costs associated with capital asset acquisition, depreciation, interest expense (either working capital or capital indebtedness), property taxes, amortization costs associated with loan financing costs (letters of credit, asset acquisition legal fees) and specific lease expenses. The Plant Cost Component of the reimbursement rate determined for a nursing facility remains consistent throughout the State's fiscal year period (October through September), unless the facility qualifies for an interim reimbursement rate.

Example: Plant cost data from cost report year-end December 31, 2002 is the basis for the Plant Cost Component for the October 2003 through September 2004 rate period. Refer to the Cost Classification and Cost Finding, and the Rate Determination sections of this appendix for additional information.

The process used to determine if a facility qualifies for an interim reimbursement rate is called Plant Cost Certification. Special rate setting provisions qualify facilities to use current year costs associated with capital ownership instead of the prior year's cost report data to determine the Plant Cost Component of the reimbursement rate. Rate setting provisions are available for facilities incurring exceptional changes in the facility's plant costs during the current year. Qualifying situations such as new construction or renovation, new asset acquisition, new ownership, or changes in the nursing facility's bed size or the type of resident services are considered to determine eligibility for Plant Cost Certification.

5.1 PLANT COST CERTIFICATION ELIGIBILITY CRITERIA

A facility may plant cost certify when there is no plant cost data available or when the plant cost data inadequately reflects the current rate period plant costs. Plant Cost Certification is available in the following situations:

- The nursing facility provider is constructing a new building or incurring physical plant improvements with Certificate of Need (CON) approval, or the asset costs are, on average, $1500 per licensed bed in capital expenditures in a single cost reporting period.
- There is an approved CON ownership change for an existing facility, or the nursing facility assets have changed ownership in a manner that requires CON review.
- The State Survey Agency has changed the class level of the facility, change in Medicaid certified beds, or the type of nursing or resident care services provided in the nursing facility.
- The nursing facility has an approved non-available bed plan in the cost report period.
- The nursing facility is in the first full cost report year following the termination of an approved non-available bed plan.

5.2 PLANT COST CERTIFICATION SUBMISSION

The provider must complete the Plant Cost Certification process and qualify in order to receive an interim reimbursement rate. The RARSS must receive a compilation of the nursing facility's expected allowable plant costs and a statement signed by the nursing facility's authorized representative attesting to the data's accuracy and adherence to the Plant Cost Certification policy. The provider must use the MDCH

required format for document preparation. A provider having a nursing facility license and leasing the facility must report facility costs of the lessor in accordance with Medicaid's reimbursement policy. Refer to the Allowable Cost and Non-Allowable Cost, and Cost Classification and Cost Finding sections in this appendix for additional information.

A provider requesting an interim reimbursement rate must provide the information in the Medicaid Long Term Care Plant Cost Certification format and submit copies of supporting documentation. A copy of the format is available on the MDCH website. (Refer to the Directory Appendix for website information.) The Plant Cost Certification packet of accepted sample formats is available by request to RARSS. An electronic copy of the packet can also be accessed on the MDCH website.

Supporting documentation must include the following items for Facility Purchase:

- CON approval
- Purchase Agreement
- Mortgage and Loan Agreements
- Interest Amortization Schedules for Financing
- Property Tax Statements
- Capital Asset Cost Appraisal
- Purchase Closing Statement or Recording

Supporting documentation must include the following items, where applicable for Renovation, Addition, or New Construction:

- CON approval
- Licensed Bed Notice issued by the State Survey Agency
- Mortgage and Loan Agreements, if applicable
- Interest Amortization Schedules for Financing
- Property Tax Statements
- Construction Contract Statement or Summary

The completed information and support documentation may be mailed or delivered to the RARSS. Inquiries relating to the submission of the data should be directed to the RARSS office. (Refer to the Directory Appendix for contact information.)

If RARSS determines that the plant certification eligibility criteria are met, the submitted cost data will be desk reviewed, adjusted if necessary, and used to calculate the nursing facility's Plant Cost Component. If the fiscal year cost report filing and subsequent cost report audit determine the data used to calculate the reimbursement for the Plant Cost Component resulted in an overpayment or underpayment to the provider, the Medicaid recovery or additional reimbursement due the provider is included in the cost report reimbursement settlement. (Refer to the Cost Report Reimbursement Settlement section of this appendix for additional information.)

5.2.A. Plant Cost Certification Requirement for Reimbursement – Building and Equipment Changes

A new or existing provider or business entity operating a nursing facility that is incurring a change involving the nursing facility's building and equipment must complete a Plant Cost Certification. A provider that obtains ownership of the nursing facility building and equipment or enters a lease agreement for the facility must submit a completed Plant Cost Certification. In the instance that a lease change is the result of a facility ownership change where the provider has a different landlord, a plant cost certification is required if any terms of the lease agreement changes, such as lease amount, duration, etc.

The Plant Cost Component of the reimbursement rate will be zero until the Plant Cost Certification is received by the RARSS. In order to be eligible for retroactive reimbursement, the provider must submit a completed Plant Cost Certification on or before the date of the initial filing of cost report for the year in which the ownership change or asset transaction occurred. The effective date of the Plant Cost Certification will be the month that new ownership becomes the licensed entity or the asset transaction. Plant Cost Certification requests received by RARSS subsequent to the cost report filing will not be eligible for retroactive reimbursement, and future plant cost reimbursement rates will be effective as outlined under the effective time period policy.

5.2.B. Plant Cost Certification Submission Waiver

If the provider qualifies for Plant Cost Certification under the approved non-available bed plan or because it is the first cost report year after the non-available bed plan termination, the data submission requirement is waived. The provider has the option to file during the rate year or to defer the plant cost rate revision until the cost report reimbursement settlement. Settlement adjustments for plant costs for the cost report period will automatically apply to non-available bed time periods. If a Plant Cost Certification is not filed, the nursing facility's interim Plant Cost Component will continue to be based on the previous year's cost report, and the cost report reimbursement settlement will be adjusted to the allowable plant cost level for the cost report time period. Refer to the Cost Report Reimbursement Settlement section of this appendix for additional information.

5.3 Plant Cost Certification Effective Time Period

The effective time period of the plant cost certification will be determined by the RARSS. A completed Medicaid Long Term Care Plant Cost Certification request in required format, with documentation, received by the RARSS prior to the 16th of the month is effective and included in the reimbursement rate as of the first day of the following month (e.g., a request received between September 16 and October 16 will be reflected for days of care beginning November 1).

The effective date of the plant cost certification cannot be prior to the month in which the facility experienced the change of ownership or the qualifying asset change. The rate is not revised for partial months. For interim rate setting, the revised reimbursement rate due to the Plant Cost Certification will not be applied to prior service dates except in instances where a provider meets certification eligibility under the nursing facility ownership change or lease provisions. If a plant cost certification is filed prior to the provider's cost report year end, an interim reimbursement rate is effective on a prospective basis

for service dates after filing date. Retroactive reimbursement due to the plant cost change for that cost report year services will be addressed in the initial and final settlement determination of the cost report. Refer to the Cost Report Reimbursement Section of this appendix for additional information.

If a Plant Cost Certification is filed after the provider's cost report year end, the plant cost reimbursement rate change is only effective on a prospective basis in accordance with the time period established by the Plant Cost Certification request receipt date.

The Plant Cost Certification interim reimbursement ends when the nursing facility's prospective Plant Cost Component is based on the first complete cost report year that reflects the plant costs which qualified the nursing facility for Plant Cost Certification.

Example: A nursing facility with a cost report period of January 1, 2004 through December 31, 2004 completes an eligible renovation project in June 2004, and submits a Plant Cost Certification before June 16, 2004 to be effective July 1, 2004. (**Note:** Rate Year refers to a time period coinciding with the state fiscal year rate period. The time periods listed below the Rate Year identify the period during which the rate will be paid and the cost report year on which the rate is based.)

Nursing Facility Initial Period Interim Rates for Plant Cost Reimbursement

Rate Year: October 2003 – September 2004	October 2003 – June 2004: Plant cost for the cost year end December 2002	July 2004 – September 2004: Plant cost based on plant cost certification reflecting expected cost for the cost report year end December 2004

Nursing Facility Final Rates for Plant Cost Reimbursement

Rate Year: October 2003 – September 2004	October 2003 – December 2003: Plant cost for the cost report year end December 2002	January 2004 – September 2004: Plant cost for the cost report year end December 2002
Rate Year: October 2004 – September 2005	October 2004 – December 2004: Plant cost for the cost report year end December 2004	January 2005 – September 2005: Plant cost for the cost report year end December 2005
Rate Year: October 2005 – September 2006	October 2005 – December 2005: Plant cost for cost report year end December 2005.	January 2006 – September 2006: Plant cost for the cost report year end December 2006.

Rate Year: October 2006 – September 2007	October 2006 – September 2007: Plant cost for cost report year end December 2005.

5.4 Plant Cost Certification Updates and Revisions

The nursing facility's initial Plant Cost Certification will continue to be used for the interim Plant Cost Component unless the nursing facility submits a revision to the Plant Cost Certification.

Following the initial submission of the Plant Cost Certification, the nursing facility is responsible to submit an updated or revised Plant Cost Certification to assure the interim Plant Cost Component reimbursement is representative of the current rate period plant costs.

The nursing facility provider may revise its submitted Plant Cost Certification at the beginning of subsequent fiscal year rate periods or the beginning of a calendar quarter, but not more than two times per year. The effective timeframes for payment based on the updated information are the same as noted above.

The overpayment penalty provisions, if applicable, remain in effect regardless of payment based on initial submission or revised data.

5.5 Plant Cost Certification Overpayment Penalty

At the time of the MDCH audit of the provider's fiscal year cost report, if the interim reimbursement payments resulting from Plant Cost Certification exceed cost report settlement plant cost reimbursement, all excess funds paid as a result of the Plant Cost Certification request will be recovered by Medicaid. The provider will be assessed a penalty for overpayments resulting from Plant Cost Certification. The penalty will be 10 percent of the aggregate dollar amount difference between the interim reimbursement payments resulting from the Plant Cost Certification and the cost report settlement plant cost reimbursement. The penalty will be waived if the aggregate dollar amount difference is equal to or less than 10 percent of the provider's aggregate Plant Cost Component reimbursement amount for the cost settlement period. Overpayment recovery and penalty determination are included in the Cost Report Reimbursement Settlements Section.

SECTION 6 - AUDIT

The goal of the cost report audit is to provide the MDCH assurances that the cost report information is accurate for the determination of Medicaid reimbursement rates, and includes the following objectives:

- To review, analyze, and test the nursing facility's Statement of Reimbursable Cost and underlying financial records to confirm that only reasonable and allowable costs have been included.
- To confirm that the methods used to calculate the required statistical information are adequate and that the statistical data is recorded accurately.
- To confirm that the cost finding and cost apportionment have been accurately and fairly computed.
- To confirm the accuracy of the costs allocated to Medicaid by independently applying the method approved for the provider's use in computing reimbursable cost.
- To confirm that, in all material aspects, the nursing facility provider is in compliance with the reimbursement regulations.
- To review, analyze and test the nursing facility's revenue and billings to determine the propriety of billing practices and identify potential errors and financial risk to Medicaid.
- To identify the underlying causes of significant errors or problems noted during the audit and to suggest improvements.
- To follow up on significant problem areas identified in previous audits.
- To confirm consistent and uniform application of federal and state laws, rules, and regulations for reimbursable costs.

6.1 AUDIT PROCESS

The annual audit process may include a desk audit/review, a computer check, and/or an onsite audit. This process may be performed by MDCH audit staff or by a qualified designee.

Onsite audits will be conducted no less than once every four years. An audit of either limited or full scope will be performed on the records of each participating nursing facility provider to ensure that the expenses attributable to allowable cost items are accurately reported in accordance with established principles and guidelines.

A Preliminary Summary of Audit Adjustments Notice is issued to the facility upon completion of the audit.

6.1.A. Required Information

Each provider must allow access or arrange for access by MDCH staff, or their designees, to required financial records and statistical data including:

- Records required by the Medicare Principles of Reimbursement
- Complete financial records of related organizations
- Complete records of lessors necessary to determine underlying costs of leasing facilities and items of equipment

These records include, but are not limited to, the following:

- Census records and numbers and types of leave days for each Medicaid beneficiary/resident (i.e., hospital, therapeutic)
- Resident medical records, with details of medical services received by each resident
- Resident service charge schedules
- Resident trust fund account records, with evidence of quarterly reporting to each resident
- Medicaid Cost Report with supporting documentation for cost finding statistics utilized on the report
- Supporting documentation for Nurse Aide Training and Competency Evaluation Program activity and cost data
- Documentation to support the cost and activity level for special Medicaid reimbursement provisions beyond the scope of services included in routine nursing care
- Total and Medicaid ancillary charge summaries and logs
- Medicare Cost Report, if applicable
- Medicare and other health insurance billing and payment records for each resident
- Books of original entry, including standard/special journals, payroll journals, disbursement journals, etc.
- Employee records, including detailed payroll records, personnel files, employee wage scales, shift schedules, union contracts, agreements, fringe benefits (e.g., deferred compensation, pension plans, insurance, personal use of assets, special allowances), individual accounts of leave days, job descriptions, and payroll tax returns.
- Facility policy and procedure manuals and related materials
- Plans for internal control
- Minutes of meetings of the governing body
- General and subsidiary ledgers, including stock ledgers, cash receipts, etc.
- Purchase requisitions and orders
- Vouchers and invoices in detail to support services and goods purchased
- Records related to management fees, executive services or personal services contracts, and contracts for services under arrangement
- Charts of accounts
- Checking account registers, canceled checks, and bank statements
- Vehicle mileage and use logs
- Fixed asset records
- Capital expenditure records and depreciation lapse schedules
- Copies of long-term debt obligations, mortgages, notes payable/receivable, amortization schedules, year-end statements, and loan histories

- Tax returns, or federal informational returns for tax-exempt facilities
- Provider organization ownership disclosure records, e.g., Articles of Incorporation, Partnership Agreement, and other similar documentation
- Records regarding chain organizations, including corporate home office costs
- Work papers and records regarding the preparation of cost reports
- Audit reports of financial statements
- Work papers of internal and external accountants used in the preparation of the cost report(s)
- Records regarding working capital. Analysis of source and use of funds, which includes working capital loan principle payments
- Leases and all related records
- Accounts receivable Aging Schedule
- Accounts payable Aging Schedule

6.1.B. Availability of Information

The nursing facility must have an accounting and records maintenance system to provide accurate cost, revenue and statistical data, and other information that can be verified by Medicaid auditors. MDCH audit staff or their designees will not complete an audit if the nursing facility does not make required information available. If the required information is not released within 15 business days of a written request by an auditor during an audit, the MDCH may assess a financial penalty to the provider until the requested records are made available to the auditor. The MDCH will issue prior notice to the provider that they will assess the penalty equal to 20 percent of the facility's monthly Medicaid payments, effective in the first month following the expiration of the 15-day notice period. Waiver of the penalty assessment is only allowed by approval of the Medicaid Director following the provider's request for waiver consideration, including justification for the request and additional time to provide the records.

NOTE: A nursing facility provider that has been assessed a penalty is prohibited from collecting additional funds from Medicaid beneficiaries to compensate for the penalty.

If, after the 15-day period, the records become available for auditor review, an authorized representative of the nursing facility must give written notice of record availability to the MDCH Office of Audit. This acknowledgement to release the requested records must designate the contact person and record location. The payment penalty will be discontinued effective for the month following the date the auditor determines that the required records have been released and the dollar amount of penalty assessments will be refunded to the nursing facility provider. The auditor's determination that the requested records have been provided will be made within 60 calendar days of such written agreement to release the requested records.

The auditor may determine that records necessary to verify specific cost report expenses are required to complete the audit. Failure to release the requested records within 15 business days of a written request will result in a disallowance of costs associated with the item in question. If the nursing facility disagrees with the disallowance, this disallowance can be appealed at the completion of the audit. (Refer to the Appeal Process Section of this appendix for additional information.)

6.1.C. Retroactive Rate Changes

A retroactive change in a nursing facility's rate and reimbursement may be made after completion of an audit in the following situations:

- For those providers that are retrospectively settled.
- For those providers that had an interim rate set prior to completion of the cost report audit.
- For those providers that were retrospectively settled because they were granted Rate Relief.
- For audit adjustments required as a result of a hearing decision.

Refer to the Reimbursement Rate Determination section of this appendix for detailed information regarding retroactive effective time periods for rate determination and reimbursement actions.

6.1.D. Reopening Audit Determinations

The MDCH may elect to reopen an audit determination following completion and closing of the audit of a nursing facility cost report. The MDCH will provide notice to the nursing facility of the audit reopening and the issues for which the audit is under review. Results of the audit reopening will be submitted to the provider, who will be given the opportunity to review the findings and appeal in accordance with Medicaid policy. If it is determined that the audit cost report contains incorrect data, the MDCH will use corrected data to compute future rates. The audit revisions will be effective for reimbursement rate determination and payment for nursing facility services rendered beginning the month following notice to the provider that the subject audit is being reopened.

The results of audit reopening actions will only be effective for retroactive reimbursement revision in cases of fraud or when the provider's failure to disclose required information was pertinent to the determination of allowable cost.

The Department will not reopen an audit determination for any reason other than fraud beyond three years following the date of final settlement.

6.1.E. Record Retention

Each nursing facility's accounting and related records must be kept for a period of not less than seven years. This obligation does not end if a provider closes or sells a facility. All records, source documents, contractual agreements, and corporate minutes must be available onsite, or at a readily accessible location, for verification and inspection by MDCH staff or their designees. When accounting personnel, books and records are located out of state, the provider is required to pay auditor travel expenses if MDCH staff or their designees deem it necessary to access documentation during the course of an audit.

6.2 Financial Fraud and Abuse

Federal Medicaid law and regulations require the Medicaid program to establish and maintain methods and criteria for the identification, investigation, and referral of potential fraud and abuse. In accordance with federal and state requirements, the MDCH will authorize the suspension of Medicaid payments (in whole or in part) to a nursing facility provider on receipt of reliable evidence that the provider committed fraud or willful misrepresentation while enrolled as a Medicaid provider. The provider will receive written notice of such suspension and may request an administrative review. (Refer to the Appeal Process Section of this appendix for additional information.)

A MDCH auditor or designee that observes potential fraud or financial abuse will prepare a separate report of observations. Observations of potential fraud or abuse include, but are not limited to, the following:

- Recording of personal expenses
- Overutilization of services to inflate charges
- Unauthorized use of resident trust funds
- Payroll entries of personnel who provide no services
- Concealment of business activities
- Falsifying records
- Charging Medicaid for costs not incurred
- Duplicate billing
- Billing beneficiaries inappropriately for Medicaid services
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Knowingly failing to disclose required information in the Medicaid cost report

Reports of observations will be reviewed by MDCH staff and appropriate actions taken. This may include forwarding a copy of the report and supporting documentation to the state Attorney General's Health Care Fraud Division.

SECTION 7 - COST REPORT REIMBURSEMENT SETTLEMENTS

The nursing facility reimbursement rate is determined in accordance with the policy provisions outlined in the Rate Determination Section of this appendix. The reimbursement rate may include routine nursing care services and various rate add-on amounts depending on the Medicaid reimbursement policy effective at the time. The reimbursement rate is a per diem amount determined by the Provider Type. Rate determination may be based on filed cost report data, audited cost report data, cost data submissions and projections for specific reimbursement activity, or interim reimbursement provisions in accordance with Medicaid policies. The reimbursement rate is determined at the beginning of the rate year and the nursing facility is provided notice of the rate determination prior to implementation of the rate. The reimbursement rate may be revised any time during the rate year in accordance with rate determination policies. Rate revisions can result from the following actions as detailed in the Rate Determination Section:

- More recent Fiscal Year filed cost report
- Audited cost report
- Plant Cost Certification
- Nurse Aide Training and Competency Evaluation Program
- Special Dietary Cost Allowance
- Special Reimbursement policy actions

Reimbursement for ancillary services provided to Medicaid-eligible residents will be made in accordance with policies identified in the Coverage portion of this chapter and in the Billing & Reimbursement for Institutional Providers Chapter.

7.1 INTERIM REIMBURSEMENT AND RATE REVISIONS

The Rate Determination Section in this appendix outlines the process for determining the nursing facility's annual reimbursement rate. If RARSS determines that a reimbursement rate must be revised, the rate change may affect payment for future and/or previous dates of service. RARSS will notify the provider of the rate change and the rate's applicable time period.

If a rate revision applies to future dates of service, RARSS will send written notice to the provider's designated address specifying the revised rate and the applicable time period for the rate.

If a rate revision must be applied to previous dates of service in the current cost report year, RARSS will notify the provider of the applicable time period and the reimbursement rate. If the rate revision applies to previous dates of service in the current cost report year, RARSS will make the determination of an underpayment or overpayment amount, and RARSS will notify the provider of the process for implementing the payment adjustment(s).

If the rate revision applies to a prior cost report year's dates of service, the payment adjustment process is addressed in the Initial Settlement Section of this appendix.

7.2 Initial Settlement

The SMA may determine that a retroactive adjustment to the nursing facility reimbursement rate and payments is needed after the end of the provider's rate year. The retroactive adjustment may be due to a previous interim rate revision or to implement a rate based on actual cost report data. After the filing and acceptance of the cost report, the RARSS will determine if an Initial Settlement adjustment is necessary to make a retroactive payment adjustment for the rate period covered by the cost report. The Initial Settlement uses the most recent accepted cost report data to calculate the retroactive reimbursement and paid Medicaid claims and other payment data. (Refer to the Rate Determination Section of this appendix for additional information.)

The RARSS will consider provider requests for Initial Settlements on an exception basis in the following situations:

- The provider anticipates a significant amount due them by Medicaid and requests an Initial Settlement in writing. The provider may make the request with the filing of the cost report.
- A payment adjustment is necessary for several months of the cost report period, and the current date is beyond the cost report period end date.
- The review of a filed cost report identifies that the interim rate add-on amount, plant cost certification amount, or other special reimbursement interim amount included in the interim rate exceeds the amounts filed in the cost report.
- The provider has terminated Medicaid participation and has failed to file an acceptable cost report. An overpayment determination will be made for the payments to the provider during the time period that cost report data is required for determining final reimbursement.

If the RARSS determines that the Initial Settlement is an underpayment amount to the nursing facility, additional payment will be made to the provider for not less than 70 percent and not more than 80 percent of the determined settlement amount due the provider based on a review of the provider's financial situation and the effect of the filed cost report data on the reimbursement settlement determination. Although the provider may request a review of the Initial Settlement amount, the Initial Settlement payment level percentage is not subject to appeal.

If RARSS determines there is an overpayment to the nursing facility, the SMA will recover the overpayment amount as outlined in the Medicaid Recovery of Overpayments subsection.

Before making any payment adjustment, the RARSS will notify the provider in advance using a Notice of Program Reimbursement letter. The provider is given 15 calendar days for review of the settlement determination. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is mailed to the provider. A provider may request up to an additional 30 days to review an Initial Settlement. The provider must submit a written request stating the reason and the amount of the additional time needed (up to 30 days) for review. RARSS will review the request and notify the provider in writing of the approval or denial for additional time.

If the settlement action requires correction following the review, a new notification and review time period will apply to the corrected settlement. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the recovery payment date(s) is mailed to the provider.

The RARSS may process a Revised Initial Settlement for the cost report period if it determines that additional payment adjustment is necessary after processing an original Initial Settlement and before completing a final settlement. A Revised Initial Settlement will be completed when there are significantly more approved claims, rate revisions or errors in the prior determination and a final settlement action cannot yet be completed. The notification and payment processing actions identified with the original Initial Settlement procedures also apply to the Revised Initial Settlement process. The payment criteria will be applicable to the aggregate dollar amount of the Initial and Revised Settlements for the reimbursement time period.

7.3 Final Settlement

The RARSS may determine that withholding of payment is necessary or that a retroactive adjustment to the nursing facility reimbursement rate and payments is needed after the end of the provider's rate year. A retroactive adjustment may be due to a previous interim rate revision or to implement a rate based on actual cost report data. After a cost report is audited, RARSS will determine if a Final Settlement adjustment is necessary to make a retroactive payment adjustment for the rate period covered by the cost report. The Final Settlement uses the audited cost report data to calculate the retroactive reimbursement and paid Medicaid claims and other payment data. Final Settlements determine if additional payment is due to the nursing facility or Medicaid.

When Medicaid participation is terminated voluntarily or involuntarily, payment for at least one month of services rendered is retained for Final Settlement.

RARSS mails a Notice of Program Reimbursement to the provider's designated address. The notice explains the:

- Settlement adjustment(s) and the process prior to RARSS taking the payment action.
- Provider's appeal rights.

The provider is allowed 15 calendar days for review of the settlement determination. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is mailed to the provider.

To obtain an extension, RARSS will review written requests from the provider stating the exceptional reason and the amount of additional time needed for the review (up to 30 calendar days). RARSS will review the exceptional circumstances stated in the request and notify the provider in writing of the approval or denial for additional time. If approved, an extended time period of up to an additional 30 calendar days may be granted to the provider for review. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the recovery payment date(s) is mailed to the provider.

If the settlement action is corrected following a review, a new notification and review time period will apply to the revised determination. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is mailed to the provider.

RARSS may process a Revised Final Settlement for the cost report period if RARSS determines that additional adjustments are necessary subsequent to processing the Final Settlement. The adjustment(s) will be processed if significant adjustments or errors exist in the prior settlement calculation. Notification and payment processes outlined in the Final Settlement process also apply to the Revised Final Settlement process.

7.4 Depreciation Recapture Reimbursement Adjustment

If a provider has been reimbursed for asset depreciation expense in the Plant Cost Component and has sold the nursing facility assets, the sold assets may be subject to a depreciation recapture reimbursement adjustment in the reimbursement settlement for the cost report period in which the nursing facility assets are sold. The depreciation reimbursement adjustment uses reimbursement rates paid for services between October 1, 1984 and the date the facility was sold, or the date the Plant Cost Component of the per diem rate was converted to the tenure plant cost reimbursement method. (Refer to the Rate Determination Section of this appendix for additional information.)

The depreciation recapture adjustment is only applicable to the reimbursement rate time periods the provider was paid a rate that specifically included depreciation expense in the Plant Cost Component of the Medicaid per diem rate. If the provider has never received Plant Cost Component reimbursement that specifically includes depreciation expense as a cost element of the rate calculations, the provider is not subject to the depreciation recapture reimbursement adjustment and is not required to complete the Medicaid Program Depreciation Recapture reporting.

A nursing facility provider that was reimbursed for depreciation in the Plant Cost Component and sells the nursing facility's assets must complete the Medicaid Program Depreciation Recapture reporting schedules for each applicable cost reporting year where depreciation was reimbursed. The Medicaid Program Depreciation Recapture schedule must be submitted with the cost report for the year that the asset sale occurs. Reporting schedules and instructions will be provided to the provider with the final period cost reporting request or may be requested from RARSS. The reporting schedules (Excel file) and completion instructions (Word file) are available in electronic format or hard copy format.

If the Medicaid Program Depreciation Recapture is not applicable, the schedules must indicate N/A (not applicable) and be submitted with the cost report filing. If RARSS does not receive completed reporting schedules, RARSS will apply a 100 percent depreciation expense reduction rate to calculations for each cost report period used to calculate the settlement.

The net depreciation reimbursement adjustment for each cost report year the provider was reimbursed by Medicaid will be included in the settlement calculation. The depreciation adjustment will be limited to the amount Medicaid reimbursed for depreciation expense in each cost report year. Plant cost reimbursement allowances will be included in the calculation of the depreciation adjustment, and may result in reducing the net depreciation adjustment if the provider had not previously qualified for the incentive allowances prior to the depreciation reduction. The cost report reimbursement settlement notice will include the determination of depreciation recapture reimbursement adjustment.

7.5 Medicaid Recovery of Overpayments

Overpayment(s) due from a participating provider will first be offset against other settlements, payment adjustments, claims processing or any amounts due to the provider through lump sum or sequential installments until the overpayment amount is satisfied. If the provider is not participating in Medicaid, the overpayment amount must be paid to the State of Michigan for the Medicaid program immediately upon notification.

7.5.A. Request for Settlement Extended Payment of Schedule

If a participating provider alleges inability to repay the total overpayment amount in a lump sum or in sequential offset(s), the provider may request consideration for an extended repayment schedule. Extension requests for Settlement repayments must be received by RARSS within 15 calendar days of the Notice of Program Reimbursement date sent to the provider from RARSS. RARSS will notify the provider in writing of the decision. Requests received after 15 calendar days will be considered at the discretion of RARSS.

7.5.B. Criteria for Determining Extended Payment Arrangements

Extended settlement repayment schedules will only be considered if the net dollar amount of the current settlement notice reflects an overpayment amount of more than 10 percent of the provider's normal monthly Medicaid reimbursement payment(s). The provider's request must demonstrate that lump-sum recovery will create extraordinary financial hardship on the provider, and that the cash flow need of the nursing facility prevents the immediate repayment of the overpayment amount. Other factors that must not be present in creating financial hardship to the provider are significant expenditures for unallowable costs, ownership and management compensation exceeding Medicaid allowable cost limits, or significant dollar amounts for unallowable related party business transactions.

RARSS will mail the notification of the provider's repayment schedule and the repayment recovery dates and dollar amounts to the designated address. Requests for longer than three months will only be considered under exceptional circumstances, e.g., the monthly recovery schedule amount would be greater than 50 percent of the provider's normal monthly Medicaid reimbursement payment.

SECTION 8 - ALLOWABLE AND NON-ALLOWABLE COSTS

Unless stated to the contrary in this section, Medicaid allowable costs for nursing facilities are determined in accordance with provisions in the federal Principles of Reimbursement established for the Medicare program. This section does not propose to set reimbursement standards or reimbursement methodology. The focus here is the determination of allowable costs. Reasonable costs associated with nursing facility services included in the provider's per diem rate, as identified in the Coverages portion of this chapter, are allowable costs within the parameters of the Principles.

NOTE: Definitions for the principal terms used in this section may be found in the Definitions Section of this appendix. A copy of the cost report referenced in this section, completion instructions for the report and related information are available on the Michigan Department of Community Health (MDCH) website. (Refer to the Directory Appendix for website information.)

8.1 ADVERTISING

Allowable advertising costs are considered those costs incurred by the nursing facility for an informational objective to inform the public about its services. Costs incurred for a promotional objective in an attempt to increase patient utilization are not properly related to patient care and are not allowable. Advertising in the Yellow Pages is an allowable cost, except that Medicaid limits the cost to that associated with a black ink Yellow Pages ad listing not to exceed 2" x 2" in size.

8.2 APPRAISALS

Appraisal expenses incurred by providers may be allowable costs (administrative and general) if the appraisal is of assets related to resident care and if it meets the Medicaid Appraisal Guidelines. Expense for an appraisal of assets not related to resident care is not an allowable expense. Refer to the Appraisal Guidelines Section of this appendix for additional information.

8.3 ATTORNEY AND LEGAL FEES

The provider must maintain documentation and evidence of expenses incurred for legal fees and related costs as being related to the nursing facility's furnishing of patient care in order for such expenses to be allowable costs. Attorney fees are considered allowable costs incurred in the course of providing patient care, except as noted below.

Where the Michigan Department of Community Health (MDCH) or the Centers for Medicare and Medicaid Services (CMS) takes action against the provider by initiating an enforcement action or issuing an audit finding, then the legal costs of responding to the action are allowable only in the following circumstances.

8.3.A. Audit Findings and Rate Actions

- The provider prevails and the action is reversed.
  Example: The audit finding is not upheld and the audit adjustment or rate action is reversed.
- The provider prevails as defined by reduction of the contested audit finding by 50 percent or more.
  Example: An audit finding for an adjustment of $50,000 is reduced to $25,000.

8.3.B. Enforcement Actions

- The provider prevails and the action is reversed.
  Example: A Denial of Payment for New Admissions is rescinded and does not go into effect, or when a provider is not in compliance before the effective date of the DPNA but succeeds in disputing the imposition and the DPNA is rescinded with no interruption in payment for the covered service.
- The time period of imposition of a DPNA is reduced by 50 percent due to a change in the date that a nursing facility is determined to have been in compliance.
  Example: The length of a DPNA is reduced from 20 days to 10 days.
- The provider prevails as defined by reduction of a fine by 50 percent or more.
  Example: A Civil Money Penalty fine is reduced from $5,000 to $2,500.
- A federal enforcement action (F tag) is reduced in scope or severity.
  Example: An H-level citation reduced to a G-level citation, an F (SQOC)-level citation reduced to an E-level citation, or an Informal Dispute Resolution decision results in a reduction from an E-level citation to a D-level citation. Abatement of an Immediate Jeopardy or correction of a deficiency does not constitute a reduction.
- A state enforcement action (M tag) is eliminated.
- A settlement agreement is reached between the provider and the state and federal government prior to a Hearing.

8.3.C. General Administration of the Facility

- Attorney fees incurred in connection with facility acquisition, mortgage or finance transactions are allowable if Medicaid determines the fees reasonable. The fees must be reported under plant cost and capital asset cost reporting. Legal expenses incurred relative to a nursing facility or capital asset acquisition are considered allowable if they are capitalized and amortized over the loan for up to a five-year period.
- Legal fees incurred in the process of securing financing or refinancing of facility loans must be amortized over the life of the mortgage.
- Attorney fees relating to employer activities, labor negotiation, or in response to employment related issues or allegations, to the extent that the engaged services or actions are not prohibited under federal principles of allowable cost.

8.4 Bad Debts, Charity and Courtesy Allowances

Bad debts, charity, and courtesy allowances, as defined in the Medicare Principles, are deductions from revenue and are not allowable costs.

Bad debts are amounts considered to be uncollectable from accounts and notes receivable that were created or acquired in providing services. Charity allowances are reductions in charges made by the nursing facility provider due to the indigence of a resident. Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the nursing facility, for services received by the provider.

Uncollected revenue for Medicare co-insurance and deductible billing amounts and patient payments for Medicaid eligible residents, and for non-covered services for Medicaid are not allowable costs.

8.5 Civil Money Penalties

Costs incurred for fines or money penalties for violation of federal, state, or local laws are not allowable.

8.6 Educational Activities and In-service Training

Medicaid has established credentials/requirements for educational activities to be recognized as allowable costs. Educational activities outside the continental United States are not allowable.

Approved educational activities are formally organized or planned programs of study engaged in by nursing facility providers in order to enhance the quality of resident care in a facility. These activities must be licensed where required by state law. Where licensing is not required, those presenting the educational activity must be recognized as a professional for the particular activity. Examples of allowable educational activities costs are:

- Part-time education for a facility's employee at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work to enhance the quality of medical care or the operating efficiency of the nursing facility.

- Costs, including associated travel expense within the continental United States, for employees to participate in educational seminars and workshops to enhance the quality of medical care or the operating efficiency of the nursing facility that does not lead to the ability to practice and begin employment in a nursing or allied health specialty.

The costs of the following in-service training activities are recognized as routine nursing care costs and are allowable costs:

- Orientation and on-the-job-training.
- Mandatory in-service education for Medicaid and Medicare certification.
- Maintenance of a medical library.
- Training of a resident or resident's family in the use of medical appliances.

Costs incurred for activities related to an approved Nurse Aide Training and Competency Evaluation Program (NATCEP) are not allowed under routine nursing care, except as provided in the Medicaid allowable cost and reimbursement policy outlined in the Cost Classifications and Cost Finding Section of this appendix.

8.7 Facility Vehicles and Travel

The cost of operating a facility-owned or leased vehicle must be adequately documented and differentiated between types resident care serviced, business use or personal use. Only the costs for resident care and costs related to the conducting of facility business are allowable vehicle and travel costs. Use of a facility vehicle by facility personnel to commute from home to the facility and to return home at the end of the daily work period or other personal travel activity is considered personal use. Cost related to personal use travel activity is not allowable. Vehicle personal use is only allowable if the

costs are reported employee compensation and satisfies Internal Revenue Service individual compensation tax reporting requirements.

The minimum documentation that must be retained and be available to auditors for all vehicles is:

- A Mileage log for each vehicle.
  - The log must contain at least the date, total miles for business use, name of driver, origination and destination, and the reason(s) for the vehicle use.
  - The log must report the monthly beginning and ending odometer reading.
- Business mileage and total mileage use of the vehicle to support the dollar allocation for determining allowable cost.
- Charge slips or invoices for fuel, maintenance, and other similar items.

If the reason for a trip is to transport a resident for medical care or treatment, the medical condition necessitating the trip must be documented. If the reason is to attend a seminar, convention, or meeting is related to nursing facility operation, invoices must document proof of attendance and mileage logs must be documented to identify the reason for the trip. Vehicle use for general business travel or other activity must include the reason in the mileage log.

Medicaid considers mileage that is not logged as not related to resident care or facility operation. The cost relating to unrecorded or non-supported as business use mileage is not allowable.

Travel by nursing facility personnel via personal vehicle use is an allowable expense if the travel is consistent with the aforementioned purpose criteria. Medicaid will allow such documented mileage at the State of Michigan, Department of Management and Budget (DMB), approved private vehicle rate. The mileage rate includes all vehicle costs and is treated as a variable support cost. The approved private vehicle mileage rate information can be accessed on the DMB website. (Refer to the Directory Appendix for website information.)

8.8 INTEREST

Interest is the cost incurred for the use of borrowed funds. Necessary and proper interest on both current and capital indebtedness is an allowable cost in accordance with Medicare Principles of Reimbursement. The allowance for interest expense is determined using one of the following principles.

- Allowable interest expense is determined in accordance with current Medicare Principles. Medicaid applies the following guidelines, although not fully inclusive, in determining allowable interest expense. Interest expense must be reduced by all investment income, except where such income is from:
  - Gifts, grants, and endowments held separately or pooled with other funds.
  - Qualifying deferred compensation and/or self-insurance trust funds.
  - Income from a provider's qualified pension fund.
- The rate of interest on a loan must not be in excess of what a prudent borrower would have had to pay in the market place at the time the loan was made.

- Interest expense, to be allowable, must be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization. Interest paid by the provider to partners, stockholders, or related organizations of the provider is, therefore, not allowable.

  Exception: A nursing facility operated by a religious order is allowed to borrow funds from the order and claim necessary interest expense for those funds.

- Interest on loans in excess of asset value acquisitions (after July 1970) is not an allowable cost. In a situation where the purchase price exceeds the historical cost or the cost basis, the interest expense on that portion of the loan used to finance the excess is not allowable.
- Interest expense applicable to borrowings principle balance for a nursing facility acquisition must be separately identified and reported from interest expense applicable to working capital or miscellaneous capital asset acquisitions (assets that are not part of or related to a facility acquisition). See Cost Finding and Cost Classifications for borrowing principle balance descriptions.
- Working capital borrowings are considered funds borrowed for a relatively short time period to meet current normal operating expenses. Interest on current indebtedness - loan amounts meeting program working capital criteria is allowable, whereas interest expense for long-term working capital indebtedness is not considered allowable. The nursing facility must document the reason(s) and need for the working capital loan. The use must be to meet normal operating expenses and must be supported by an application of funds analysis demonstrating the use of loan proceeds for nursing facility expenses. The loan must include/require repayment of the principle balance within a prescribed time period, including regular scheduled repayment amounts applying to the principle borrowings amount. The loan must meet allowable cost principles.
- Interest income is applied first as a reduction to mortgage related borrowing allowable interest expense, and then to other borrowings allowable interest expense.
- Interest expense is distinguished from penalty or finance late fees by the existence of a lender and borrower relationship pertaining to the financed amount. Penalty and finance fee assessments relating to late payment of liabilities are not considered borrowing costs and are not allowable.

8.8.A. Interest Class I and Class II Nursing Facilities

For the Class I and Class II facility, interest on borrowed funds related to the facility acquisition allowable interest expense is determined in accordance with the Principles in effect on July 17, 1984, prior to the changes associated with the mandates of the DEFRA of 1984 and its limitations on the revaluation of assets.

- The dollar amount of facility acquisition financing is limited to the lesser of:
  - the purchase price of the nursing facility,
  - the current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of purchase, or
  - fair market value at the time of purchase; minus the purchase down payment.
- Interest expense on the dollar amount of a facility acquisition loan principle in excess of the financing limit is not allowable.

- Depreciated replacement cost is defined as the current reproduction cost adjusted for straight-line depreciation over the life of the asset.
- Depreciated replacement cost must be determined by an independent appraiser, chosen and paid for by the nursing facility provider, in accordance with the "Appraisal Guidelines" in the Principles.

Note: For Class I and Class II facilities that choose to forego increased reimbursement for interest expense, they must adopt the prior owner's financing and acquisition costs, interest expense schedule of borrowings, principal amortization, and interest expense recognized for reimbursement by the Medicaid program prior to the sale. Annual cost reporting must continue to be based on the prior owners.

8.9 LEASE COSTS

The Medicaid allowable cost provisions for asset lease transactions depend on the type of asset. Generally, asset lease transactions require that the lease expense be removed from cost and replaced by the underlying ownership cost of the property owner. Lease or long-term rental agreement (more than twelve months duration) transactions must be reported in the Medicaid cost report Statement of Leased Capital Assets. Cost reporting disclosure of lease costs is required to properly classify ownership costs for determining Medicaid reimbursement. There are also specific asset lease transactions that must be reported in the cost report statement, but are exception to the underlying ownership disclosure requirement. Specific types of lease expenses are discussed in the following sections.

Maintenance costs for leased capital assets, other than lease situations qualifying under "pass-through lease" criteria, are classified as variable costs. The nursing facility must determine and report these costs in the appropriate cost center or department. This requirement may necessitate the breakout of the maintenance costs for the lease contract.

Lease costs are differentiated from incidental or non-recurring rental expenses incurred to address a limited need of the facility. Rental expense incurred for incidental or limited time rental items, or non-recurring rental transactions, are allowable operating costs in the applicable cost center or department requiring the rental action. Limited time rental is considered as not longer than twelve months, non-recurring, and prohibits several/numerous sequential transactions for the same or similar rental items.

Exception: An extended period up to 24 months may be approved by RARSS in instances related to construction or renovation. The provider must submit an extension request to RARSS in writing at least 45 calendar days prior to the effective date of the extension. The request requires disclosure of item, duration, and action that precipitated the need to extend the project. RARSS will respond in writing.

8.9.A. Facility Lease

Cost reporting and reimbursement for capital assets relating to the nursing facility premises are under the same methods whether the items are owned or leased. For items to be considered allowable costs, the acquisition dates and asset costs, interest expense and other applicable ownership costs must be reported. Allowable lease costs are determined using one of the following principles:

- A nursing facility provider that entered into an acceptable, arm's-length lease prior to September 1, 1973, where the lessor has refused to open its books, is allowed an actual

lease cost up to a maximum of $2.50 per resident day. This limit was developed from the average lease/rental costs for facilities leased prior to September 1, 1973, at which time the current method of calculation was effected. The pre-September 1, 1973, lessee has the right of appeal of an acceptable, arm's-length lease agreement for costs that exceed the $2.50 limit.

- A nursing facility provider that entered into, or amended, an acceptable, arm's-length lease agreement on or after September 1, 1973, is allowed a plant cost component determined in accordance with the Rate Determination section of this appendix, as applicable to an owner-provider, if the lessee discloses the allowable cost information required for rate setting. Leased assets are treated as though the lessor and the lessee are one and the same. Without full disclosure, lease expenses are not an allowable cost.

Interest expense allowed in the case of the lessor is also limited by Medicare Principles of Reimbursement. Further, interest income of the provider (lessee) is offset against all interest expense, including interest expense allowed on rental properties.

8.9.B. Plant Cost Lease Other Than Facility Space

Lease expense for nursing facility equipment or other activity that does not qualify for pass through lease expense is not allowable and must be reported utilizing the ownership underlying cost reporting requirement. If a lease is a virtual purchase and the lessee becomes the property owner at the termination of the lease, or for a nominal buyout amount, ownership cost reporting must be applied. The definition criteria of a virtual purchase are addressed in the federal Principles of Reimbursement.

Office space costs incurred in a home office or related party administrative service transaction are allowable under application of allowable depreciation, interest and property tax underlying ownership cost principles. Reasonable and necessary lease expenses incurred by a home office or related party for administrative services office space are allowable. Ownership underlying cost reporting is not required for leased business office space or similar leased space except in rental transactions involving a related party landlord. Related party transactions for office space are limited to ownership underlying costs applicable to allowable depreciation cost principles. The cost of office space is included in the cost of the home office or related party administrative services space cost and must be reported in accordance with Medicaid policy identified in the Cost Classification and Cost Finding Section of this appendix.

8.9.C. Plant Cost Pass Through Leases

A select group of rental and lease situations are exceptions to the requirement for disclosure of the underlying ownership costs. The lease or rental cost of qualifying items is allowed as plant cost in the lease rental cost classification to the extent that the asset use and cost is related to patient care. The pass through lease allowance applies to the following:

- Vehicle lease to a maximum of $425/month or $5,100/year, per vehicle
- Photocopiers
- Postage meters

- Telecommunications systems (including fax machines)
- Desktop or notebook computers and printers
- Parking lots and off-site record storage for rental from an unrelated party ownership and arm's length transaction

8.10 Life Insurance Premiums

Life insurance premiums are allowable when the premium is a fringe benefit for the insured employee when the beneficiary of the employee's insurance is not the provider. The cost of life insurance premiums for insurance on the lives of officers and employees, including provider-based physicians, is an allowable cost only within the provisions of Medicare Principles of Reimbursement.

8.11 Liquidation of Short-Term Liabilities

A short-term liability must be liquidated within one year after the end of the cost reporting period in which the liability is incurred. The liquidation of liabilities requirement for Medicaid applies the federal Principles of Reimbursement for the determination of allowable costs. In instances where a nursing facility provider does not liquidate a short-term liability within the period specified in the federal requirements, the costs for the related goods and services are not allowed in the cost reporting period in which the liability was incurred, but are allowable in the cost report period when the liability is paid.

Exception to the one-year time limit to liquidate a short-term liability will be considered in accordance with the federal Principles of Reimbursement. A provider may request an extension for good cause to liquidate short-term liability. The provider must submit a written request at the time of submission of the Medicaid cost report to RARSS identifying the liability amount(s) and an explanation for the nonpayment of the liabilities and expected payments to liquidate the liability. RARSS will review the request and notify the Provider of the approval of an extension, not to exceed three years after the end of the cost report period that the request is filed, or of the denial of the request.

8.12 Lobbying and Political Activity Costs

A provider's costs incurred to support or oppose decisions of the federal Congress or state Legislature, costs related to campaigns for particular candidates or issues, and contributions to political action committees involving partisan elections are not allowable. Costs incurred, whether directly or indirectly through organization membership dues, fees or assessments, for these activities or to influence legislation are not allowable. Contacts with federal or state agencies in the course of business operations of the nursing facility and general comment on proposed policies are not considered lobbying activity.

8.13 Maintenance of Effort Contributions by County Government

In accordance with Public Act 408 of 1984, as amended, county governments that own and operate a nursing facility are responsible for maintenance of effort funding levels for the operation of the county owned and operated nursing facility. The county government contributions to the nursing facility operations specifically due to the provisions of the Act, as amended, are not allowable costs of the county medical care facility Medicaid cost reporting.

8.14 Membership Fees

Reasonable costs of memberships in professional, technical, or business-related organizations are allowable if the organization's mission or objectives are primarily related to resident care and/or long term care services activities. Costs of memberships in civic organizations for the purpose of implementing civic objectives are also allowable for Medicaid purposes (e.g., Chamber of Commerce). Any portion of membership fees used for lobbying, supporting political candidates and campaigning, or in social, fraternal, and other such organizations are not allowable. Awareness of an organization's ongoing lobbying and political activities requires identification of the portion of the organization's fees, dues, assessments or other allocations of costs to members or associated nursing facility providers. If an amount of non-allowable cost is not identified relating to this purpose, all costs associated with the fees or dues are non-allowable, unless the provider can document the appropriate unallowable portion.

8.15 Medical Director/Physician Services

The nursing facility must have a designated medical director that maintains responsibility for the implementation of resident care policies, for coordinating medical care, and is directly accountable to nursing facility management. The cost(s) applicable to the provision of the duties and responsibilities of the medical director is allowable routine nursing care. The nursing facility must maintain adequate records to document the level and type of services rendered by the medical director as a facility employee, or under a service contract or some other designated capacity. The cost(s) relating to the medical director duties and responsibilities must be distinguished from physician services activities that are not allowable routine nursing care. Refer to the Practitioner Chapter for discussion regarding physician services.

8.16 Non-Paid Workers/Volunteers

The value of services of non-paid workers is an allowable cost. The services must be performed on a regular, scheduled basis. The services must be of the type customarily performed by full-time employees and necessary to enable the nursing facility provider to carry out the functions of normal resident care and the operation of the facility. The value of services of a type for which providers generally do not remunerate individuals performing such services is not an allowable cost.

Example: Donated services of individuals in distributing books and magazines to residents, administering a provider canteen or cafeteria or a provider gift shop are not allowable/reimbursable.

8.17 Owner and Administrator Compensation

The cost for compensation to nursing facility owners is determined in accordance with Medicare Principles of Reimbursement, except the compensation to administrators, owner/administrators, or owners who function as administrators or assistant administrators, and corporate office executive management compensation is subject to specific dollar amount cost limits. Allowable cost limits are applied to nursing facilities based upon the bed size of the facility. Allowable cost limits are applied to individuals based upon the aggregate number of beds in nursing facilities being served or within the corporate organization. Compensation is remuneration to the individual for job performance and includes the costs of salary and wages, fringe benefits, director fees, and costs of services or items provided to the individual.

The compensation limit schedule is available on the MDCH website. MDCH annually adjusts the Owner/Administrator Compensation Limits to include cost-of-living changes as reflected by the United States Department of Labor Consumer Price Index for the metropolitan Detroit area. (Refer to the Directory Appendix for the website address.)

8.17.A. Compensation Limit for Individual Nursing Facility

The allowable cost limit for compensation to nursing facility administrators, owner/administrators, or owners who function as administrators or assistant administrators is determined according to the following criteria.

- Facility bed size includes licensed beds for nursing home, home for the aged and hospital services beds. Other categories of resident beds or housing arrangement beds are not included in determining the facility bed size for determining the appropriate compensation limit.
- The owner/administrator compensation limit used must coincide with the number of beds available for occupancy. The measurement criteria for determining the facility bed size is the number of beds available for resident or patient care at the beginning of the cost reporting period.
- Each nursing facility having 50 licensed beds or more must have a full-time licensed facility administrator. As required under State law, this individual is expected to be in the facility directing, conducting, or participating in activities directly related to the nursing facility during the normal 40-hour business week. A current position description that adequately defines the duties and responsibilities for the administrator position must be retained at the facility.
- The total compensation amount claimed for allowable costs for the facility administrator and related positions must not exceed amounts established by the State Medicaid Agency. These amounts are established by facility bed size: 1-49 beds, 50-99 beds, 100-149 beds and 150 beds or more. Owner/Administrator Compensation Limits are expressed as facility annual compensation amounts and must be pro-rated on a monthly basis in situations where the cost reporting time period is not twelve months.

The owner/administrator compensation limits apply to the costs for the positions of administrator, assistant administrator, and/or other administrative employees performing functions or having work responsibilities normally considered nursing facility administrator work activity. If an individual is functioning in a position that requires a nursing facility administrator's license, that person's compensation must be subjected to the limit. However, if a person does not have a license, but is performing the job functions and work activity of an administrator, that individual's compensation must also be included in the amount subjected to the limit. Inclusion of an individual's compensation in the total amount subjected to the limit is not only based on the individual having a license, it is also based on the job functions and work activity. Compensation paid by a related party or central office and charged directly to the nursing facility for individuals performing these activities must be included in the individual nursing facility compensation amount subject to the limit.

The compensation limit schedule does not apply to the salary of owners employed in capacities other than administration of the nursing facility provider's operation. The allowable salary level of an owner employed in a non-administration position cannot exceed the market value salary for that position, e.g., director of nursing, social services director. The allowable salary level must be commensurate with the amount of time the owner spends working in the non-administration position. If the owner also participates in facility administration, the portion of the payroll costs attributed to the administrative work must be included in the owner/administrator salary compensation and subject to the appropriate salary limits. The individual's administrative work must be appropriately documented with a position description and job responsibilities, and the allowable salary level for the administrative work must not exceed salary levels for similar administrative positions.

8.17.B. Compensation Limit for Owner and/or Administrator Serving Multiple Nursing Facilities

Where an individual is involved in the administration of more than one nursing facility, the maximum compensation allowed for allocation per facility and the allowable facility compensation is computed as follows:

- Total the number of beds, as defined in the individual nursing facility section, in all facilities served by the owner and/or administrator.
- Determine the appropriate compensation limit from the published schedule for the total number of beds.
- Compare the appropriate compensation limit with the actual allowable total salary and fringe benefits paid to the individual. The compensation limit is expressed as an annual amount (12-month time period) and applicable to a full time position defined as a minimum of 40 hours per week committed to nursing home related management and administrative activity. Adequate work activity records must be available for verification of time expended for nursing facility related activity. Time commitment for less than full time requires the compensation limit be prorated to reflect the portion of time committed to this activity. Example, if 30 hours per week during an annual period is attributed to this activity, the adjusted limit for the individual is 75 percent of the appropriate compensation limit.
- The lesser of total allowable compensation or the compensation limit per the schedule is then allocated to all the facilities served by the owner and/or administrator based on a ratio of the number of beds in the individual facility to the total number of beds in all facilities served. The hours directly devoted to individual homes may be used as the allocation basis if verified by auditable records.
- Combine the allocated owner and/or administrator compensation with the allowable compensation of the facility's administrator/assistant administrator/co-administrator.
- Compare the combined compensation amount to the compensation limit schedule maximum allowable for the number of beds for that particular sized facility. The lesser of the facility's combined compensation or the facility's compensation limit is the allowable compensation to be used in the determination of allowable cost related to resident care.

The following illustrates an example of the allowable owner/administration compensation limit application for a group of four facilities of varying sizes with a total of 330 beds, and the allowable facility compensation. The owner and/or administrator total compensation is $225,000 for full time nursing facility related activity for a cost reporting period ending December 31, 2003. The compensation is $48,914 greater than the limit ($225,000 minus $176,086 equals $48,914).

Total number of beds in all facilities served	330
Compensation Cost Limit for 150+ bed facility as of 12/31/2003	$176,086
Owner and/or Administrator Total Compensation	$225,000
Amount allowed for allocation to individual facilities (lesser of bed size limit or actual compensation)	$176,086
Amount of compensation not allowed	$48,914

Nursing Facility Bed Sizes	1-49 Beds	50-99 Beds	100-149 Beds	150+ Beds
Facility Compensation Limit 12/31/2003	$58,696	$97,826	$117,393	$176,086
Example Facilities	Facility 1	Facility 2	Facility 3	Facility 4
Total Facility Beds	40	70	100	120
Allocation of Owner and/or Administrator Compensation[1]	$17,609	$30,815	$44,021	$83,641
Compensation of Facility Administrator	$35,000	$75,000	$85,000	$100,000
Facility Total Compensation to be compared to Limit[2]	$52,609	$105,815	$129,021	$183,641
Disallowed Compensation per Facility	$0	$7,989	$11,628	$7,555

[1] The percentage of the facility's beds of the total across all four facilities is multiplied by the compensation limit, e.g., 40/330 x $176,086.

[2] Total compensation equals the sum of the allocation amount and the individual nursing facility administrator compensation.

8.17.C. Compensation Limitation for Home Office Executive/Management

Salary and wages, fringe benefits and other related compensation costs for home office executive and management staff are included in the provider's home office cost report, and costs are allocated to the individual nursing homes and other business activities conducted by the organization. The allocation of the compensation costs is made to the operating entities of the corporation through the home office cost statement, and these

costs are not included in the limit imposed on the individual nursing facility owner/administrator compensation.

The compensation limit for high-level management employees at the corporate home office level is enhanced to acknowledge increased scope of the business activity and corporate responsibility. The enhanced compensation limit is applicable in chain organization or related party management services situations where home office cost statement reporting exists, and full management oversight and administrative services are being provided to the nursing facilities and other business activities of the organization. Compensation costs for corporate office individuals under the enhanced compensation limit must be documented by a current position description, employment contract or other verifiable documentation that adequately defines the position, duties and responsibilities for the individual, and demonstrates the presence of services provided to the organization. Compensation to an individual employee of the corporate or central office, regardless of employment position or job activity function, is subject to the enhanced compensation limit to determine allowable cost. The enhanced compensation limit is expressed as an annual amount (12 month time period) and is applicable to a full time position.

Employees paid by the corporate or central office but charged directly to the individual nursing facility for administrator or assistant administrator work functions at that facility are not eligible for the enhanced compensation limit. Allowable cost limits for such employees are addressed under individual nursing facility compensation limit.

The enhanced Medicaid allowable compensation for individual corporate office official and executive management employee personnel is applicable only to organizations greater than 150 beds. The enhanced compensation limit is based on the total number of beds owned and operated by and under full management control of the corporate organization and determined in accordance with the following schedule:

Number of Beds in the Chain Organization	Enhanced Compensation Limit
151 to 500 beds	100% of the 150+ bed facility limit
501 to 1,000 beds	120% of the 150+ bed facility limit
1,001 to 2,000 beds	130% of the 150+ bed facility limit
Over 2,000 beds	150% of the 150+ bed facility limit

The total number of beds includes all types of nursing home, home for the aged, hospital services, resident and other housing arrangement beds. If the business activity for the beds is not included in the allocation of the home office costs, the beds must not be counted for determining the number of beds in the chain organization. The 150+ bed

facility limit used to determine the enhanced compensation limit amount is the MDCH published limit for the year end corresponding to the reporting time period end date of the home office cost statement.

8.18 Oxygen

Medicaid coverage of oxygen services for residents in nursing facilities is addressed in the Medicaid Services Descriptions Section of the Coverages portion of this chapter. The costs of oxygen gas, equipment, and supplies for intermittent and infrequent use are allowable in the routine nursing care cost and are included in the per diem reimbursement rate. Oxygen equipment rental costs for a limited time period for purposes of providing this service are allowable in accordance with the incidental rental cost provisions addressed in the Lease Cost subsection of this appendix.

The costs of oxygen related services for frequent or prolonged use by individual nursing facility residents, regardless of payer source, is an ancillary services cost and is not an allowable routine nursing care cost. These costs must be separately identified in the facility's accounting records or adequately compiled and verifiable for audit, and excluded from Medicaid cost report routine nursing care unit cost.

8.19 Patient Transportation

The Transportation Section of the Coverages portion of this chapter addresses the nursing facility's responsibility to arrange or provide for non-emergency patient transportation. The cost for this transportation is a routine nursing care cost included in the nursing facility's annual cost report, and any reimbursement for the services is included in the routine nursing care per diem rate. Patient transportation costs are classified as support costs for Medicaid cost reporting.

The nursing facility is encouraged to utilize an efficient and cost effective mode of transportation for resident care which may include utilizing a facility owned vehicle or contracted outside service. Costs relating to the nursing facility vehicle operation are addressed under the Facility Vehicles and Capital Asset Cost subsections of this appendix.

Costs incurred for contracted outside service for patient transportation must be included in the Medicaid cost reporting under the following reporting procedures:

- Administration and General Transportation – when the expense is not directly identified for specific residents or the care unit in which the resident resides in the facility; or
- Routine Nursing Care, Miscellaneous Support Cost
  - when there is only one routine nursing care unit in the facility and all resident transportation is for residents in that unit, or
  - when there are multiple nursing or residential care units in the facility, and the expense is directly identified by individual resident and location unit where the individual resides in the facility. Costs must be allocated to the corresponding nursing unit cost center identified in the Medicaid cost report.

8.20 Personal Comfort Items

The costs of services and items that do not contribute primarily to the resident's treatment of an illness or the resident's ability to function are not allowable. Direct costs, and the appropriate share of indirect costs, relating to such items as telephones, televisions and/or radios that are located in the patient's accommodations and furnished solely for the personal comfort of the resident are not allowable. The cost of television and radio services furnished to residents generally is allowable if furnished in common use areas of the facility such as day rooms, recreation rooms or similar purpose area of the facility for the common benefit of facility residents. The cost of nurse-patient communications system that has no capability other than nurse and patient communication is allowable.

The costs of systems, including nurse-patient communications, television and telephone services, and similar items, may have the capability of providing residents with outside entertainment and providing nurse-patient communications. Only the cost of the component for nurse-patient communication is allowable routine nursing care. Direct distinction of cost related to the nurse-patient communication must be made for proper cost reporting, or an appropriate allocation must be established for Medicaid approval for the purpose of identifying the patient related and personal comfort related cost portions of combined systems.

8.21 Private Duty Nurses

Costs for nursing staff services provided by or under the supervision of a registered professional nurse are allowable, however, the costs of services of a private-duty nurse or other private-duty attendant are not allowable routine nursing care. Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient under arrangement between the patient and the private-duty nurse or attendant.

A patient, or someone acting on their behalf, may arrange and pay for a private-duty nurse, or the nursing facility that initially incurs the requested costs may look to the patient for payment of the non-covered nursing facility service. Where the nursing facility acts on behalf of the resident, the services of the private-duty nurse or other attendant(s) under this arrangement are not allowable routine nursing care services regardless of the payment process to the private duty or other personnel or the control which the nursing facility may exercise with respect to the services rendered by the private-duty nurse or attendant.

8.22 Provider Donations for Outstationed State Staff

Provider donations and administrative costs and incidental costs (workspace and telephone), incurred by the provider for outstationed staff are allowable costs. Costs are allowable to the amount contractually determined with the State.

8.23 Purchase Discounts

All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

Purchase discounts have been classified as cash, trade, or quantity. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required.

As with discounts, allowances and rebates received from purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. In addition, late charges on purchases are not an allowable expense. These would be in addition to regular costs authorized.

8.24 Rebates Larger Than One Year's Expense and Extraordinary Expense

Normal refund or rebate amounts are reported as a reduction offset to current operating costs in accordance with federal Principles of Reimbursement. A refund or rebate amount of previous years' allowable expenses must not be reported in total in the current fiscal year-end cost report where the refund or rebate amount pertains to more than one prior year reported expense. Likewise, extraordinary expense pertaining to more than one prior year must not be reported in total in the current fiscal year-end cost report. Refund or rebate and the extraordinary expense amounts pertaining to more than one prior year must be equally spread over as many subsequent years as the number of years represented by the refund or rebate or the extraordinary expense amount not to exceed three years. In the instance of a sale, the selling provider must include 100 percent of the remaining rebate balance in the final cost report. The apportionment will start in the cost-reporting year in which the refund amount is received or the extraordinary expense is discovered. These provisions are limited to Medicaid cost reporting requirements and do not change the applicable accounting principles for financial reporting.

8.25 Research Activities

The cost of research activities is allowable in accordance with Medicare Principles. If research is conducted in conjunction with, and as a part of, the care of residents, the costs of usual resident care are allowable to the extent that such costs are not met by funds provided for the research.

8.26 Routine Nursing Services

A provider's costs associated with the provision of necessary medical, nursing and mental health services, within the provisions of Medicare Principles of Reimbursement and requirements specified in the Coverages portion of this chapter, are allowable expenses. This includes costs incurred for meeting state federal requirements associated with specialized mental health rehabilitation services, e.g., monitoring the necessity for Annual Resident Reviews and coordinating or providing required services. The medical supply costs associated with routine nursing services and reimbursed by Medicare Part B are not allowable routine costs for Medicaid if the provider is reimbursed by Medicare.

8.27 Sick Leave

The reasonable cost of sick leave taken (or payment in lieu of sick leave taken) by an employee is recognized as a fringe benefit and is included in allowable costs in the cost reporting period when paid. If the sick leave is vested and refunded, contributions to the fund are allowed under applicable provisions of the Medicare Principles. However, where the nursing facility provider's sick pay plan grants employees

the right to demand cash payment for unused sick leave at the end of each year, the pertinent accruals are includable, without funding, in the cost reporting period when earned.

8.28 Taxes and Fees

Taxes, including employee payroll taxes, sales taxes, and state imposed sales and use taxes, are allowable variable costs. The Michigan Single Business Tax is an allowable variable support cost.

8.28.A. General Taxes

Real and personal property taxes are allowable plant costs.

8.28.B. Quality Assurance Assessment Tax

A nursing facility's Quality Assurance Assessment Tax is an allowable cost and must be reported in the nursing facility Medicaid annual cost report. The tax must be reported on the provider's cost report as assessed and accounted for on the accrual basis. The Quality Assurance Assessment Tax cost is adjusted through the cost reporting process to be segregated from use in rate setting.

8.28.C. Fees and Assessments

Costs incurred for late payments, or for violation of federal, state, or local laws, are not allowable.

8.29 Therapy and Pathology Services

A nursing facility provider must establish accounting procedures to reflect individual cost centers for reimbursable ancillary services, including physical therapy, occupational therapy, speech pathology and other services not classified as routine nursing care. Whether the therapist/pathologist is salaried, under contract, or an independent provider, a nursing facility provider must record Medicaid program payments as income and all expenditures for therapist/pathologist supportive personnel, equipment and its maintenance, supplies, and other costs directly attributable to rendering services in these cost centers.

The service is considered ancillary if the complexity of the service prescribed for the resident is such that it can be performed safely and/or effectively only under the general supervision of skilled rehabilitation personnel. Ancillary therapy services are evidenced by the presence of the following conditions:

- A written physician order.
- The skills of a qualified technical or professional health personnel, such as physical therapists, occupational therapists, speech pathologists or audiologists, are required.
- Services are provided directly by, or under the general supervision of, the skilled personnel to assure the safety of the patient and to achieve medically desired results. General supervision requires that initial direction and periodic inspection of the actual activity is necessary.
- Services are rendered as part of an active treatment for a specific condition that has resulted in a loss or restriction of mobility or function.

Therapy services considered routine nursing care are services rendered under circumstances where the general supervision of exercises, which have been taught to the patient, can be performed repetitiously without skilled rehabilitation personnel. This includes maintenance programs where the performances of repetitive exercises, which may be required to maintain functions, do not require the involvement and services of skilled rehabilitation personnel, but may require the assistance of a trained nurse aide. Routine nursing care may include repetitive exercises to improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.

The cost of the development of the maintenance plan when prepared by a licensed therapist is allowable. A provider must maintain documentation, which includes the amount of time required by the therapist to develop the maintenance plan. Medicaid considers maintenance plan development as routine nursing care included in the per diem rate.

The cost of the MDS assessment is allowable. A provider must maintain documentation, which includes the amount of time required by the therapist to complete the MDS assessment. Medicaid considers the MDS assessment as routine nursing care included in the per diem rate.

Depreciation for equipment and facility space assigned to these services must be included as an expense in the ancillary cost centers and computed in accordance with Medicaid guidelines for allowable depreciation. A uniform charge structure must be applied to the entire facility population receiving the services.

SECTION 9 - COST CLASSIFICATIONS AND COST FINDING

Medicaid-enrolled providers must develop and adopt a uniform Chart of Accounts that meets the minimum requirements established by Medicaid for classifying and reporting costs incurred in providing care to nursing facility residents. A nursing facility's accounting system will normally include more detailed accounts for recording facility costs. However, for cost reporting purposes, the detailed accounts are compiled into aggregate cost classification centers in accordance with program policies.

The following cost descriptions are guidelines to provide consistency in nursing facility provider cost reporting. Reimbursement classifications are identified for individual cost elements in examples available on the MDCH website. (Refer to the Directory Appendix for website information.) More detailed discussions of cost categories are in the Allowable and Non-Allowable Costs section of this appendix.

9.1 NURSING FACILITY BED DAYS AND RESIDENT OCCUPANCY

A provider must report nursing facility bed days and resident occupancy statistics in the annual cost report. Policy related to facility census is presented in the Definitions section of this appendix. Specific attention should be directed to the following definitions: available bed, available bed days, ban on admissions, census, census day, denial of payment for new admissions, hold a bed day, leave day – hospital, leave day – therapeutic, occupancy, occupancy rate, per resident day cost, resident, resident days/occupancy, therapeutic leave day.

The nursing facility's resident occupancy statistics and cost reporting requirements will be significantly affected in cases where the provider requests, and is granted, approval for designating non-available beds as outlined in the Non-Available Beds subsection of this appendix.

9.2 VARIABLE COSTS – BASE AND SUPPORT

Variable costs include the total allowable base and support costs in a facility's routine nursing service units. A provider must allocate variable costs (support or base) depending on the activity for which the cost was incurred. The provider must also report direct costs for ancillary service costs and other non-reimbursable service costs. The direct costs incurred or attributed to these activities will not specifically be identified as base or support costs, however, the cost report cost finding process will allocate general services cost activities as base or support costs depending on the activity for which the cost was incurred.

9.2.A. Base Costs

Base costs cover activities associated with direct patient care. Major activities under these categories are payroll and payroll-related costs for departments of nursing, nursing administration, dietary, laundry, diversional therapy and social services, food, linen (excluding mattress and mattress support unit), workers compensation, utility costs, consultant costs from related party organizations for services relating to base cost activity, nursing pool agency contract service for direct patient care nursing staff, and medical and nursing supply costs included in the base cost departments.

9.2.B. Support Costs

Support costs cover allowable activities not associated with direct patient care. Major items under these categories are payroll and payroll-related costs for the departments of housekeeping, maintenance of plant operations, medical records, medical director, and administration, administrative costs, all consultant costs not specifically identified as base, all equipment maintenance and repair costs, purchased services, and contract labor not specified as base costs. Contract services costs for these departments are also support costs.

9.2.C. Base/Support Costs – Payroll Related

Nursing facility expenses related to payroll taxes and employee health and welfare are classified as base/support costs. These costs include fringe benefits such as employer contributions to FICA, FUTA, MESC, employee life and health insurance, retirement, physicals and all other insurance provided to employees as fringe benefits. If a nursing facility's accounting records do not separately reflect the payroll taxes and employee health and welfare expenses for "base" and "support" personnel by cost center identification, the total amount of these costs must be reported in the appropriate "base/support" cost category. Workers compensation is a base cost and not divided between base and support.

If the nursing facility's accounting system allows the allocation of costs to specific personnel or activities, the specified costs must be used on the cost report. If the nursing facility accounting system does not allow for this specificity, then a reclassification of costs must be made to the appropriate service areas. In these cases, it will be necessary to reclassify such costs on the basis of salary and wage costs distribution.

9.2.D. Base/Support Costs – Contract Services for Direct Patient Care

A provider that purchases direct care services as an alternative to employing personnel may apportion the contract services costs between base and support cost by applying the industry-wide average base-to-variable cost ratio. The nursing facility must appropriately report these costs in the annual cost report. Medicaid reviews the industry-wide average base-to variable cost ratio annually and revises it if a difference of 2 percent or greater exists between the current calendar year cost report aggregate average industry data and the previously promulgated industry-wide base-to-variable cost ratio. If a revision is applicable, the revised cost ratio will be effective for subsequent year cost reporting.

9.3 Plant Costs

Plant costs include depreciation, interest expense (either working capital or capital indebtedness), real estate and personal property taxes, amortization costs associated with loan financing costs (amortization of legal fees, recording fees or other fees relating to the capital asset acquisition points, letters of credit), and specific lease expenses.

9.4 CAPITAL ASSET EXPENDITURE

Medicaid limitations on capital expenditure costs are determined in accordance with Medicare Principles except as modified by Medicaid policy.

A nursing facility provider anticipating capital expenditures should contact the CON Health Facilities Evaluation Section to make application for a CON. (Refer to the Directory Appendix for contact information.)

If a CON is approved, the provider may be eligible for increased reimbursement, subject to Plant Cost Component limits. If a new capital expenditure required CON review and was denied, the provider's reimbursement rate must exclude the costs of the denied capital expenditure. The provider's cost report must identify capital expenditures approved and denied by CON.

The nursing facility must have written policies and procedures that establish dollar level thresholds beyond which an asset acquisition is considered a capital asset. Medicaid sets the thresholds at having an estimated useful life of at least two years and a historical cost of at least $5,000. The nursing facility capital asset policy may have lower dollar level threshold than the Medicaid limit, but may not have a higher limit. The provider must follow its established policy for cost reporting when its capitalization policy sets lower thresholds than Medicaid.

Assets that are acquired as part of an integrated system must be considered as a single asset for capitalization purposes. Assets that have a stand-alone functional capability may be considered on a single item basis. Individual asset items that do not meet the dollar and useful life threshold are classified as minor equipment and will be reported as minor equipment expense in the cost report of the year of acquisition.

Example: An office workspace with connecting portions dependent upon other portions for support and stability; a communication system installed in the facility and in resident rooms to allow the full functioning of two-way communication system.

Repair and improvement costs related to assets that result in extending useful life or increased productivity must be capitalized for Medicaid if they are capitalized under Generally Accepted Accounting Principles. Providers must demonstrate consistency in financial reporting.

Providers must follow Generally Accepted Accounting Principles (GAAP) in reporting repairs to capital assets. Repairs that should be capitalized under GAAP must not be an expense item on the cost report.

9.4.A. Capital Asset Cost Data for Class I Facilities

9.4.A.1. CAPITALIZED ASSET ACQUISITION COSTS

Capitalized asset acquisition costs are used to determine the Current Asset Value for the Plant Cost Component in the Class I nursing facility reimbursement rate. The Medicare Principles of Reimbursement are used to determine the acquisition costs allowable to the original provider/owner of the asset. The SMA uses only the acquisition cost incurred by the original owner to determine the capital asset value cost data. Asset acquisition costs are allowed for related party transactions in accordance with Medicare's interpretation for costs to related organizations.

The cost basis for capital assets is the CAV value determination of the original owner's audited historical acquisition cost. It is the responsibility of the current owner to provide the audited historical cost and purchase year of the original owner; otherwise, the assets are assumed obsolete for payment determination purposes, i.e., of no current asset value. The current provider must annually report the cost and the applicable year's depreciation for newly purchased assets and value changes to previously acquired assets. Cost reporting for asset acquisition costs related to a capital asset that is traded-in for a new replacement item must also report the value of the capital assets.

Capital costs related to assets that are no longer used in the facility operation and assets that are not necessary for resident care, e.g., excessive land not allowed under the Principles, are not allowable in the nursing facility capital asset value cost data.

To ensure that Medicaid does not pay for assets that are no longer being used to provide resident care, the original acquisition costs, or an estimate thereof, are removed from the current capital asset cost data. The costs of retirement or replacement of buildings, building improvements, building additions, fixed building equipment, land improvements, or movable equipment are removed from the capital asset cost data for the corresponding year of the original acquisition of that retired or replaced asset.

When the original value can be ascertained through such methods as component part depreciation records, the provider must remove the original costs of the retired or replaced assets from the year of the original acquisition, and report the new asset item cost for the year purchased.

Building components, building services equipment or other fixed equipment assets or land improvements may have historically been included within the asset price of the building to which they are attached and, as a result, are not separable for purposes of calculating depreciation or the capital asset cost data. However, in the determination of the Current Asset Value, an asset must exist in the nursing facility for it to have a value. Therefore, if a fixed asset has been retired or replaced and the asset cost cannot be determined from the provider's Medicaid/Medicare asset cost schedule, construction records, or tax records, the provider must determine and report the original asset cost based on the cost of a similar asset.

If a nursing facility provider is unable to report the original asset cost by either individual asset cost or component basis, the new asset will be assumed as a replacement of a similar asset for determining the necessary revisions to the capital asset cost data using the asset trade-in provisions.

When a capital asset is traded-in for a new replacement item, either the original owner's cost or a derived value of the item traded in is removed from the capital asset cost data. The purchase price of the new asset, prior to consideration of the value of any trade-in, is added into the capital asset cost data for the current year of purchase. If the original cost of the item is unknown, the provider must derive a value by backdating the purchase price amount for the new replacement asset. If the asset being replaced is of a different quality or type than the new asset, the amount to be backdated may be based on the expected current cost of a similar asset of like quality and type. The derived value calculation is made by applying the annual Marshall Valuation Services Book of Comparative Cost Multipliers (exclusive of the annual obsolescence adjustment) to the

value of the new asset item cost, then subtracting the derived value from the previous capital asset cost data historical cost for that original acquisition year. An electronic copy of the annual economic index compilation and reference to Marshall Valuation data, and the derived application process used for nursing facility cost reporting can be accessed on the MDCH website. (Refer to the Directory Appendix for website information.)

Capital assets that are leased or rented are treated as obsolete assets for rate determination purposes when the underlying historical acquisition cost to the original owner has not been disclosed, or when the underlying information cannot be verified through audit.

Capital assets recorded in the central office, home office, or related organization financial records that are identifiable to a specific nursing facility are included in that facility's capital asset cost data determination process. The asset values, interest, and property taxes identified with these assets must be charged directly to the nursing facility and will be reimbursed in accordance with the applicable policy.

Costs of capital assets associated with the operation of related organizations are not included in the capital asset cost data determination for a specific nursing facility. The plant and variable costs of such organizations are treated as purchased services. (Refer to the Variable Costs – Base and Support subsections for discussion regarding purchase and contract services.)

9.4.A.2. EXCEPTIONS TO ASSET ACQUISITION COST CAPITALIZATION

Exceptions to the acquisition cost basis for assets may be allowed in the following situations:

- For the occasional purchase of used, movable equipment for ongoing nursing facility operations when the purchase is not related to a change in facility ownership. For the purchase of used replacement equipment, e.g., re-manufactured beds, a used lawn tractor, or used vehicles, the asset acquisition is treated as if new items were purchased. The allowable cost of acquisition is included in the year the asset is put into service by the current purchaser.
- For the nursing facility land value. The land value to be included in the Current Asset Value is based on the current owner's allowable acquisition cost determined in accordance with Medicare Principles, and not to exceed the amount reported to the Internal Revenue Service for federal tax purposes. The cost of the prior owner's land improvement asset, which is an integral part of the nursing facility land component, and is included in the new or current owner's land acquisition cost, must be excluded from the historical capital asset cost data. The current facility ownership capital asset cost data cannot include both the land purchase price and the original owner's land improvement cost data.
- When equipment is purchased as "used" equipment as part of a facility change of ownership, or only a change of ownership of the facility equipment has occurred, the prior owner's (seller) computation of value at the time of sale is continued to the new owner.

9.4.B. Capital Asset Categories (Fixed Assets)

Capital asset classifications and asset useful life for depreciation purposes are determined in accordance with the American Hospital Association (AHA) guidelines in effect at the time of the asset acquisition.

General descriptions of the asset cost categories for cost reporting are:

Land – includes the land owned and used in the provider operations and includes off-site sewer and water lines, public utility costs necessary to service the land, government assessments for street paving and sewers, cost of permanent roadways and grading of a non-depreciable nature, cost of curbs and sidewalks where the replacement is not the responsibility of the nursing facility, and other land expenditure of a non-depreciable nature.

Land Improvement – improvements of a depreciable nature including paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. where replacement is the responsibility of the nursing facility.

Building – includes the basic building structure, shell or frame, and additions thereto, building components, exterior walls, interior framing, walls, floors and ceiling, architectural, consulting, and interest expense associated with new construction or acquisition.

Building Improvement – includes building equipment attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating and air conditioning systems, etc. The general characteristics of fixed equipment are: (a) attached or installed to the building structure, and (b) fairly long life but may be less than the building.

Leasehold Improvement – includes betterments and additions made by the lessee to the leased property, whereby the improvements become the property of the lessor after expiration of the lease. These items generally meet the requirements of building improvement assets.

Department Equipment – includes assets generally assigned to a specific department within the nursing facility with relatively fixed location but capable of being moved; as distinguished from building equipment. (Refer to Building Improvement.)

Furniture and Fixtures – includes assets similar in characteristic to department equipment, however, normally with no fixed location or used by various departments within the facility.

Transportation Equipment – includes vehicles used in conducting nursing facility operations relative to resident transportation, plant operations and maintenance, or general means of transport.

Capital asset costs incurred by a landlord who is leasing facility assets to a provider must be disclosed and reported in the provider's annual cost report. Capital asset cost reporting and allowable cost policies are applicable to the reporting of the leased assets in the same manner as if the assets were owned by the provider.

9.4.C. Depreciation

Class I and Class II nursing facilities are under the tenure plant cost reimbursement methodology, and potential reimbursement is not based on depreciation expense for the nursing facility capital assets. The costs of services provided from home office or related party transactions, other than for capital assets related to the nursing facility physical plant, may include depreciation expense for asset costs applicable to the operations of the home office or related party business. Allowable depreciation costs for the home office or related party will be determined in accordance with Medicare Principles. These costs will be included in the home office or related party administrative services space costs and must be reported in accordance with Medicaid policy identified in the Related or Chain Organization Cost Allocations subsection of this appendix. Class III and Class IV nursing facilities reimbursed under the depreciation plant cost reimbursement methodology will have depreciation costs determined in accordance with allowable cost principles defined in this policy. The allowance for depreciation is determined in accordance with Medicare Principles except that only the straight-line method of depreciation may be used. The historical asset cost basis and the depreciation basis for nursing facility sales is subject to the limitation on the valuation of assets mandated by the Medicare Principles.

In addition to the depreciation standards in the Medicare Principles, Medicaid also requires adherence to the following standards:

- Consistent use of either component or composite asset depreciation schedules. Component depreciation is permitted in the case of a newly constructed facility and for recognized building improvements where the costs can be separated and acceptable useful lives determined. Composite depreciation must be used in the case of a newly purchased, existing facility.
- All abandonment losses are considered as a depreciation expense item.

9.4.D. Disposal of Depreciable Assets

9.4.D.1. Class I Nursing Facilities

Class I nursing facilities will account for asset acquisition and disposal in accordance with the Capital Asset Cost Data for Class I Facilities subsection of this appendix.

A Class I nursing facility purchased on or after March 31, 1985 is not subject to depreciation adjustment. In the event of a sale, the assets of Class I facilities whose ownership began prior to March 31, 1985, amounts included in the Medicaid per diem rate as an explicit depreciation expense item are subject to recapture in the event of a gain on the disposal of assets. The selling Provider must complete Medicaid Program Depreciation Recapture reporting schedules along with the applicable fiscal year cost report. Refer to the Cost Report Reimbursement Settlement, Depreciation Recapture Reimbursement Adjustment subsection of this appendix for additional information.

9.4.D.2. CLASS III NURSING FACILITIES

Class III providers whose Medicaid rate includes depreciation expense must adhere to the Medicare Principles of Reimbursement to account for the disposal of depreciable assets. If the disposal of depreciable assets in the reporting year results in a gain or aggregate loss below $5,000, the adjustment will be made in the nursing facility provider's current year cost reporting allowable cost. The allowable gain is limited to the amount of depreciation previously included in the provider's allowable costs for the disposed assets.

In the event of a sale of the entire nursing facility and the termination of Provider participation in the Medicaid program, the terminating Provider must complete Medicaid Program Depreciation Recapture reporting schedules along with the applicable fiscal period cost report. Refer to the Cost Report Reimbursement Settlement, Depreciation Recapture Reimbursement Adjustment section of this appendix for additional information.

9.5 LOANS/BORROWINGS BALANCE REPORTING

Necessary and proper interest on current and capital debt is a Medicaid allowable cost. All interest expense, whether on current or long term debt, is classified as a plant cost. Determination of allowable interest expense will be in accordance with Medicare allowable cost principles. However, there are reimbursement limits for determining the Plant Cost Component specific to Medicaid which are addressed in the Rate Determination section of this appendix.

Medicaid requires nursing facilities to report the loans and borrowings balance in the annual cost report. The cost report instructions identify the schedules that must be used to report borrowing principle balances. The nursing facility must report the beginning balance and monthly end balance of outstanding allowable loans and borrowings for the time period corresponding to the cost report year. The loans and borrowings in the borrowing balance report must only include the outstanding loans or other liability obligations for which the nursing facility is claiming interest expense related to that borrowing principle. If the nursing facility is filing a cost report claim for interest expense as an allowable cost, the nursing facility must document the corresponding borrowing obligation related to the interest expense. The outstanding borrowing balance is defined as the allowable borrowing principle amount on which the interest rate, normally expressed as an "interest rate percentage", is applied for the purpose of calculating the interest expense applicable to the specific cost report time period.

Loans from related parties or unallowable borrowings must be excluded from the cost report borrowing balance schedule. The interest incurred on excluded borrowings must be removed from incurred interest costs in a like manner. Interest income or investment income which is required to be offset to interest expense in the cost report period must not be considered a reduction in the outstanding borrowing balance principle.

Mortgage principle balances or similar finance arrangements for the purpose of nursing facility or business acquisition must be separately identified from other loan balances in the cost report borrowing balance schedule. Examples of other loan balances include working capital and miscellaneous asset acquisition purpose loans. In the event of refinancing and co-mingling of separate loan balances into a single finance arrangement, the nursing facility must identify the appropriate portions of the combined financed amount used for different purposes, and maintain the separation for cost reporting. Likewise, multiple loans for the same purpose must be combined for the appropriate category for cost reporting.

Borrowing principle obligations incurred by a home office must be reported on the individual nursing facility cost report borrowing balance worksheet only for loans directly associated with financing the individual nursing facility asset purchases or facility acquisition costs. The interest expense applicable to such loans must also be identified, directly charged to the individual nursing facility, and reported as interest expense for the nursing facility. Working capital and other loans incurred directly under the home office operation and not related to nursing facility acquisition are considered general administrative costs and are included, to the extent determined necessary and reasonable, in the home office cost allocation to the individual nursing facilities and other business operations of the corporate chain.

Allowable outstanding loan balances of landlord entities that are leasing nursing home facility assets to a provider must be disclosed and reported in the provider's annual cost report. Borrowings balance cost reporting and allowable cost policies are applicable to the reporting of the underlying cost of the landlord entity in the same manner had the borrowings been recorded on the financial records of the provider.

9.6 Cost Finding

Cost finding is the process of recasting the data from the accounts kept by a provider to determine the cost of services rendered, allocating direct costs, and prorating indirect costs in accordance with Medicare Principles of Reimbursement, except where modified by Medicaid policy. Medicaid determines reimbursement rates for nursing facility providers based on specific categories of cost, as addressed in other sections of this appendix.

9.6.A. Cost Allocation Basis

The Medicaid cost reporting process establishes the cost finding process. Indirect and non-revenue producing cost centers are allocated using a statistical basis that reflects an equitable measurement of the services provided to, or benefits derived by, a revenue producing or non-reimbursable activity. The nursing facility must develop and maintain adequate statistical data to corroborate the basis of the cost allocation. Adequacy requires that the data be accurate and include sufficient detail to accomplish the purpose for which it is intended. When completing the allocation of the general service cost centers, the nursing facility provider should first allocate those cost centers that render the most services to, and receive the least services from, other cost centers.

9.6.A.1. Facility Square Footage and Space Reporting

A facility space cost allocation is based on square footage identified with specific service areas or activities occupying and using that space. Square footage is an allocation base that may be applicable for multiple indirect cost center activities. However, for cost centers where the basis is the same (e.g., square feet), the total statistical basis over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been allocated.

A consistent and uniform process must be used by the nursing facility for compiling and charging the square footage to each service activity that is primarily benefiting from or using that space. Facility space that is used for multiple activities must be documented and connected to each applicable activity based upon current data that reflects actual use and is available for audit verification. Hallway space located within a specific department or service area is considered usable space for that department. Areas of the

facility for general use, such as connecting hallways, reception areas, lobby, and elevator, used or benefiting all service activities are considered common space. Identifying and counting common space must be consistent for all service areas of the facility.

For example, common space in one service department cannot be excluded from space allocated to that service activity, while similar common space located in other services departments is included in the space allocation of other services activities. The allocation basis must apply either the gross method, where all common area is included and charged to the specific services activity, or the net method, where common space located within the identified service area is not charged to the service activity. The nursing facility's handling of common space area in the cost report allocation must result in equitable distribution of costs associated with the common space to appropriate activities. A change in the process or methodology that the nursing facility uses for allocating space is a change in allocation basis, so appropriate notice and a request must be made to the SMA.

9.6.A.2. ANCILLARY / THERAPY SERVICES SPACE REPORTING

Facility space used for ancillary services delivery must be identified and charged to the appropriate ancillary services cost center. For example, space used for skilled rehabilitation services provided based on a physician's order must be allocated to the appropriate ancillary cost center.

Accounting procedures must be established and implemented to reflect individual cost centers for reimbursable therapy and pathology services. Irrespective of the therapist or pathologist's status as an employee, contractor or independent provider, the nursing facility must record all charges as income and all expenditures for supportive personnel, equipment and its maintenance, supplies and other costs directly attributable to reimbursable expenses in these cost centers.

9.6.A.3. ANCILLARY / THERAPY SERVICES ADMINISTRATIVE OVERHEAD

Medicaid requires that administrative overhead associated with ancillary services be allocated to the ancillary services cost center. The required basis for distribution of administrative costs to the benefiting activities of the nursing facility is accumulated costs. The accumulated costs base generally includes all service activities of the nursing facility.

In specific situations, the nursing facility may request exclusion of certain ancillary service groups from the administrative cost overhead allocation in the Medicaid cost report. The determination applies only to those service items where the billing to the third party only allows for the recovery of the direct cost of the service. The provider must demonstrate considerable inequity of the overhead cost allocation to these service activities that have been identified as excluded groups under the Medicare regulations and that it is not incurring additional costs beyond the activity for arranging for the services. The incidental costs for inclusion of the ancillary service bill preparation must be as follows:

- The facility representatives arrange for the services to be performed by an agency or entity that is not part of the nursing facility operation.
- The nursing facility is not directly involved in providing the ancillary service.
- The nursing facility does not incur any costs for supplies and equipment necessary to perform the service.
- The ancillary service is being recorded through the accounting records and billing system of the nursing facility for the consolidated billing of the services provided to the nursing facility resident.
- The nursing facility does not have physical space dedicated for the purpose of delivery or rendering of the ancillary service. Dedicated space is considered space that is used predominantly for the purpose of the ancillary service delivery.
- The nursing facility is not charging a mark-up related to the billing of the service.

If the nursing facility is allowed to bill for, or recover revenue in excess of, the direct cost of the services, the statistical and fiscal worksheet of the cost report may be adjusted to reflect the revenue received. The amount of revenue exceeding the direct cost will be considered the overhead amount that must be reflected as an adjustment to the "miscellaneous expense" in the Administrative and General cost center, in addition to the direct cost adjustment to exclude the ancillary service cost from the cost allocation step-down. The nursing facility must demonstrate that the excess revenue is a fair representation of the overhead cost or activity associated with providing the service. If this requirement is not met, the ancillary services activity must be included in the administrative cost allocation basis for the apportionment of overhead to the activity.

9.6.A.4. Ancillary Group Exclusion

A provider may request an ancillary group exclusion. The exclusion request must be approved by RARSS. The request must include the parameters under which the exception is requested. If the request is approved by RARSS and it is later determined non-applicable, the exclusion is void for that entire cost report period.

9.6.A.5. Change of Ownership – Exclusion Request

If a CHOW occurs, the prior owner's ancillary group exclusion is no longer applicable. The new owner may submit an ancillary group exclusion request to RARSS for approval. The exclusion process is outlined in the Ancillary Group Exclusion subsection of this appendix.

9.6.B. Change in Cost Allocation Basis

A provider who wishes to change the allocation basis for a particular cost center, or the order in which the cost centers are allocated, must submit a written request to the RARSS. (Refer to the Directory Appendix for contact information.) The request must include reasonable justification and supporting documentation that the new basis is more accurate and appropriate for allocation of the cost activity for Medicaid reimbursement determination. The request must be made prior to the beginning of the cost-reporting period in which the change is to apply. The effective date of the change will be the

beginning of the cost-reporting period for which the request has been made. Failure to submit a timely written request will result in an audit adjustment. The nursing facility provider must maintain both prior and proposed statistics base data until the change is approved.

Medicaid may reject a submitted cost report if a request to change the allocation basis has not been submitted and approved by RARSS. If the previous allocation basis methodology has not been maintained for the current year, Medicaid may accept previous year's statistics for the current year cost reporting.

9.6.C. Related or Chain Organization Cost Allocations

The Medicare Principles of Reimbursement define a related organization as an organization linked to a nursing facility provider by common ownership or control, including a chain organization. An immediate family relationship establishes an irrefutable presumption of relatedness.

For Medicaid purposes, a chain organization consists of a group of two or more nursing facilities, or at least one nursing facility and any other business or entity owned or operated and controlled by one organization. To the extent that the home office furnishes services related to patient care to the nursing facility, the reasonable costs of the services are included in the nursing facility's cost report. Medicaid policy for related organization costs is determined in accordance with provisions in the federal Provider Reimbursement Manual for related organization costs. Exceptions to the application of federal provisions are addressed in the Cost Classifications and Cost Finding and the Allowable and Non-Allowable Costs sections of this appendix.

Home office costs apportioned to individual nursing facilities through the Home Office Cost Statement are classified as support costs. Cost report requirements for home office are addressed in the Cost Reporting section of this appendix.

Costs incurred by a nursing facility for services furnished by the related organization are allowable costs to the nursing facility at the level of cost to the related organization for the service provision. The cost allocated to the nursing facility cannot exceed the price of comparable services, facilities, or supplies that could be purchased in competitive market conditions. The principles of reimbursement applied for the determination of allowable cost to the nursing facility are also applicable in the determination of the allowable cost of the related organization. If a cost would be unallowable to the nursing facility, it would be unallowable to the related organization.

The operating costs of a related ownership organization are allocated to an individual nursing facility as a "purchased service" and must be identified within the appropriate cost center for Medicaid cost reporting. The type of service determines if the costs qualify to be apportioned between base and support cost using the industry-wide base and support cost percentages. If the service does not qualify to be apportioned by this method, the allocated costs are classified as support costs in the individual nursing facility. Refer to the Cost Classifications and Cost Finding section of this appendix for additional information.

If the home office accounting period differs from the cost reporting period of the nursing facility, the allowable home office costs in the facility cost report must only include the costs allocated to the facility for the time period in which the completed home office cost statement coincides with the facility's cost report period. There may be a portion of the year where home office costs have not yet been determined or finalized. The facility must submit to RARSS a disclosure letter with it's cost report data stating that the cost report includes partial year home office costs. After the home office reporting period is completed, the nursing facility must amend it's cost report submitted to RARSS to include complete home office cost data. The cost report filed originally will be used for program reimbursement actions until an amended cost report is filed. An accepted, amended cost report will be used for reimbursement determination actions for the same time period as the initial cost report. The nursing facility amended cost report must be submitted to RARSS within three months after the end of the home office or related party cost report year. Amended cost reports submitted after the three-month filing requirement will be effective only on a prospective basis for the routine nursing care per diem rate determination. The Medicaid audit of the home office cost statement and related allocation to the nursing facility will be made in accordance with the final cost report filing data.

Example: The home office has an accounting year ending August 31; Nursing Facility A has a cost report year ending December 31; Nursing Facility B has a cost report year ending March 31.

Year 1

Home Office Cost Period and Amount	Facility A	Facility B
9/1/2003 – 8/31/2004 $204,000		
Allocation to chain provider facilities	$120,000	$84,000
Applicable to facility cost report year	12/31/2003 - 3/31/2004	
4 months 9/1/2003 – 12/31/2003	$40,000 (4/12)	
7 months 9/1/2003 – 3/31/2004		$49,000 (7/12)
Applicable to facility cost report year	12/31/2004 - 3/31/2005	
8 months 1/1/2004 – 8/31/2004	$80,000 - (8/12)	
5 months 4/1/2004 – 8/31/2004		$35,000 (5/12)

Year 2

Home Office Cost Period and Amount	Facility A	Facility B
9/1/2004 – 8/31/2005 $228,000		
Allocation to chain provider facilities	$132,000	$96,000
Applicable to facility cost report year	12/31/2004 - 3/31/2005	
4 months 9/1/2004 – 12/31/2004	$44,000 (4/12)	
7 months 9/1/2004 – 3/31/2005		$56,000 (7/12)
Applicable to facility cost report year	12/31/2005 - 3/31/2006	
8 months 1/1/2005 – 8/31/2005	$88,000 (8/12)	
5 months 4/1/2005 – 8/31/2005		$40,000 (5/12)

Year 3

Home Office Cost Period and Amount	Facility A	Facility B
9/1/2005 – 8/31/2006 $216,000		
Allocation to chain provider facilities	$126,000	$90,000
Applicable to facility cost report year	12/31/2005 - 3/31/2006	
4 months 9/1/2005 – 12/31/2005	$42,000 (4/12)	
7 months 9/1/2005 – 3/31/2006		$52,500 (7/12)
Applicable to facility cost report year	12/31/2006 - 3/31/2007	
8 months 1/1/2006 – 8/31/2006	$84,000 (8/12)	
5 months 4/1/2006 – 8/31/2006		$37,500 (5/12)

Individual Nursing Facility Cost Reporting	Facility A	Facility B
Amount reported in facility cost report initially filed for:	FYE 12/31/2004	FYE 3/31/2005
Home office cost year 8/31/2004	$80,000 (8 months)	$35,000 (5 months)
Amount reported in facility cost report amended for:	FYE 12/31/2004	FYE 3/31/2005
Home office cost year 8/31/2004	$80,000 (8 months)	$35,000 (5 months)
Home office cost year 8/31/2005	$44,000 (4 months)	$56,000 (7 months)
Total home office costs in cost report	$124,000	$91,000
Amount reported in facility cost report initially filed for:	FYE 12/31/2005	FYE 3/31/2006
Home office cost year 8/31/2005	$88,000 (8 months)	$40,000 (5 months)
Amount reported in facility cost report amended for:	FYE 12/31/2005	FYE 3/31/2006
Home office cost year 8/31/2005	$88,000 (8 months)	$40,000 (5 months)
Home office cost year 8/31/2006	$42,000 (4 months)	$52,500 (7 months)
Total home office costs in cost report	$130,000	$92,500
Amount reported in facility cost report initially filed for:	FYE 12/31/2006	FYE 3/31/2007
Home office cost year 8/31/2006	$84,000 (8 months)	$37,500 (5 months)

Individual nursing facility cost reports for 12/31/2006 and 3/31/2007 must be amended following completion of the home office cost reporting year 8/31/2007 to include the portion of that year costs in the nursing facility cost report.

9.7 Distinct Part Unit Reporting

For reimbursement purposes, the Nursing Facility is defined as the unit that is certified for participation in the Medicaid program, whether that unit comprises all of, or a distinct part of, a larger institution.

Certification regulations require that a distinct part be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. The provider must demonstrate to Medicaid that the system used for recording the hours of nursing services can be audited and equitably allocates the nursing services costs between the distinct part and other parts of the facility. The nursing services costs are only the gross salaries and wages of nursing and related personnel, such as RNs, LPNs, and CNAs. Costs applicable to general services areas of the institution must be allocated in accordance with the Cost Finding section of this appendix.

Nursing services costs allocated to that distinct part of the facility must relate only to services provided to those residents. While a provider may choose the record keeping method used to allocate these costs, the preferred system is time records identifying the time spent providing nursing care in the Medicaid distinct part and in other parts of the institution. Providers using the preferred method must obtain approval from the RARSS prior to changing its cost allocation method. The request must identify the reason for the change and must demonstrate that the proposed method is representative of actual

nursing staffing within the facility and results in an equitable and accurate allocation of nursing services costs.

A nursing services cost allocation using an average cost per patient day may be used, with prior permission from RARSS, in the following situations:

- In the case of an inadequate payroll record keeping system.
- Facility failure to maintain backup assignment schedules or staffing reports.

An institution may have more than one Medicaid distinct unit in specific cases where Medicaid has certified beds as special use for specialized nursing care. The specialized nursing care beds must be physically distinguishable, within a designated area, and identified as a separate nursing bed class for Medicaid reimbursement. Requirements for reporting nursing services costs also apply to nursing services for residents in specialized nursing care beds. The nursing facility must have prior approval from Medicaid for participation in a program for specialized nursing care.

9.8 Day Care Services provided in the Nursing Facility

According to federal regulations, day care services provided to an employee's dependent are not a fringe benefit when furnished for the convenience of the provider. Medicaid considers day care services provided to an employee's dependent a convenience to the provider due to potential support of staff recruitment and retention.

9.8.A. Employee Dependents

According to federal regulations, a nursing facility operating a day care center for the children of its employees and for employees of a related facility is classified as such an activity and must not be included in facility costs as an employee fringe benefit. The costs are allowable to the extent that the amount is reasonable. "Reasonableness" means that the services are provided in accordance with regulations established for the provision of such services and must take into account both direct and indirect costs of the services. The provision of services must also be considered reasonable in that the costs of operating a facility demonstrate sufficient benefits. For example, the number of children participating justifies the provision of services.

Total cost must not exceed what a prudent and cost conscious buyer pays for like services. If costs are determined to exceed such level and the nursing facility cannot provide clear evidence that the higher costs were unavoidable, the excess costs are not allowable. The day care center operations must be provided in accordance with, and satisfy applicable regulatory requirements governing the operations of, such activities. The nursing facility must maintain accounting records and documentation to demonstrate the total cost and utilization of day care services.

The following costs are non-allowable:

- diapers
- towelettes
- lotions

- oils
- similarly used hygiene products

9.8.B. Services Provided To Non-Employee Dependents

If a provider renders services to non-employee dependents, the day care center must be established as a separate entity even if services are also provided to employee dependents. Medicaid will allow costs relative to intergenerational activities as an offset when the day care center suffers a financial loss, which is limited to the lesser of total documented intergenerational activities or the amount of the loss. Intergenerational activities must be documented, organized activities between the children attending the day care and the nursing facility residents.

The nursing facility must maintain accounting records and documentation to demonstrate the total cost and utilization of day care services.

9.9 Nurse Aide Training and Competency Evaluation Program (NATCEP) and Competency Evaluation Program (CEP)

The Omnibus Budget Reconciliation Act (OBRA) of 1987 and 1990 requires that any nurse aide employed in a nursing facility complete a competency evaluation program. Medicaid will reimburse a Medicaid certified nursing facility for the Medicaid share of allowable costs directly related to meeting the nurse aide training and competency evaluation requirements. Reimbursement includes only costs incurred with a NATCEP or CEP approved by the State Survey Agency (SSA). Medicaid reimbursement applies only to Certified Nurse Assistants (CNA) working in a Medicaid certified nursing facility and are not available to CNAs in other residential or patient care settings.

A nurse aide who is employed by a nursing facility or who has received an offer of employment from a nursing facility on the date on which the nurse aide begins a NATCEP may not be charged for any portion of the cost of the program. The nursing facility must reimburse newly employed CNAs who have personally paid for NATCEP or CEP costs prior to employment in the facility, in accordance with criteria identified in the Nurse Aide Reimbursement section of this appendix. Medicaid in turn reimburses the nursing facility.

Providers may obtain reimbursement from Medicaid for CNA costs. The reimbursement process and necessary forms are available on the MDCH website. (Refer to the Directory Appendix for website information.)

9.9.A. Nurse Aide Competency Evaluation Program and Nurse Aide Registry

Nurse aide candidates must pass both a clinical skills test and a knowledge test in order to become certified. Fees for the individual nurse aide to take the tests, and retake each test up to three times - are allowable costs for nursing facility reimbursement. Refer to the Nursing Facility Reimbursement and Nurse Aide Reimbursement subsections of this appendix.

When a nurse aide has successfully passed the CEP, their name is placed on the Michigan Nurse Aide Registry. Fees relating to initial registration and biennial registry

renewal are allowable costs for nursing facility reimbursement. Refer to the Nursing Facility Reimbursement and Nurse Aide Reimbursement subsections of this appendix.

Information about training requirements, competency evaluation program and registry data is available on the MDCH website. (Refer to the Directory Appendix for website information.)

9.9.B. Nursing Facility Reimbursement

Reimbursement to the nursing facility for NATCEP related costs is calculated as an add-on to the routine per diem rate. The Nurse Aide Training and Testing Program Interim Reimbursement Request (MSA-1324) and instructions are available on the MDCH website. The total NATCEP add-on amount will be adjusted through the annual cost report settlement process. The Medicaid share of the costs is computed based on the ratio of Medicaid resident days to total resident days for all nursing care provided in the facility during the cost report period. Refer to the Cost Report Reimbursement Settlement section and the Rate Determination section of this appendix for additional information.

The NATCEP cost center on the Medicaid cost report must be used to report the following:

- Costs of conducting a nursing facility based NATCEP.
- Costs of having employees participate in an approved NATCEP outside the nursing facility.
- Costs of employee competency testing by a regional testing facility.

The costs and staffing levels relating to and charged to the NATCEP cost center must not be included in the nursing facility determination of routine nursing care costs.

The determination of allowable NATCEP costs is made in accordance with provisions in the federal Principles of Reimbursement established for the Medicare Program, and cost limitations in Medicaid policy. Training and evaluation program costs claimed for services and supplies furnished to or purchased by the facility from related organizations must adhere to related party allowable cost principles. The cost of such transactions must not exceed the cost of like items or services in an arms-length transaction with a non-related organization, or the actual cost to the related organization, whichever is lower.

The following are not NATCEP costs and must be classified as routine nursing care costs on the cost report:

- Administrative overhead in a facility-based training program.
- Space costs in a facility-based training program.
- Uniform allowance costs.
- Required in-service training.

NATCEP and CEP allowable cost must only include the costs of activities or items that are directly related to providing approved training and the competency evaluation process. The following table contains eligible training and evaluation activities.

Training Staff	Salaries and wages, employee benefits and payroll taxes for conducting training and evaluation activities, including supervised practical training, and direct time devoted to development and preparation for conducting the NATCEP. Payroll costs allowed for NATCEP do not include the cost of time that the training staff devote to routine in-service training activities, general nursing administration or direct patient care, except for supervised practical training. These costs must be classified as routine nursing care cost for consideration in the routine per diem rate.
Training Consultants	Costs incurred for non-facility staff to assist in developing and conducting the facility's NATCEP.
Student Staff	Salaries and wages, employee benefits and payroll taxes incurred for the time the student is enrolled in the approved training program, i.e., classroom and required supervised practical training. A reasonable time allowance for student employees traveling to and from the off-site training location or competency evaluation, in accordance with a nursing facility's established and documented travel policy, is allowable as NATCEP cost. Payroll costs allowed for NATCEP do not include the cost of staff time for patient care activities that the nurse aide is performing during the time period the student is completing the training program. These costs must be classified as routine nursing care cost for consideration in the routine per diem rate.
Training Program Supplies	Costs of supplies and materials used in conducting an approved NATCEP.
Training Program Transportation	Travel or transportation costs incurred by facility staff in conducting the NATCEP activity, and for transportation or travel reimbursement to student staff for off-site NATCEP or CEP attendance. Refer to the Facility Vehicle and Transportation, Allowable and Non-Allowable Cost section of this appendix for mileage allowance provisions. Use of a facility owned vehicle for staff transportation for training is not charged to NATCEP. Facility vehicle operation cost must be classified as administrative overhead and is considered in the routine per diem rate.
Outside Contracted NATCEP Paid Directly by the Facility	Cost to obtain approved nurse aide training of facility employees by an outside entity approved NATCEP. The nursing facility is responsible to ensure that the contractor is an approved NATCEP.
Outside Contracted NATCEP Costs Reimbursed to Employee	Cost for reimbursement to an employed CNA who had personally paid for an approved NATCEP participation and completion prior to being employed in the facility. Refer to the Nurse Aide Reimbursement subsection of this appendix for additional information.

Competency Evaluation Fees Paid Directly by the Facility	Fees paid by the nursing facility to a State-approved competency evaluator. This includes testing and retesting fees, rescheduling fees, and nurse aide registry.
Competency Evaluation Fees Reimbursed to Employee	Cost for reimbursement to an employed CNA who had personally paid for State-approved competency evaluation and registration fee prior to being employed in the facility. Refer to the Nurse Aide Reimbursement subsection of this appendix for additional information.
Miscellaneous Costs	Allowable costs that are not specifically identified in another category include, but are not limited to, the following items: ▪ Rental costs for space located out of the facility are allowable only if the space is used solely for the training and competency evaluation program. Space costs not meeting this requirement are reimbursable with the Plant Cost Component of the routine per diem. ▪ Reasonable rental expense for training equipment necessary for conducting an approved training program. ▪ Nurse aide biennial Registry Document renewal fees for current employees.
Equipment Purchased	Equipment purchased and used specifically for the nursing facility based NATCEP are reported as NATCEP cost center costs for Medicaid cost reporting and reimbursement purposes. NATCEP equipment costing less than $5,000 may be expensed in the year of acquisition and reported in the NATCEP cost center. Equipment acquired as part of an integrated system costing greater than $5,000 must be amortized at an annual rate of 15% for each cost reporting year the equipment is used in the NATCEP, up to a maximum of seven years. Instructions for NATCEP equipment reporting are included in the annual cost reporting instructions.

9.9.C. Nurse Aide Reimbursement

A nursing facility must reimburse a newly hired CNA if the CNA paid for nurse aide training, competency evaluation and registry, and completed the approved training program within 12 months prior to employment in that facility. The nursing facility is not required to reimburse the CNA in cases where the expenses were paid by an employment or education training program, or were reimbursed by the CNA's previous employer. The nurse aide should not be reimbursed for more than 100 percent of the NATCEP or CEP costs they paid.

The nursing facility is responsible to ensure that a newly hired CNA who requests reimbursement of training and testing expenses has not already received payment for these costs. An aide who paid for any of these eligible costs and received payment of a portion of the expenses from prior facility employment is eligible for only the remaining balance from the new employer.

The CNA must request reimbursement by submitting to the nursing facility the Nurse Aide Training and Competency Evaluation Program, CNA Reimbursement Form, available in the Forms Appendix and on the MDCH website.

NATCEP costs that are eligible for reimbursement to the individual nurse aide include:

- Training program cost including fees for textbooks and required course material up to a maximum of $650. Medicaid will update the maximum allowable reimbursement limit effective October 1, 2006 and biennial thereafter, based on the Global Insight's Skilled Nursing Facility Market Basket without Capital Index corresponding to that update period.
- Competency Evaluation Program testing fees, including retesting fees; CEP testing required due to the nurse aide registry document expiration; and rescheduling fees.
- Registry or Registry Renewal Document fees that the CNA personally paid within 24 months prior to being employed in the nursing facility.

For cost reporting and audit purposes, the nursing facility must maintain a copy of the Nurse Aide Training and Competency Evaluation Program CNA Reimbursement Form signed by the employee and documentation reflecting reimbursement to the employee. This documentation must include a copy of a receipt for cash payment, a copy of a cancelled check, or a credit card receipt showing the amount paid by the nurse aide and the date of payment, as well as copies of the nursing facility's cancelled checks disclosing reimbursement to the employee.

The nursing facility has the option to reimburse the individual via a one-time payment or payment installments. The reimbursement to the individual, regardless of full-time or part-time employee status, must be fully paid within six months of the individual's date of employment in the facility. If the nursing facility fails to reimburse a CNA employed in the facility within this timeframe, the unpaid balance will not be an allowable NATCEP or routine nursing care cost. This determination does not relieve the nursing facility of its obligation to reimburse the nurse aide. Wages may not be reduced to offset the facility's obligation to pay the nurse aide for training, competency evaluation, and registry costs.

The nursing facility is not obligated to pay the remaining balance of nurse aide training costs at the time an employee who has worked less than six months leaves facility employment. The CNA has the opportunity to recoup the non-reimbursed costs through subsequent employment at other nursing facilities. The facility should properly record payments so that the unpaid amount is not carried as a payment obligation.

9.9.D. Nursing Facility Lockout and Loss of NATCEP Approval

A provider with a facility-based training CNA program is not eligible for Medicaid reimbursement of training costs when it has been issued a final notice from CMS or the SSA of the withdrawal of NATCEP approval, or of a NAT prohibition (lockout). For Medicaid reimbursement purposes, the lockout effective time period coincides with the SSA time period notice to the nursing facility. The nursing facility must not claim Medicaid reimbursement for costs associated with any facility-based training class beginning after the withdrawal or lockout effective date identified in the final notice. Nurse aide students beginning training prior to the withdrawal effective date are allowed to complete training, and the related costs to complete that training class are eligible for

NATCEP reimbursement. Nurse aide training costs incurred for that facility based program subsequent to completion of that student class are not allowable NATCEP costs. This disallowed cost is also not allowable under routine nursing care cost.

Although the nursing facility experiencing approval withdrawal or lockout status cannot conduct its own training, the nursing facility must provide and reimburse for training and competency evaluation of its new nurse aide employees at approved sites. Such costs are eligible for Medicaid cost reporting and reimbursement in the annual cost report under the appropriate NATCEP cost categories. Nurse aide reimbursement for eligible training and competency evaluation personally paid expenses are allowable to be reported as NATCEP cost in the nursing facility annual cost report.

In the event that the nursing facility has been granted a waiver for a NAT program prohibition or lockout by the SSA, the nursing facility must comply with the provisions of the nursing facility waiver request and the requirements set forth by the SSA in the waiver approval. The facility-based NATCEP operating under a waiver is subject to audit by Medicaid for compliance with these requirements. If the nursing facility fails to conduct the program in accordance with these requirements, the training program expenses are not allowable costs for NATCEP or routine nursing cost reimbursement by Medicaid.

9.10 Beauty and Barber Service Cost Center

Personal services for residents, such as simple barber and beautician services (e.g., shaves, haircuts, shampoos, and simple hair sets), that residents need are considered routine patient care. The provision of such services is reimbursed in the routine per diem rate when provided routinely without charge to the resident in the nursing facility.

If the nursing facility designates an area for providing non-routine personal hygiene services, such as professional manicures, or hair styling, costs must be separately reported and accounted for in the cost report. Direct and overhead costs related to these services must be separately accounted for in this special services cost center and should not be included in the cost of providing routine nursing care.

9.11 Special Dietary Cost Center

Medicaid provides for reimbursement outside the per diem rate to non-profit nursing facilities for the cost of meeting residents' special dietary needs for religious reasons. Nursing facilities requesting reimbursement must report these costs as a separate cost center in the Medicaid annual cost report. Direct costs may include food purchase, salary and wages for the extra staff time for preparation, supplies and kitchen utensils necessary for preparation and service. The costs applicable to plant operations costs related to the special dietary needs will be determined through the Medicaid cost finding process.

9.12 Hospital Leave Days

A separate accounting of costs incurred due to hospital leave days is not necessary.

9.13 NON-AVAILABLE BEDS

In special circumstances, nursing facility beds may be designated "non-available for occupancy" for Medicaid cost reporting when the patient care rooms in which the beds are located are not used for resident care. Beds with a "non-available" designation remain licensed or certified; the designation is for Medicaid cost reporting and reimbursement determinations only. An approved non-available bed plan reduces the total number of beds used for calculating available bed days for the annual cost report period coinciding with the time period of the non-available bed plan. Non-available beds must be located in a discrete area and readily identified for statistical cost reporting. During the time period the area is designated non-available for patient care, Medicaid does not reimburse for variable and plant costs attributed to the area designated as having non-available beds.

9.13.A. Qualifying Criteria

A non-available bed plan must include all of the licensed beds in a patient care room. The rooms must be a discrete area and primarily consist of a contiguous physical arrangement of rooms. Rooms may not be a random collection of individual rooms or beds located throughout the nursing facility.

Common physical space located adjacent to or within the designated rooms area will normally be included in the designated non-available bed area. Planned use of any common areas within the designated non-available bed area must be disclosed in the written notice to the RARSS.

Rooms with non-available beds may not be used for resident care service regardless of payer source nor can the space be used for any other normally reimbursable purpose.

Resident rooms that are not used for resident care do not qualify for non-available bed designation. Although the rooms may be used for alternative services, the beds located within the room area must continue to be counted as available for resident care. Physical plant area used for alternative use must appropriately be charged to the applicable alternative services cost center if the services activity results in ancillary care services or other revenue services.

The written request must be submitted within 30 calendar days of the date that the provider removes the beds from service.

9.13.B. Written Notice and Request for Plan Approval

The provider must submit a written request for a non-available bed plan to RARSS. The RARSS must receive the request within 30 calendar days of the date that the beds are to be removed from resident care service. Non-available bed plan requests will not be approved on a retroactive basis. (Refer to the Directory Appendix for contact information.)

The written notice from the provider to RARSS must:

- Indicate the date that the beds will be removed from resident care service and the expected duration of the non-available plan.

- Indicate the reason for the request.
- Include a floor plan of the facility that marks the beds to be designated as non-available.

The RARSS will review the request and provide a written response of approval, denial or a request for additional information. If approved, the RARSS will notify the SSA of the non-available bed designated rooms and effective time period.

9.13.C. Life of an Approved Plan

Beds must remain non-available for not less than the balance of the provider's fiscal cost reporting year in which the beds are deemed non-available plus the entire following fiscal year. An exception is when the non-available bed plan is effective on the first day of the provider's fiscal year. The cost report year may qualify as the entire time period of the non-available bed plan if the cost report period is not less than twelve months.

Non-available bed designations will be effective on the first day of the month. If the notice is not received within the required 30 calendar day period, the plan will become effective on the first of the month in which RARSS received the notice if the beds have not been utilized during that month.

The initial period of the non-available bed plan expires upon completion of the minimum required time period.

The nursing facility may request up to two extensions of 12 months each following this minimum time period. The agreement may be extended on the basis of the provider's fiscal year. A request for extension must be submitted in writing to the RARSS 30 calendar days prior to expiration of the initial plan. The request for a second extension must be submitted to RARSS 30 calendar days prior to expiration of the first extension. The requests must include at least one of the following items:

- The same rooms and bed area.
- A revision to bring some, but not all, of the beds back into service (if applicable).
- A revision to increase the number of non-available beds that includes all of the beds already designated as non-available.
- A change in the room and bed designation area that is equal to the number of beds designated as non-available in the initial plan.

Requests for a revision to bring some, but not all, beds back into service must include:

- The same rooms and the same bed area.
- If applicable, the change in room and bed designation area that is equal to the number of beds designated as non-available in the initial plan.

The extensions must meet the elements of the qualifying criteria, notice requirements and related policy for initial non-available bed requests.

Non-available bed plans expiring on or after April 1, 2005 are limited to two 12-month extensions. When a provider's initial or extended non-available bed plan ends, the nursing facility must return the beds to service or decertify the beds from Medicaid

participation. Medicaid will not approve a non-available bed plan that substitutes beds elsewhere in the facility for the formerly non-available beds.

The nursing facility will not be eligible to submit a new non-available bed plan for 24 months following the expiration of the previously approved plan.

A provider may only request a grace period after the final extension period if the provider can demonstrate progress to place the non-available beds into resident care service. The request for a grace period must be made to LTC Services 30 calendar days prior to the expiration of the final extension period. (Refer to the Directory Appendix for contact information.) The request for a grace period must be submitted before expiration of the final extension period, and must meet the elements of the qualifying criteria, notice requirements and related policy for initial non-available bed requests. The request must specify the date that the beds will be available for occupancy and may not exceed 12 months. An example for such action is gradual facility renovation involving periodic non-available beds in a nursing unit and replacement with non-available beds in another unit as renovation plans progress.

The provider must meet all appropriate certification requirements for distinct part units for the remaining Medicaid beds. Additional beds may have to be decertified in order to meet the distinct nursing unit requirements. The nursing facility may request re-certification of these beds for Medicaid participation after a 24-month time period. A request to re-certify must meet all current Medicaid certification requirements.

9.13.D. Change of Ownership (CHOW)

The non-available bed plan approval expires with a change of ownership of the nursing facility. If the new owner wishes to continue the non-available bed plan, they must submit a written request to the RARSS within 90 calendar days of the CHOW. A non-available bed plan submitted after the 90-day period will be considered a new request and must satisfy the qualifying criteria and related policy requirements. If the new owner does not request continuation of the existing plan, the beds will be deemed available for occupancy effective with the date of ownership change.

The new owner may apply to extend the plan to coincide with its cost reporting period by following the extension request policy outlined in the Life of an Approved Plan subsection. The nursing facility change of ownership does not relieve the nursing facility from the restrictions for non-available bed designation limitations for plan extensions other than allow for coinciding with the cost report year of the new ownership.

9.13.E. Amending a Plan

The nursing facility may amend an approved non-available beds designation by submitting a written request to the RARSS. (Refer to the Directory Appendix for contact information.) A non-available bed plan may be amended only one time during the life of the unavailable bed plan. A request for an amendment must include the same information as an initial request and will be reviewed using the same criteria. A plan amendment increasing the number of non-available beds is subject to the minimum time period requirement and the designation of all the beds must be effective for the time

period of not less than the balance of the provider's current fiscal cost reporting year in which the beds are deemed non-available plus the following fiscal cost report year.

9.13.F. Penalty for Use of Non-Available Beds

Admitting residents to any beds in the area designated non-available for occupancy, regardless of payer source, before the end of the plan negates the plan retroactive to the beginning of the nursing facility's fiscal cost reporting period. All beds covered by the negated non-available bed agreement will be considered available for patient care for the entire cost report period.

9.13.G. Returning Beds to Service

All of the beds in the non-available bed plan will be considered returned to service and available for occupancy when the non-available bed plan expires.

In special circumstances, such as a sudden increase in demand due to closure of a nearby facility, non-available beds may be returned to service before the end of the approved plan with prior approval of the RARSS. A nursing facility with an approved non-available beds plan may submit a written request to return beds to nursing care if the individual nursing facility experiences the need for the beds due to the exception circumstances. The request must identify the reason for the need and the specific beds and room designations being made available. RARSS will provide immediate review and response to the nursing facility request.

9.13.H. Plant Cost Certification

A provider with an approved non-available beds plan has the option to submit to a Plant Cost Certification for the cost report fiscal period in which the beds are approved as non-available for occupancy or the termination of the plan. Refer to the Plant Cost Certification Section in this appendix for additional information.

9.13.I. Cost Reporting

The variable and plant costs attributed to the area designated as non-available and the related capital asset cost are not Medicaid reimbursable costs. The non-available rooms and bed numbers must be reported as a Non-Available Beds cost center on the provider's Medicaid cost report.

Each general service cost center must be evaluated separately to determine if the non-available bed area benefits from the service. The nursing facility may charge specific costs to the Non-Available Beds cost center only when the dollar amount is identifiable. Costs that cannot be specifically identified must be apportioned to the non-available beds cost center using the Medicaid cost report allocation methodology. The statistic or measure used for the general services cost center must also be used to allocate costs to the non-available bed cost center.

Example: If square feet are used to allocate costs to the housekeeping activity, the general services cost center, then square feet must also be used to allocate costs to the

non-available bed area. The allocation to the non-available bed cost center is zero when the non-available bed area receives no benefit from the general service.

Example: If a wing is designated as non-available and does not receive any housekeeping services, then the allocation to the non-available cost center is zero.

The reduction in available beds is included in the provider's cost report effective for the fiscal period in which the non-available bed plan is approved by the RARSS. For Medicaid reimbursement determination of tenure and allowable average borrowings, the percentage of the total plant asset costs applicable to available beds must equal the percentage of the facility remaining available for resident nursing care.

9.14 Memorandums of Understanding (MOU) – Special Agreements for Complex Care

Memorandums of Understanding (MOU) – Special Agreements for Complex Care provide Medicaid reimbursement for residents receiving specialized services. Separate cost records are not required for identifying these costs. The Program has designated the special care revenue amount equal to cost. Providers with an MOU must adjust the annual Medicaid cost report by removing from the appropriate nursing care costs the dollar amount of the total difference between reimbursement at the special care rate and the established routine Medicaid rate. The rate provisions are identified in the provider's memorandum of understanding issued with the placement of the special care resident in the facility.

SECTION 10 - RATE DETERMINATION

There are six classes of nursing care facilities for which there are specific reimbursement methods. For a definition of the six classes, refer to the Definitions section in this appendix. Providers reimbursed for care using a special reimbursement calculation or method are addressed at the end of this section.

The determination of a nursing facility's class is made by the State Survey Agency. If a nursing facility changes ownership or the services it provides such that a change in class is appropriate, the facility will be reimbursed according to the respective facility class to which it has been changed. The effective date of the reimbursement change is the effective date of the State Survey Agency's determination. Nursing facility providers other than Class IV are reimbursed under a methodology that pays the lower of the customary charge to the general public or a prospective payment rate determined by Medicaid.

Payment rates described in this section refer to the provider's prospective per resident per diems and are generally set 30 calendar days in advance of the State's fiscal year, which is October 1 through September 30. (Rate determination timing is dependent on legislative approval of the Department of Community Health's budget.)

NOTE: An illustration of the timeline and calculations for per diem rate setting is available on the MDCH website. (Refer to the Directory Appendix for website information.)

Prospective payment rates are calculated using the facility's cost report ending in the previous calendar year. If this cost report covers a time period that is less than seven months, the cost report used for rate setting is the most recent cost report available prior to the previous calendar year that covers a period of at least seven months.

The reimbursement rate determination process uses a provider's most recent fiscal period audited cost data to calculate the routine nursing care per diem rate. If audited data is not available, an interim prospective rate is calculated using the filed cost report, if the cost report was acceptable and was filed with Medicaid within five months from the end date of the cost reporting period. If an acceptable cost report was not filed within this time frame, Medicaid is not required to set the prospective payment rate in advance of the State's fiscal year. If the nursing facility did not file within the five month time period, or has amended an original cost report subsequent to the five month period, Medicaid will calculate the prospective rate for an effective date for services no later than the beginning of the fourth month (January 1) of the State fiscal year. Nursing facilities that are required to file an amended cost report in order to include home office costs that were not included in the original cost report due to the difference in cost reporting period from the home office are exempt from this provision. The amended cost report, if filed timely following the completion of the home office cost statement, will be considered timely filed if the original cost report had met the five month filing requirement. Refer to the Cost Classification and Cost Finding section of this appendix for home office cost statement and nursing facility amended cost reports.

10.1 RATE DETERMINATION PROCESS

The per diem reimbursement rate for Class I and Class III nursing facility providers is made up of three components: a plant cost component, a variable cost component, and add-ons.

- For Class I facilities, the plant cost component is made up of the Property Tax/Interest Expense/Lease Component plus the Return on Current Asset Value Component.

- For Class III facilities, the Plant Cost Component is the lesser of the Facility Per Patient Day Plant Cost or the Facility Plant Cost Limit. The Facility Plant Cost Component is the depreciation, interest and lease expenses calculated on a per patient day basis.
- For Class I and Class III facilities, the Variable Cost Component is made up of the facility's Variable Rate Base plus the Economic Inflationary Update.

Class II facilities, being proprietary nursing facilities for the mentally ill or mentally retarded, are reimbursed an all-inclusive prospective payment rate negotiated with the MDCH State Mental Health Agency on an annual basis. Final reimbursement is a retrospective cost settlement, not to exceed a ceiling limit. The provider may be eligible for a reimbursement efficiency allowance in the final rate if total allowable costs do not exceed the prospectively established ceiling limit.

Class IV facilities, being state-owned and operated institutions, Intermediate Care Facilities for the Mentally Retarded (Developmentally Disabled), and non-profit nursing facilities for the mentally retarded, are reimbursed allowable costs determined in accordance with Medicare Principles of Reimbursement and are retrospectively cost settled.

Per diem rates for Class V facilities, Ventilator Dependent Care Units, are set prospectively. Services included in the per diem rate are outlined by contract with Medicaid.

Payment rates for Class VI Hospital Swing Beds are set prospectively as a flat per resident day rate determined by Medicaid.

10.2 Retroactive Rate Changes

A retroactive change may be made for facilities that have interim prospective rates based on filed cost reports. A retroactive change may be made for:

- audit adjustments to a filed cost report that was used for setting an interim rate.
- facilities that were approved for Plant Cost Certification due to capital cost changes, an approved non-available bed plan, or a plant rate affected by a DEFRA rate limitation for the cost report time period.
- audit adjustments that are required as a result of an appeal.
- audit adjustments that are required as a result of fraud or facility failure to disclose required financial information.
- Class I nursing facilities approved for Rate Relief for the rate year period.

The Plant Cost Component of a rate for the nursing facility that experiences a change of ownership will be retroactively adjusted under the Plant Cost Certification process. The DEFRA Reimbursement Limit application will continue to apply to each rate year until a fiscal year retrospective rate change results in zero DEFRA limit. The nursing facility Plant Cost Component will be calculated on a prospective basis for the year following the zero DEFRA limit rate year.

10.3 Plant Cost Component Class I Nursing Facilities

The prospectively established Plant Cost Component for each Class I nursing facility provider is the sum of the facility Net Property Tax/Interest Expense/Lease Component and Return on Current Asset Value Component. The Plant Cost Component is expressed as a per patient day amount.

10.3.A. Net Property Tax/Interest Expense/Lease Component Per Patient Day

The Net Property Tax/Interest Expense/Lease Component per patient day is calculated under the following formula:

Property Tax/Interest Expense/Lease Plant Cost	-	CAV Excess Borrowings Limit	+	DEFRA Reimbursement Limit (not to exceed zero)	=	Net Property Tax/Interest Expense/Lease Plant Cost	

Net Property Tax/Interest Expense/Lease Plant Cost	÷	Nursing Facility Resident Days	=	Net Property Tax/Interest Expense/Lease Plant Cost Per Patient Day

10.3.A.1. Property Tax/Interest Expense/Lease Plant Costs

These plant costs consist of allowable costs for real estate and personal property taxes, interest expense, and lease expense defined under the Allowable and Non-Allowable Cost section and the Cost Classification section of this appendix. The aggregate dollar amount for these plant costs is obtained from the nursing facility cost report. The time period of the cost report will correspond with the cost basis period identified for the respective State rate year.

10.3.A.2. CAV Excess Borrowings Limit

The CAV excess borrowings limit is unreimbursable interest due to excess borrowings. An example of the calculation is available on the MDCH website. (Refer to the Directory Appendix for website information.)

The dollar amount of allowable interest expense included in the reimbursable plant cost will be reduced if the nursing facility loan balance applicable to the nursing care unit exceeds the facility reimbursement limit. The nursing facility's average allowable borrowing balance cannot exceed the lesser of the "Nursing Facility Current Asset Value" or the "Nursing Facility Capital Asset Value Limit." If the nursing facility borrowing balance exceeds the limit, a reduction is made to the allowable plant cost for the portion of the excess borrowing. The amount of the reduction is based on the ratio of the limit amount to the average borrowings balance times the dollar amount of allowable interest expense. The following formula is applied to calculate the reduction:

Lesser of (NF CAV) or (NF CAV LIMIT)	÷	Facility Average Borrowing Balance	x	Total Allowable Interest Expense	=	Reimbursable Interest

Total Interest Expense	-	Reimbursable Interest Expense	=	CAV Excess Borrowings Limit (N/A if less than zero)

A nursing facility that has undergone a change of ownership and is incurring interest costs relating to the acquisition financing will be subject to a DEFRA Reimbursement Limit disallowance. The DEFRA Reimbursement Limit calculation will determine if the nursing facility acquisition and financing costs exceeds Medicaid allowable reimbursement increase limit. Reductions to the facility total borrowing balance are made to avoid including the borrowings balance in the reimbursable interest, and to avoid including the total allowable interest expense amount in both the DEFRA limit and the CAV excess borrowing limit.

If the nursing facility has a DEFRA Reimbursement Limit due to the nursing facility acquisition, the nursing facility's total average borrowing balance used in the calculation for CAV excess borrowings limit will be reduced by a calculated dollar amount of borrowings corresponding with the DEFRA Reimbursement Limit. The borrowing amount corresponding with the DEFRA Reimbursement Limit is calculated under the following formula:

Dollar Amount of DEFRA Reimbursement Limit	÷	Nursing Facility Total Allowable Interest Expense	x	Nursing Facility Total Borrowing Balance	=	Reduction to NF Average Borrowing Balance

10.3.A.3. DEFRA REIMBURSEMENT LIMIT

Increases in reimbursement for tenure and interest expense subsequent to a sale or resale (after July 18, 1984) are limited under provisions of the Deficit Reduction Act (DEFRA) of 1984 as defined in federal Medicaid law. The Medicaid application of DEFRA provisions is a limit on the dollar amount of plant cost component reimbursement increase to the provider due to the nursing facility change of ownership. An established formula calculation is used to determine the new ownership's eligible increase reimbursement for tenure and interest (DEFRA Application Limit). If the new ownership tenure and interest increase before application of the DEFRA Reimbursement Limit does not exceed the DEFRA Application Limit , the DEFRA Reimbursement Limit is not applicable. If the new ownership tenure and interest increase before application of the DEFRA Reimbursement Limit exceeds the DEFRA Application Limit allowable increase, the DEFRA Reimbursement Limit reduction will be made to the allowable plant costs.

The calculation is made as follows:

DEFRA Application Limit	-	Increase in tenure and interest for new ownership prior to DEFRA Limit	=	DEFRA Reimbursement Limit (not applicable if greater than zero)

DEFRA Application Limit is determined as:

Allowable historical capital asset cost to the asset original owner (excluding land) for assets in the NF at the time of sale	x	3.33%	+	[Allowable land value to the seller	+	Historical capital asset cost of the asset's original owner for assets in the nursing facility at the time of sale]	-

Purchaser down payment	x	Purchase Mortgage interest rate	-	Allowable interest expense of the seller for the rate period prior to the sale	=	DEFRA Application Limit

For purposes of the DEFRA Reimbursement Limit calculation, allowable acquisition cost is the cost to the original owner of the asset. An example of this calculation is available on the MDCH website. (Refer to the Directory Appendix for website information.)

Increase in tenure and interest for the new ownership prior to DEFRA Limit is determined as:

Purchaser tenure and allowable interest after acquisition	-	Seller tenure and allowable interest in the Medicaid rate prior to the sale	=	Increase in tenure and interest for new ownership prior to DEFRA Limit

The calculation formula is defined for application when using annualized cost data (reflective of twelve-month time period). Tenure refers to the purchaser's initial ownership year. Allowable interest refers to interest associated with a facility acquisition. If all of the data elements needed in the calculation do not include data for a twelve-month period, the data elements must be adjusted to reflect a time period of equal duration to the cost report base period used in determining the "purchaser tenure and allowable interest after the sale."

The DEFRA Reimbursement Limit continues to apply to the new ownership annual Property Tax/Interest Expense/Lease Component rate using the Plant Cost Certification reimbursement settlement procedure until the limit amount is zero.

10.3.B. Return on Current Asset Value (CAV) Component

The Return on Current Asset Value Component is a per resident day amount representing a use allowance on facility assets. The return amount is determined by multiplying the "tenure factor" times a CAV calculated for the nursing facility. A nursing facility's CAV is determined by a formula using historical costs of the nursing facility's capital assets, as identified in the Allowable and Non-Allowable Costs section in this appendix, times the difference between an asset value update factor and an obsolescence factor. Assets purchased prior to 1960 are treated as assets brought into service in 1960. A nursing facility's CAV for rate reimbursement calculation cannot exceed the "current asset value upper limit" and will not be less than the "current asset value floor."

The calculation for the return on current asset value component is:

Lesser of NF CAV or NF CAV Limit	X	Tenure Factor	=	Total NF Return on CAV		
Total NF Return on CAV	÷	NF Resident Days	=	Return on CAV Component Per Resident Days		

10.3.B.1. Asset Value Update Factor

The asset value update factor used to calculate CAV depends on the type of capital asset. Land improvements, buildings, building improvements, and fixed building equipment are updated, using the Marshall Valuation Service Construction Cost Index for Class A Buildings in the Central United States, from the fiscal year the asset was brought into service until the most recent period for which cost report data is available for the respective rate year calculation. The asset value update factor is not applied to land and other assets not specifically listed above.

10.3.B.2. Asset Value Obsolescence Factor

The obsolescence factor is applied based on the classification category of the capital asset. Land has an obsolescence factor of zero. Land improvements, buildings, building improvements, and fixed building equipment have an obsolescence factor of .03 for each year the asset has been in service. Movable equipment and other capital assets have an obsolescence factor of .10 for each year the asset has been in service up to a maximum of 10 years. The number of years that the asset has been in service is determined by subtracting the year the asset was put into service from the most recent fiscal year for which data is available under the standard rate setting timeframe.

10.3.B.3. Current Asset Value Formula

A nursing facility's CAV is determined by a formula using historical costs of capital assets. The current asset value for each asset is the historical cost of that asset times the difference between its Asset Value Update Factor and its Asset Value Obsolescence Factor. Assets purchased prior to 1960 are recorded as assets brought into service in 1960. Current asset values are updated annually based on the most recent audited or reviewed cost report. A nursing facility's current asset value is the sum of current asset values for the various asset types.

Example: Building assets with historical cost of $100,000 in service for 10 years through the cost report year used in the rate calculation; the update factor for the 10 years is 1.50; the obsolescence factor is .30 (10 years times .03); the amount included in the CAV compilation for the nursing facility for these assets is $120,000 [$100,000 times (1.50 minus .30)].

If the nursing facility Plant Cost Component is calculated based on Plant Cost Certification data, the new capital assets acquired in the current cost report year and the immediate prior cost report year will be included in the nursing facility historical asset costs for compiling the CAV. The update factor for these assets will be 1.0, and the obsolescence factor will be zero.

10.3.B.4. Nursing Facility Current Asset Value

The current asset value calculation process determines the CAV for the entire nursing facility since capital assets are used for all types of service delivery in that facility. Only the portion of the nursing facility assets having a use related to routine nursing resident care are included for reimbursement under the return on current asset value component. The reference to Nursing Facility CAV is defined as the nursing unit portion of the nursing facility's total current asset value applicable to routine nursing care. The apportionment, expressed as a percentage, of a total facility that is applicable to the routine nursing care unit is determined by means of the facility's annual cost report. The SMA cost reporting process apportions the nursing facility asset costs into the appropriate cost centers for reimbursement purposes.

The Nursing Facility CAV is calculated as:

Total CAV for the NF	x	Percentage representing the nursing unit apportionment	=	NF CAV

10.3.B.5. Class I Nursing Facility Current Asset Value Limit Per Bed

The current asset value upper limit is a maximum per bed dollar amount that will be used for calculating the individual Nursing Facility CAV. The per bed value of the upper limit is based on the historical costs of construction and other asset acquisition costs for nursing facilities opened on or after January 1, 1975. The historical costs are updated through

1983 using the U.S. Department of Commerce Composite Construction Index, and annual updates after 1983 are made using the Marshall Valuation Service Construction Cost Index for Class A Buildings. The update index does not apply an obsolescence factor. The current asset value limit is the sum of the updated historical costs for the facilities included in this calculation divided by the total number of beds in those facilities. The current asset value limit is recalculated annually to include construction costs of new facilities reported on the most recent calendar year filed cost report and the construction index update. The per bed upper limit is effective for the time period corresponding to the State rate year.

The current asset value floor is 30 percent of the current asset value upper limit.

Class I nursing facility current asset value limits per bed for each rate year are available on the MDCH website. Refer to the Directory Appendix for website information.

10.3.B.6. NURSING FACILITY CURRENT ASSET VALUE LIMIT

A current asset value limit is determined by the individual nursing facility and is dependent on the number of beds in the Medicaid nursing unit for the time period corresponding with the respective rate effective date. The current asset value upper limit is a maximum dollar amount for the individual Nursing Facility CAV that will be used for calculating the return on current asset value. The Nursing Facility CAV Limit is the number of available beds in the nursing unit times the Class Current Asset Value Limit Per Bed.

The current asset value floor limit is a minimum dollar amount for CAV that will be used for calculating the return on current asset value for that nursing facility. The individual Nursing Facility CAV floor is the Nursing Facility CAV Limit times 30 percent.

10.3.B.7. TENURE FACTOR

The tenure factor is dependent on the nursing facility provider's number of full years of continued licensure as of the beginning of the Medicaid rate year, i.e., months of continuous licensure divided by 12 and ignoring fractions.

Continued licensure is based on the number of full years that have elapsed from the effective date of a nursing facility provider's license (issued by the State Survey Agency) to the beginning of the Medicaid rate year. For example, a provider that has been licensed for 42 continuous months has, for purposes of the tenure factor, been licensed for three full years. The provider's years of ownership are translated into a tenure rate, and applicable rates are identified in the following table.

Years of Ownership at Start of Provider Fiscal Year	Rate of Return on Current Asset Value
0-1	.0250
2	.0275
3	.0300

Years of Ownership at Start of Provider Fiscal Year	Rate of Return on Current Asset Value
4	.0325
5	.0350
6	.0375
7	.0400
8	.0425
9	.0450
10	.0475
11	.0500
12 or more	.0525

The rate of return on current asset value is expressed as an annual return rate. Qualification for the total return rate requires that the time period included in the nursing facility cost report used as the basis for the facility plant cost rate include twelve calendar months. In cases where the nursing facility cost report does not include twelve calendar months, the following formula is used to calculate the return rate:

Number of calendar days in the cost report period	÷	365	X	Rate of return on CAV (for the respective years of ownership)	=	Return Rate

Example: A nursing facility has seven years of ownership and the cost report period used for plant costs in the rate calculation is for a nine-month time period (275 days). The adjusted return rate is .030 (275/365 times .0400).

If a nursing facility is sold or totally replaced (regardless of facility ownership), years of ownership return to zero. If a facility is remodeled or expanded and facility ownership remains unchanged, the years of ownership remain continuous.

When licensure has changed but there has been no effective change in operator/provider, and there has been no transaction that would affect Medicaid reimbursement other than the tenure factor, the provider may request that Medicaid recognize the continuous tenure such that the licensure tenure schedule would not revert to zero years at the time of the licensure change. The provider's written request must be submitted at the time licensure is changed.

Exception: Where licensure does not change after a sale of nursing facility assets, the nursing facility provider (new owner) must choose either to retain the original licensure tenure schedule and forego increased reimbursement for interest expense, or to receive increased reimbursement for interest expense, subject to the DEFRA Reimbursement Limit, and allow the licensure tenure schedule to revert to zero years and a tenure factor

of .0250. Should the provider elect to retain the previous licensure tenure schedule, Medicaid will not recognize, for allowable cost and per diem rate determination purposes, any interest expense beyond the schedule of borrowings, principal amortization, and interest expenses that would have been incurred were the former owner's loans maintained or assumed by the new owner. This provision applies to all property transactions between lessors, lessees, and/or operators.

10.4 Plant Cost Component Class III Nursing Facilities

The prospectively established plant cost component for each county medical care facility provider and hospital long term care unit provider is the lesser of the allowable per resident day facility plant cost or the per resident day facility plant cost limit. Proprietary providers are permitted to retain, as part of the plant cost component, up to $.50 of the difference between allowable per resident day plant costs and the per resident day plant costs in effect on March 31, 1985 ($5.66 per resident day).

10.4.A. Facility Plant Cost Per Resident Day

The allowable per resident day plant cost is the sum of depreciation expense, interest expense, property taxes, and allowable lease costs divided by total resident days as determined from the provider's cost report. A facility with a change in facility asset costs may qualify for plant cost limit updates.

10.4.B. Facility Plant Cost Limit Per Resident Day

The individual provider facility Plant Cost Limit is dependent upon when facility beds were constructed and brought into service for Medicaid residents. Nursing facilities existing prior to July 1, 1978 were initially assigned the facility Class Plant Cost Limit for new construction as of that date. A nursing facility constructed after that date is initially assigned the facility Class Plant Cost Limit effective in the year facility beds are constructed and brought into service for Medicaid.

A facility's Plant Cost Limit, expressed as per resident day, is the sum of the per resident day component limits for depreciation expense, interest expense, financing fees and property taxes. The individual nursing facility Plant Cost Limit is updated for a nursing facility that undergoes a significant change in facility asset costs. The nursing facility must complete the Plant Cost Certification process to qualify for consideration of the update to the individual facility Plant Cost Limit. The provider must meet the qualifying provisions for Plant Cost Certification eligibility, other than non-available bed designation or returning non-available beds to service, to be eligible for a revised plant cost limit. The non-available bed plan designation criteria does not qualify the nursing facility for an update to the facility plant cost limit. An existing provider with a change of facility class, major addition, renovation or new construction may be eligible for a Plant Cost Limit update to reflect the change in facility asset costs. An existing facility that chooses to become a Medicaid-participating provider may also qualify for an updated plant cost limit.

The updated plant cost limit is applicable to a nursing facility dependent upon the facility's capital asset project. A nursing facility that is a total new construction, a facility that incurs major capital asset renovation and/or addition, a facility newly participating in the Medicaid program, or a facility that experiences a change in facility class are eligible

for updated depreciation, interest, finance fees and property tax components for the facility Plant Cost Limit. The update in the limit is based on a compilation of the facility limit prior to the capital asset change and the Class Plant Cost Limit.

The individual facility updated Plant Cost Limit effective with the completion of the capital asset project is a weighted average of the historic individual facility Plant Cost Limit for the portion of the facility prior to the new construction and the current Class Plant Cost Limit applicable to the new capital asset project. The weighting factors used are the respective ratios of the allowable historic asset costs of the facility prior to the new construction, and the allowable asset costs of the new construction, to the combined allowable old and new asset costs of the nursing facility after construction. The current Class Plant Cost Limit used in the weighted calculation applicable to the new capital cost portion will be the class limit in effect for the year corresponding to the new asset acquisitions being placed into service.

Nursing facility providers that incur a capital asset change resulting from a facility sale of assets will use, as a plant cost basis, only those allowable costs identified in the Allowable and Non-Allowable Costs section in this appendix. The individual nursing facility updated Plant Cost Limit after the sale is only eligible for an update for the interest expense component limit to reflect changes in interest rates.

10.4.C. Facility Class Plant Cost Limit Per Resident Day

The Class Plant Cost Limit is the maximum reimbursement rate, expressed as per resident day amount, for a nursing facility's new construction. The Class Plant Cost Limit is applicable to new construction nursing facilities dependent upon when facility beds were constructed and brought into service for Medicaid residents. The Class Plant Cost Limit is the sum of the per resident day component limits for depreciation expense, interest expense, financing fees and property taxes. The Class Plant Cost Limit components are updated annually to reflect changes in industry construction cost, interest rates and corresponding effect on financing fees and real estate taxes due to changes in capital costs. The new construction limit is used in determining the individual nursing facility limit in cases where the nursing facility is an entire new construction or an existing nursing facility has completed a significant capital improvement.

The per resident day Class Plant Cost Limit is the amount that would be paid for a recently constructed and prudently financed facility. Calculation of the plant cost limit is based on a survey of nursing facilities constructed between January 1, 1975 and December 31, 1977, and initially updated to June 30, 1978. The original Class Plant Cost limit individual components are updated annually using published economic indicators identified in the subsections addressing the specific component of the limit. The Class Plant Cost Limit annual updates are available on the MDCH website. (Refer to the Directory Appendix for website information.)

10.4.C.1. Facility Class Plant Cost Limit Depreciation Expense Component

The value for the depreciation expense component is a sum based on the mean of the surveyed values of depreciable assets (referenced above) and the mean depreciation rate for assets of similar type using straight-line depreciation with useful lives determined in accordance with Medicare Principles of Reimbursement. The per resident day depreciation expense component is updated each calendar quarter to reflect the change in costs of construction and changes in standards and regulations which have a direct impact on plant costs. The depreciation component is updated using the economic index release as published under U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts Tables for Nonresidential Structures.

10.4.C.2. Facility Class Plant Cost Limit Interest Expense Component

The value for interest expense is based on the surveyed mean of interest rates paid (referenced above) and the mean asset values for facilities constructed during the initial three-year survey time period. The per resident day interest component is updated annually based on the changes in interest rates. The interest rate data used to calculate the interest component limit is updated by applying an index of change in interest rates for home mortgage loans (reflected in conventional new home mortgage rates, as published by the Federal Housing Finance Board for Newly Built Homes) to the interest rate used to calculate the original interest component limit.

A nursing facility that undergoes a change of ownership is eligible for an update to the individual facility Plant Cost Limit. The update will only include an adjustment to the interest component of the individual facility Plant Cost Limit in effect prior to the sale. The adjustment will be made to the interest component of that prior limit to reflect the change in the interest rate index between the time period reflected in the prior limit calculation and the date of the facility sale.

10.4.C.3. Facility Class Plant Cost Limit Financing Fees Component

The value for financing fees is based on the mean of financing fees of the surveyed construction (referenced above). The per resident day financing fees component limit is updated using the same update factor used for the depreciation expense component limit update. The update factor is applied to the original financing fees component limit.

10.4.C.4. Facility Class Plant Cost Limit Tax Expense Component

The value for property taxes is based on the mean of property taxes of the surveyed taxable properties (referenced above). The per resident day property tax component limit is updated using the same update factor used for the depreciation expense component limit update. The update factor is applied to the original property tax component limit.

10.5 Variable Cost Component (VCC) – Class I and Class III Facilities

The variable cost component of the nursing facility per resident day rate reflects the Medicaid determination for reimbursement for the nursing facility base and support costs incurred for routine nursing care. Base and support cost classifications are discussed in detail in the Cost Classifications and Cost Finding subsection of this appendix. The calculation of the component uses nursing facility historical costs and economic index application to adjust cost levels to coincide with the State rate year time periods. The support costs and total variable (base plus support) costs are separately subjected to rate ceiling reimbursement limits dependent on individual facility bed size and facility class.

For Class I and Class III nursing facility rate setting periods beginning on or after October 1, 2003, the Variable Cost Component is a per resident day rate and is equal to the lesser of the facility's Variable Rate Base (VRB) or the Class Variable Cost Limit (VCL), plus the Economic Inflationary Update (EIU).

VCC = (lesser of VRB or Class VCL) + EIU

10.5.A. Variable Rate Base (VRB)

The facility Variable Rate Base is the sum of the facility's indexed base cost component and the facility's indexed support cost component. For rate setting purposes, the per resident day amount used for the provider's Variable Rate Base is the lesser of the calculated Variable Rate Base or the Class Variable Cost Limit.

VRB = Base Cost Component + Support Cost Component

10.5.A.1. Base Cost Component (BCC)

A facility's BCC is the facility per patient day allowable base costs indexed to October 1 of the year that is one year prior to the rate year being calculated.

BCC = (base costs/total number of resident days) X Cost Index

- Facility's base cost per day - the facility base costs divided by the total number of resident days for the cost reporting period.

10.5.A.2. Support Cost Component (SCC)

A facility's support cost component is the facility's BCC multiplied by the lesser of the facility's support-to-base ratio or the support-to-base ratio limit for that nursing facility bed-size group.

SCC = BCC X applicable S/B ratio (Facility or Bed-Size Group Limit)

- Facility's support cost per day - the facility support costs divided by the total number of resident days for the cost reporting period.
- Facility Support-to-Base Ratio (S/B-Facility) - the nursing facility's allowable support costs divided by the allowable base costs for the cost reporting period. The individual provider's S/B ratio for rate calculation is limited to the Support-to-Base Ratio Bed Size Group Limit for the provider's bed-size group. The individual nursing facility bed-size

group classification is based on the number of nursing home licensed beds, Home for the Aged beds, or any other type of licensed beds where nursing care is provided. The provider's S/B ratio is rebased annually from the most recent audited cost period, regardless of ownership.

- Support-to-Base Ratio – Bed Size Group Limit (S/B-Group) – the 80th percentile of the support-to-base ratios for nursing facilities in the same bed-size group for a cost reporting year. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the nursing facility. The nursing facility bed-size group classification is based on the number of nursing home licensed beds, Home for the Aged beds, or any other type of licensed beds where nursing care is provided. The 80th percentile is determined by rank ordering the provider nursing facilities within the same bed-size group from the lowest to highest S/B ratio, then accumulating nursing facility Medicaid resident days of the rank ordered providers, beginning with the lowest, until 80 percent of the total Medicaid resident days for this group of providers is reached. The S/B ratio limit for the bed-size group equals the support-to-base ratio of the nursing facility in which the 80th percentile of accumulated Medicaid days occurs.

10.5.B. Cost Index (CI)

A facility cost index is the Global Insight's Skilled Nursing Facility Market Basket without Capital Index, which is published quarterly in the Global Insight DRI-WEFA Health Care Cost Review. The cost index will be used to index reported costs from the end of the facility's cost report period to October 1 of the year that is one year prior to the rate year being calculated.

Example: Cost report data used to set reimbursement rates for the October 1, 2003 to September 30, 2004 rate year will be indexed to October 1, 2002.

10.5.C. Class Average Variable Costs (AVC)

The Class Average Variable Cost is defined as the total indexed variable costs for all facilities in the Class divided by the total resident days for all facilities in the class for a cost reporting year. An AVC is calculated for Class I and Class III nursing facilities. The Class AVC is used for rate calculations for nursing facilities that meet the qualifying criteria as a new provider for Medicaid participation and determining provider eligibility for Class I nursing facility rate relief.

AVC = (total Indexed Variable Costs for all NF's in the class)/
(total resident days for all NF's in the class)

- Facility's Variable Costs (VC) - the total allowable base and support costs for a facility to provide routine nursing care services to residents, as determined in accordance with Medicaid allowable costs and reporting requirements.
- Indexed Variable Costs (IVC) – the facility's total VC indexed to October 1 of the year that is one year prior to the rate year being calculated.

Example: The AVC for October 1, 2003, which is used for the rate year October 1, 2003 to September 30, 2004, is based on variable costs reported in cost reports ending in calendar year 2002 indexed to October 1, 2002.

10.5.D. Class Variable Cost Limit (VCL)

The Variable Cost Limit for a class of nursing facilities is set at the 80th percentile of the Indexed Variable Costs (IVC) per resident day for facilities in the class during the current calendar year. The 80th percentile is determined by rank ordering providers from the lowest to the highest IVC per resident day, then accumulating nursing facility Medicaid resident days of the rank ordered providers, beginning with the lowest, until 80 percent of the total Medicaid resident days for the facility class of providers is reached. The VCL for the class of providers equals the IVC per resident day of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs. A VCL is calculated for Class I and Class III nursing facilities.

- Facility's Variable Cost per resident day (VC/pd) - the facility VC divided by the total number of resident days for the cost reporting period.
- Indexed Variable Costs Per Resident Day (IVC/pd) – the facility's VC/pd indexed to October 1 of the year that is one year prior to the rate year being calculated.

Example: The VCL for October 1, 2003, which is used for the rate year October 1, 2003 to September 30, 2004, is based on variable costs per resident day reported in cost reports ending in calendar year 2002 indexed to October 1, 2002.

10.5.D.1. Class I Nursing Facility VCL Exception - New Provider Rate Relief

A Class I nursing facility that qualifies for rate relief as a new provider, as defined for rate relief, in a Medicaid enrolled nursing facility with a VRB less than or equal to 80 percent of the class AVC will have an exception VCL in the rebasing rate year. The rate Variable Cost Component for the initial rate year of accelerated rebasing is limited to the Class I Average of Variable Costs. Refer to the Rate Relief for Class I Nursing Facilities subsection in this appendix for additional information.

10.5.D.2. Class III Nursing Facility VCL Exception – New Hospital Long Term Care Units After July 1, 1990

Class III nursing facilities that are new long term care units of a hospital, and have a Certificate of Need (CON) approval from the Michigan Department of Community Health (MDCH, formerly Department of Public Health) dated on or after July 1, 1990, are reimbursed according to the method for Class III facilities except that the facility Variable Cost Component is determined as the lesser of the facility Variable Rate Base or the Class I Variable Cost Limit (VCL).

10.5.E. Economic Inflationary Update (EIU)

The economic inflationary update for a facility is the Economic Inflation Rate (EIR) for the class applied to the lesser of the Variable Rate Base or the Class Variable Cost Limit.

EIU = EIR X (lesser of VRB or Class VCL)

Economic Inflation Rate (EIR) - the State legislative appropriations process will determine the annual economic inflation percentage for Class I and Class III nursing facilities.

10.6 Class V Nursing Facilities – Ventilator Dependent Care (VDC) Units

The reimbursement rate for special nursing facilities caring for ventilator-dependent residents (Class V) is set prospectively as an individual nursing unit rate per resident day determined by Medicaid.

Reimbursement is made for prior authorized ventilator-dependent services/care for residents who have been transferred to a Medicaid contracted facility. The prospective rate covers all ventilator care requirements of the residents, including all the costs of benefits associated with Medicare Parts A and B while the resident resides in the special nursing facility. This includes, but is not limited to, all routine, ancillary, physician, and other services.

Factors used in the determination of the per diem rate include audited costs of facilities providing similar services, the inflationary factor for the effective period of the prospective rate, the supply response of providers, and the number of residents for whom beds are needed. The prospective rate does not exceed 85 percent, nor fall below 15 percent, of an estimated average inpatient hospital rate for currently placed acute care Medicaid residents who are ventilator-dependent. The prospective rate is periodically re-evaluated to ensure reasonableness of supply and demand for special care. A new VDC nursing unit that has not previously participated in Medicaid for VDC services will have a reimbursement rate in the initial two years of operations based upon the statewide average VDC unit reimbursement rate for the current year.

10.7 Nursing Facility Quality Assurance Assessment Program (QAAP)

The Quality Assurance Assessment Program (QAAP) was implemented by Medicaid in compliance with Michigan law. The QAAP provides a Quality Assurance Supplement to nursing facility reimbursement rates incorporating funds from the quality assurance assessment tax. The QAAP applies to Class I, Class III Non-Publicly Owned, and Class V nursing facilities.

10.7.A. Class I Nursing Facilities and Class III Non-Publicly-Owned Hospital Long-Term Care Units

The nursing facility will receive a QAAP payment as a monthly gross adjustment. The monthly gross adjustment for an individual nursing facility will be determined based on one-twelfth of the facility's annual historical Medicaid utilization (resident days) multiplied by the facility's Quality Assurance Supplement (QAS) per resident day. The facility's historical Medicaid utilization will include all routine nursing care and therapeutic leave days billed to Medicaid by the facility. A nursing facility that is experiencing a significant increase or decrease in its current rate year Medicaid utilization which will cause a difference of greater than five percent in the nursing facility's total QAS payments for the

year must contact the SMA for consideration of adjustment to the facility's monthly QAS payment. Current year Medicaid resident census data must be provided to MDCH to document the change in order to revise the monthly QAS payment amounts. It is the desired intent of MDCH to assure accuracy of total QAS monthly payments and to approximate the annual reimbursement due the facility. MDCH reserves the right to adjust the individual nursing facility monthly QAS payment to reflect the current year Medicaid activity to achieve this goal.

A facility's QAS is equal to the lesser of the facility's Variable Rate Base or Variable Cost Limit times the Quality Assurance Assessment Factor (QAAF) determined by MDCH. A provider's QAS will be reconciled at the end of the fiscal year to accommodate the actual Medicaid utilization, changes to the variable rate from filed to audited cost report data, and to adjust the increase initially estimated to accommodate the fixed pool of funds established by the QAAP and any legislative offsets to that pool.

The QAAF is determined based on the estimated pool of funds created by the quality assurance assessment tax and the projected number of Medicaid nursing facility days for the fiscal year. In aggregate, the quality assurance assessment fee may not exceed six percent of total industry revenue for the fiscal year.

It is the Department's intention that nursing facilities that provide hospice care for residents by contracting with a hospice provider also benefit from this quality program. Medicaid will reimburse hospice providers 100 percent of a nursing facility's Quality Assurance Supplement (QAS) rate add-on for Medicaid beneficiaries provided hospice care in Medicaid participating nursing facilities. It is the responsibility of the hospice provider to pay the room and board rate to the nursing facility as specified in their contract for services.

10.7.B. Class V Nursing Facilities - Ventilator Dependent Care (VDC) Units

Qualifying VDC units will receive a QAAP payment as a monthly gross adjustment. The monthly gross adjustment for an individual unit will be determined based on one-twelfth of the VDC unit's annual historical Medicaid utilization (resident days) multiplied by the unit's Quality Assurance Supplement (QAS) per resident day basis. The unit's Medicaid utilization will include all days billed to Medicaid by the VDC unit. A nursing unit that is experiencing a significant increase or decrease in its current rate year Medicaid utilization which will cause a difference of greater than five percent in the nursing unit's total QAS payments for the year must contact MDCH for consideration of adjustment to the unit's monthly QAS payment. Current year Medicaid resident census data must be provided to the SMA to document the change in order to make revision to the monthly QAS payment amounts. It is the desired intent of MDCH to assure accuracy of total QAS monthly payments to approximate the annual reimbursement due the VDC unit. MDCH reserves the right to adjust the individual VDC unit monthly QAS payment to reflect the current year Medicaid activity to achieve this goal.

The VDC unit QAS is equal to the Class I Variable Cost Limit times the Quality Assurance Assessment Factor (QAAF) determined by MDCH. A provider's QAS will be reconciled at the end of the fiscal year to accommodate the actual Medicaid utilization and to adjust

the total increase initially estimated to accommodate the fixed pool of funds established by the QAAP and any legislative offsets to that pool.

The QAAF is determined based on the estimated pool of funds created by collection of the quality assurance assessment tax and the projected number of Medicaid nursing facility days for the fiscal year. In aggregate, the quality assurance assessment tax may not exceed six percent of total industry revenue for the fiscal year.

10.8 Class II Nursing Facilities – Proprietary Nursing Facility for the Mentally Ill or Mentally Retarded

The Class II proprietary nursing facilities for the mentally ill or mentally retarded are reimbursed an all-inclusive prospective payment rate negotiated with the MDCH State Mental Health Agency on an annual basis. Rate ceiling limits are prospectively set for allowable costs and resident occupancy for determining final reimbursement for the annual services. Final reimbursement is retrospective cost settlement, not to exceed the ceiling limit. Nursing facility allowable costs included for reimbursement are determined in accordance with Medicaid cost reporting requirements and allowable and non-allowable cost policies, including plant cost based on allowable depreciation expense. The provider is paid a reimbursement efficiency allowance equal to the lesser of $2.50 per resident day or the difference between the prospective ceiling limit and the nursing facility actual allowable cost.

10.9 Class IV Nursing Facilities – Institutions for the Developmentally Disabled

State-owned and -operated institutions, Intermediate Care Facilities for the Mentally Retarded (Developmentally Disabled – ICF/MR), and non-profit nursing facilities for the mentally retarded are retrospectively cost settled.

The State Mental Health Agency must submit rate information regarding the facility's expected costs for the prospective year in an Interim Rate Request letter to Medicaid at the beginning of the Medicaid rate year. Subsequent requests may be submitted during the rate year if rate adjustments are necessary. The reimbursement rate for the new Medicaid rate year will not be updated until the State Mental Health Agency submits the Interim Rate Request letter.

The provider is reimbursed an interim per diem rate based on the cost information submitted. The interim reimbursement is adjusted to actual allowable costs through annual cost settlement. Refer to the Cost Reporting and the Rate Setting sections of this appendix for additional information.

10.10 Class VI Nursing Facilities – Hospital Swing Beds

The reimbursement rate for hospital Swing Beds (Class VI) is set prospectively as a flat per diem rate determined by Medicaid.

The current calendar year per resident day rate is the weighted statewide average routine nursing care per diem rate for the previous calendar year. The average routine nursing care per diem rate is calculated by dividing the sum of Medicaid amount approved for payment for routine nursing care in Class I and Class III facilities by the sum of nursing care days paid in these facilities for the respective time period. The reimbursement rate calculation does not include Quality Assurance Supplement (QAS) reimbursement.

10.11 ADD-ONS

Add-ons are items that provide reimbursement to a provider for costs that are not previously included in the provider's variable cost component.

10.11.A. Special Dietary

The Coverages portion of this chapter, Dietary Services and Food section provides for program reimbursement to non-profit nursing facilities for special dietary needs for religious reasons. Interim payment reimbursement to the nursing facility will be made by inclusion of a per diem rate add-on amount to the nursing facility routine nursing care rate. The total special dietary add-on reimbursement to the nursing facility during the reimbursement year will be adjusted through the annual cost report reimbursement settlement. Refer to the Cost Report Reimbursement Settlement section of this appendix for additional information.

A qualifying nursing facility that has previous year cost history of special dietary costs will have the interim payment rate add-on based on special dietary cost center allocated cost and nursing facility resident census data determined in the nursing facility cost report. The most recent annual filed or audited cost report that is used for determining the nursing facility current routine nursing care rate will be the source of the cost data for the current interim rate add-on.

A qualifying nursing facility that does not have previous year cost history of special dietary costs will have an interim reimbursement rate add-on based on estimated cost data. The nursing facility must submit a written request identifying the estimated costs to be incurred in food purchase and preparation associated with special dietary needs for religious reasons. The request must be submitted to the RARSS and must include a certification statement attesting to the accuracy of the data and signed by the nursing facility authorized representative. (Refer to the Directory Appendix for contact information.) The written request must present the following data for the current cost report year:

- Estimated resident days (not less than 85% occupancy rate for all nursing facility resident units)
- Estimated raw food purchase costs, including a detailed listing of the types of food to be purchased for special dietary needs for religious reasons.
- Estimated cost for supplies, tableware, cooking utensils, etc. for food preparation and service associated with special dietary needs for religious reasons.

The submitted data will be subject to review and adjustment by Medicaid for consideration and calculation of the interim rate and the add-on reimbursement rate to the facility. The submitted data will be utilized for interim rate determination until annual cost reporting data has been filed and accepted by Medicaid.

10.11.B. Nurse Aide Training and Competency Evaluation Program (NATCEP) Add-on

Certification, Survey & Enforcement Appendix, Staff Certification section provides for nursing facility Medicaid reimbursement for Medicaid's share of costs incurred by the

nursing facility for approved Nursing Aide Training and Competency Evaluation Program (NATCEP) expenditures. Interim payment reimbursement to the nursing facility will be made by inclusion of a per diem rate add-on amount to the nursing facility routine nursing care rate. The total NATCEP add-on reimbursement paid to the nursing facility during the nursing facility's cost report reimbursement year will be adjusted through the annual cost report reimbursement settlement. Refer to the Cost Classifications and Cost Finding section and Cost Report Reimbursement Settlement section of this appendix for additional information.

The interim rate add-on amount is limited to a maximum per diem of $0.80 per resident day; however, the nursing facility cost reimbursement settlement for these training costs is not subject to a per diem limit. The interim payment rate add-on will reflect the nursing facility's prior year cost history of NATCEP costs utilizing the NATCEP cost center allocated cost and nursing facility resident census data determined in the nursing facility cost report. The most recent annual filed or audited cost report that is used for determining the nursing facility current routine nursing care rate is the source of the cost data for the current interim rate add-on, except where a more recent interim reimbursement request has been submitted by the nursing facility.

Effective October 2005, the interim rate add-on amount limit is increased to $1.00 per resident day.

A nursing facility that is notified by the State Survey Agency of loss of NATCEP or CEP, has been placed on NATCEP lockout status, or has a NATCEP withdrawal of program approval will be notified by Medicaid that its interim reimbursement NATCEP add-on amount will be deleted from the reimbursement rate. The nursing facility must submit a completed interim reimbursement request identifying expected NATCEP allowable costs, in accordance with policy provisions referenced above, for consideration of an interim reimbursement add-on amount for allowable NATCEP costs incurred during the lockout period.

A nursing facility is eligible to submit an interim reimbursement request for a change in the interim payment rate add-on amount in the following situations:

- The nursing facility is experiencing a change in its current year NATCEP cost level that would cause a per diem increase or decrease in excess of $.25 per day in the current period reimbursement rate add-on.
- The nursing facility does not have previous year cost history of NATCEP cost.
- The nursing facility has been identified a lockout facility for NATCEP or CEP, or has loss of approval of its NATCEP, and has made acceptable arrangements for securing approved nurse aide training for nursing facility staff.

The nursing facility must submit a completed Nurse Aide Training and Testing Program Interim Reimbursement Request (form MSA-1324) identifying the estimated costs to be incurred in providing approved NATCEP training for the nursing facility staff and projected resident census data. The request must be submitted to RARSS and must include the signed certification statement attesting to the accuracy of the data and signed by the nursing facility authorized representative. (Refer to the Directory Appendix

for contact information.) Electronic copies of the request form and completion instructions can be accessed on the MDCH website. (Refer to the Directory Appendix for website information.)

The submitted data is subject to review and adjustment by Medicaid for consideration and calculation of the interim rate add-on payment to the facility. Medicaid will issue the provider a rate notice indicating the accepted cost level for interim rate determination, or a request denial and reason for such action. The submitted data will be utilized for interim rate determination until annual cost reporting data has been filed and accepted by Medicaid.

10.12 Special Circumstances – Rate Determination

10.12.A. New Facility and Provider

A new facility is a provider operating a nursing facility where there is not Medicaid historical cost. Examples include:

- A newly constructed facility.
- An existing facility that has never before participated in Medicaid.
- A facility that has participated in Medicaid in a different provider class.
- An existing nursing facility that has not provided nursing care for Medicaid beneficiaries or billed Medicaid in the past two years (24 months).

10.12.A.1. New Provider Nursing Facility Per Resident Day Plant Cost

A new provider in the Medicaid program is eligible for the Plant Cost Certification process to reflect the facility asset costs and related plant costs. The Plant Cost Certification data submission will be used for calculation of the nursing facility Plant Cost Component as outlined in the policy for the respective nursing facility class. Refer to the Plant Cost Certification section of this appendix for additional information.

10.12.A.2. New Provider Nursing Facility Variable Cost Component

The Variable Rate Base for the new facility and provider will be determined using special methods. During the first two cost reporting periods, new facilities and facilities with a change of class will have a Variable Rate Base equal to the Class Average of Variable Costs. This rate base will be used in the calculation of the nursing facility Variable Cost Component as outlined in the policy for the respective nursing class. In subsequent periods, the nursing facility's Variable Rate Base will be determined using the methods described in "Variable Cost Component" subsection of this appendix.

A new provider that purchases an existing facility participating in the Medicaid program or a provider with an existing, participating facility that makes major additions, renovations, or new construction does not qualify for these special methods because there are historical variable costs on which to base rates. The Variable Rate Base will be

determined in accordance with Medicaid policy identified in applicable subsections of this appendix.

10.12.B. Memorandums of Understanding (MOU) – Special Agreements for Complex Care

The Coverages portion of this chapter, Memorandums of Understanding (MOU) – Special Agreements for Complex Care section provides for program reimbursement for nursing facilities for providing specialized care beyond services covered by the usual Medicaid per diem rate. The payment rate for specially placed residents is a negotiated prospective rate per resident day. The rate is determined for a specified period of time, not to exceed 90 calendar days without review.

Reimbursement is made for prior authorized services/care to residents who have specialized and concentrated nursing and support service needs and who have been transferred from an acute care hospital setting to an approved skilled nursing facility. The negotiated rate provides reimbursement adequate to meet the unusual needs of this type of resident in a less costly and more appropriate environment than an acute care hospital setting.

Factors used in Medicaid's negotiation of the per resident day prospective rate include, but are not limited to, complexity, type of equipment and supplies required, the resident's condition, and the market place availability of placement. Any authorized increase in the per diem rate represents only the cost of the service. The negotiated prospective rate is re-evaluated, in consideration of the resident's needs, prior to the last day of the approval period.

10.12.C. Hospice-Owned/-Operated Nursing Facility

The Hospice Services section in the Coverages portion of this chapter outlines the program policy regarding nursing facility beneficiaries eligible for hospice care services and reimbursement to the hospice care provider for room and board for beneficiaries in Medicaid or Medicaid/Medicare certified beds. The individual nursing facility per diem rate is determined in accordance with program policy outlined in this appendix, if the nursing facility operation is not a hospice-owned/-operated licensed nursing facility.

Reimbursement for daily room and board for hospice beneficiaries in a hospice-owned/-operated licensed nursing facility is also available to the hospice care provider. The program does not require annual cost reporting and does not determine individual nursing facility per diem rates for the hospice-owned/-operated licensed nursing facility due to the unique licensure requirements applicable to these nursing facilities. The program utilizes alternative cost data elements to calculate a nursing facility per diem rate that is specifically applicable to hospice-owned/-operated licensed nursing facilities. This per diem rate determination is the basis for setting the hospice-owned nursing facility rate used for reimbursing the room and board services that will be billed to the program by the hospice provider for hospice beneficiaries cared for in its licensed nursing facility. The hospice provider will be responsible for billing the room and board services and will be reimbursed 95 percent of this "hospice nursing facility" rate.

The hospice-owned nursing facility rate is made up of four components: plant cost component, variable cost component, economic inflationary update and quality assurance supplement. The rate calculation method for the hospice-owned nursing facility rate will be in accordance with the rate determination process established for Class I nursing facility. Alternative data will be utilized for the cost data elements normally applicable to the specific nursing facility. The data elements for the rate calculation will be:

- **Plant costs**

  Nursing Facility Current Asset Value (CAV) – Class I nursing facility CAV upper bed limit for the respective rate year time period

  Nursing Facility Tenure Factor – equal to 12 years for a rate of return on CAV (.0525)

  Resident Days – equals 310 (represents 85% minimum occupancy level per bed)

- **Variable costs**

  Variable Rate Base (VRB) – Class I nursing facility Class Average of Variable Costs (AVC) for the respective rate year time period

- **Economic Inflation Rate (EIR)**

  Equal to legislative appropriated annual economic inflation percentage for Class I nursing facilities.

- **Quality Assurance Supplement (QAS)**

  QAS per diem amount – equal to the lesser of the variable rate base or Class I nursing facility variable cost limit times the Quality Assurance Assessment Factor (QAAF) determined by the Department for the respective rate year time period. Medicaid participating hospice-owned nursing facility providers will receive 100 percent of the nursing facility's Quality Assurance Supplement (QAS) rate add-on for Medicaid beneficiaries in their participating nursing facilities.

  Hospice-Owned/-Operated Nursing Facility rates are available on the MDCH website. (Refer to the Directory Appendix for website information.)

10.12.D. Hospital Leave Days

The Hospital Leave Days Section in the Coverages portion of this chapter identifies the parameters for program reimbursement.

Reimbursement for a hospital leave day is a single rate paid to all nursing facility providers regardless of facility class. The rate is determined annually with an effective time period coinciding with the State fiscal year. The rate determination utilizes the Class I nursing facility Class Average Variable Cost (AVC) for the State fiscal year. The hospital leave day reimbursement rate represents a calculated salary and wage component of the room and board cost portion of the total AVC. The room and board portion is equal to 95 percent of the Class I nursing facility AVC, and the salary and wage

component is determined as 66 percent of the room and board cost. The formula for calculating the hospital leave day rate is:

AVC (Class I NF)	x	95% (room and board portion)	x	66% (salary and wage component)	=	Hospital Leave Day Rate

Hospital Leave Day rate information is available on the MDCH website. (Refer to the Directory Appendix for website information.)

10.12.E. Therapeutic Leave Day

The Therapeutic Leave Days section in the Coverages portion of this chapter identifies the parameters for program reimbursement.

The reimbursement rate for a therapeutic leave day is the nursing facility's established per diem rate in effect for the period coinciding with the leave day.

10.12.F. One-Day Stay

The One-Day Stay section of the Coverages portion of this chapter identifies the parameters for program reimbursement.

The reimbursement rate for an approved one-day stay is the nursing facility's established per diem rate in effect for the period coinciding with the stay.

10.12.G. Out of State Nursing Facility (Nonenrolled Michigan and Borderland Providers)

The General Information for Providers Chapter, Nonenrolled Michigan and Borderland Providers and Beyond Borderland Area subsections provide for reimbursement of nursing care services to out of state nursing facilities. The out of state nursing facility must comply with the provisions outlined. There is no cost reporting or reimbursement settlement activity for out of state nursing facilities.

The routine nursing care per diem rate for the out of state nursing facility is the lesser of the individual provider's home state Medicaid rate or the Michigan Medicaid out of state provider ceiling rate. The ceiling rate is effective for the time period coinciding with the State fiscal year rate period October 1 through September 30. The ceiling rate is the sum of three components: 1) Class I nursing facility Variable Cost Limit (VCL) for the corresponding rate year, 2) Economic Inflationary Update, and 3) most recent Plant Cost 80th percentile per diem amount. Out of state nursing facility rates do not participate in the Quality Assurance Assessment program.

The out of state nursing facility must submit a copy of the nursing facility's home state Medicaid program reimbursement rate to the RARSS to be assigned a reimbursement rate. (Refer to the Directory Appendix for contact information.) Out of state nursing facility rate assignments will only be effective on a prospective basis for the first day of the month following receipt of the rate request by that office. The out of state nursing facility will be issued a written notice of the rate determination action. The

reimbursement rate request and rate assignment for an individual nursing facility are limited to once per calendar quarter.

10.13 Rate Relief for Class I Nursing Facilities

Medicaid reimbursement rate relief for current and new nursing facility providers is determined on a case-by-case basis in accordance with specific criteria for evaluating eligibility for relief and rate methodology for determining the rate level. The following definitions of nursing facility providers are applied in this rate relief policy for Class I nursing facilities:

- Current provider is defined as the provider that operated the facility during the time period of the last cost report on which the normal rate setting would occur, and will operate the facility during the time period for which rate relief is requested.
- New provider is defined as a person or business entity that has purchased or is purchasing a nursing facility that had immediate prior Medicaid participation, and the new provider ownership individual(s) or business entity is not related through family or business ties to the ownership individual(s) or business entity of the previous provider. A nursing facility sale between family members may be approved by Medicaid and the new owner may be considered a new provider under certain circumstances, as outlined in the Ownership Changes and Medicaid Termination section of this appendix.

10.13.A. Eligibility Criteria

The provider must be a Class I nursing facility:

- The provider must demonstrate that the current Medicaid reimbursement (Rate + QAS) does not provide adequate funding to deliver a level of care to Medicaid beneficiaries in the facility that assures "each resident attains and maintains the highest practicable physical, mental, and psycho-social well-being" as required by the Omnibus Budget Reconciliation Act (OBRA) of 1987.
- The nursing facility Variable Rate Base amount must meet the following criteria:
  - For a Current Provider – The facility's Variable Rate Base is at or below the corresponding Class Average Variable Cost. The Average Variable Cost used for the class is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested.
  - For a New Provider in a Medicaid-enrolled nursing facility –The facility's current Variable Rate Base is at or less than 80 percent of the corresponding Class Average Variable Cost. The Average Variable Cost used for the class is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested. A new provider in a facility with a Variable Rate Base between 80 and 100 percent of the corresponding Class Average Variable Cost is eligible for accelerated rebasing and is treated as a current provider.
- A current Medicaid provider agreement for the facility is in effect. The rate relief period is applied to the facility and not the owner, provider, or licensee. A change of ownership, provider, or licensee during the rate relief period does not end the agreement for rate relief under this policy as long as the new owner, provider, or licensee fully complies with the requirements of the rate relief agreement.

- The nursing facility provider must also meet at least one of the following five criteria:
  - The sum of the provider's Variable Rate Base, Economic Inflation Update, and other associated rate add-ons (excluding Nurse Aide Training and Testing reimbursement), plus the Net Quality Assurance Supplement, must be less than the provider's audited Medicaid variable cost per resident day for each of the two years prior to the first year of rate relief. This comparison to cost is a measurement to normal reimbursement rate calculation methodology and excludes the effect of Executive Order reimbursement actions. The provider must submit a per diem cost analysis using the outlined format presented as a reference titled "Form to Establish Criteria for Nursing Facility Class I Rate Relief". The required cost analysis information is available in electronic file format on the MDCH website. (Refer to the Directory Appendix for website information.)
  - The provider is required, as a result of a survey by the State Survey Agency (SSA), to correct one or more substandard quality of care deficiencies to attain or sustain compliance with Medicaid certification requirements. The survey must have occurred within six months prior to the provider's request for rate relief. The provider must submit a copy of the citation and an approved Plan of Correction outlining the action being taken by the provider to address the requirement(s).
  - The provider has experienced a significant change in the level of care needed for current Medicaid residents in the nursing facility. Significant change is defined as an increase of ten minutes per patient day as demonstrated by MDS data. The provider must submit an analysis comparing resident acuity levels from the rate base year to current resident acuity levels. Minimum Data Set (MDS) data must be used for this comparison. The data is subject to a clinical review by Medicaid. The analysis must also include a comparison of the previous and current nurse staffing levels required and other nursing related costs or requirements likely to increase the operational costs. This does not include nursing administration staff.
  - The provider is new in a Medicaid-enrolled facility and the facility's most recent cost report submitted to Medicaid was incomplete, undocumented or had unsubstantiated cost data by the previous provider. Inadequate cost reporting includes non-payment of accrued liabilities due to the previous provider's bankruptcy as determined by Medicaid auditors or their designees in accordance with Medicaid allowable costs, or inadequate records to support the filed cost report. Proof of the change of ownership must be submitted along with an explanation of why the cost report data is inadequate to calculate the provider's reimbursement rate.
  - Rate relief is needed to prevent closure of a Medicaid-enrolled facility due to a regulatory action by the SSA, where the facility's closure would result in severe hardship for its residents and their families due to the distance to other nursing facilities, and no new provider would operate the facility at its current reimbursement rate. A facility would meet this hardship criteria only if a new owner has agreed to take over its operation and it is either the only nursing facility in the county or the facility has at least 65 percent of the Medicaid nursing facility (Class I, III and V) certified beds in that county.

10.13.B. Rate Relief Petition Process

All petitions for rate relief must be in writing and submitted to RARSS. An authorized representative from the entity that holds the nursing facility license must sign the petition.

Medicaid will make the final determination for the approval or disapproval of the rate relief request. Medicaid will provide a written response within 60 calendar days of Medicaid's receipt of the rate relief request. The response may include a request for additional information. The 60 calendar day time period does not begin until the provider has submitted all of the necessary documentation for Medicaid to evaluate the rate relief request. Once the nursing facility provider has complied with the request(s) for additional information, a written notice of the approval or disapproval is given within 30 calendar days of Medicaid's receipt of the additional information.

If Medicaid requests additional or supporting documentation needed to complete the evaluation of the rate relief request, the provider must submit the documentation within 30 calendar days of the request. If Medicaid does not receive the documentation or the provider has not received a one-time extension for 30 additional calendar days, the SMA will issue a denial notice for rate relief. Appropriate time allowances will be made in cases where the needed data is for a time period that is not yet concluded. Subsequent rate relief requests by the provider will only be effective on a prospective basis following receipt of the new requests and documentation for rate relief.

10.13.C. Rate Relief Agreement

If the rate relief petition is approved, Medicaid will prepare a rate relief agreement to be signed by the nursing facility authorized representative and an authorized representative of Medicaid. Once the agreement is approved, the provider's Medicaid rate is adjusted consistent with the relief granted. The agreement outlines the rate relief granted, the effective date and any conditions or requirements.

Requirements may include, but are not limited to,:

- Annual and interim cost reporting requirements during the period of rate relief.
- Appointment of a monitor, at facility cost, for oversight if, after consultation with staff in the SSA, such action is deemed appropriate.
- Follow-up surveys by the SSA.

10.13.D. Rate Relief Period

Rate relief is effective on a prospective basis beginning in the month after receipt of the request by RARSS. No retroactive rate relief will be approved.

Nursing facility providers may apply and receive rate relief under this policy once every seven years, i.e., 84 months. This seven-year period begins on the effective date of rate relief.

Example: If rate relief takes effect January 1, 2003, the facility would not be eligible for rate relief again until on or after January 1, 2010.

The rate relief period is based on the facility, not on the owner or licensee. A change of ownership does not void the seven-year period under this policy.

10.13.E. Withdrawal of Rate Relief Agreement

Medicaid may withdraw the rate relief agreement if the facility is cited by the SSA for serious certification violations while receiving rate relief. If the citation(s) is for serious and immediate threat or substandard quality of care, or the provider is not spending the money in accordance with the plan filed for special rate relief, the rate relief agreement may be withdrawn. Medicaid will review the nursing facility actions to determine if rate relief termination is warranted. If Medicaid terminates the agreement, the nursing facility's Medicaid rate will be recalculated in accordance with existing Medicaid reimbursement policy without rate relief. The rate change would take effect at the beginning of the month following issuance of a 30-calendar day notice to the provider.

10.13.F. Rate Relief Appeals

Nursing facility providers that receive notices of denial for rate relief or are notified that a rate relief agreement has been withdrawn may file an appeal. Appeals are handled in accordance with the existing appeals process. Additional information appears in the Appeal Process section in this appendix.

10.13.G. Rate Relief for a New Provider in a Medicaid-Enrolled Nursing Facility with a Variable Rate Base Less Than or Equal to 80 percent of the Class Average Variable Cost

A new provider in a Medicaid enrolled nursing facility with a Variable Rate Base less than or equal to 80 percent of the Class Average Variable Cost may request an increase in the current facility rate. The new provider must be operating in a facility that has previously participated with Medicaid.

10.13.G.1. Rate Relief Methodology

A new rate is calculated using the Class I Average Variable Cost for the appropriate year as the Variable Rate Base for the calculation of the facility Variable Cost Component, thereby increasing the facility per diem rate. This Variable Rate Base is in effect through the current State fiscal year rate period ending September 30.

Effective October 1 of the State fiscal year rate period starting after the new provider begins operation, the Variable Rate Base is determined using accelerated rebasing. The accelerated rebasing utilizes the new provider's first cost reporting period that reflects at least seven months of nursing facility operation. The cost reporting time period is based on the new provider's established fiscal year. The nursing facility allowable variable cost is indexed to October 1 of the year that is one year prior to the new rate year being calculated by applying the appropriate cost index. The new provider Variable Rate Base

is limited to the Class I Average Variable Cost for the corresponding rate year time period.

The new provider receiving rate relief in this category must utilize the standardized data to file a Class I Rate Relief Interim Cost Statement prior to September 15. The Interim Cost Statement excerpted worksheets from the Medicaid annual cost report (Medicaid cost reporting formats identified below) must reflect actual or expected costs incurred by the nursing facility for the new provider's first cost reporting period (as referenced above). The facility's annual cost report may be used in lieu of the Interim Cost Statement if the cost report will be filed with Medicaid prior to September 15.

The Rate Relief Interim Cost Statement must contain the following completed schedules of the cost report in the MDCH required electronic format:

- Checklist
- Worksheet A
- Worksheet B
- Worksheet 1
- Worksheet 1-C (only if claiming allocated related party costs)
- Worksheet 2

The Interim Cost Statement is used to determine the interim rate utilizing the accelerated rebasing provisions. The interim rate is revised when the acceptable annual cost report is submitted and used for accelerated rebasing.

The subsequent rate year calculation is in accordance with standard reimbursement methodology.

Example: A new nursing facility provider begins operations on January 1, 2004 and selects a September 30 year-end cost reporting period. Following request, the provider is approved for rate relief for rate year October 1, 2003 to September 30, 2004. The facility per diem rate is set using the Class I Average Variable Costs effective for the rate year beginning October 1, 2003 (effective for the new provider on January 1, 2004). The provider must complete an interim cost statement for variable costs for the period January 1, 2004 through September 30, 2004 that must be filed by September 15, 2004. Effective October 1, 2004, the Variable Rate Base is the lesser of the variable costs from the interim cost statement indexed to October 1, 2003 or the Class Average Variable Cost effective October 1, 2004. Following the filing of the annual cost report, the variable costs from the annual report are indexed to October 1, 2003, and the interim Variable Rate Base is recalculated.

Rate relief is subject to audit and settlement with reimbursement adjustment using the principles and guidelines outlined in Medicaid policy. Rate relief reimbursement cannot exceed the appropriate cost and rate limitations. The provider is reimbursed by Medicaid for any underpayment, and the provider must reimburse Medicaid for any overpayment. If the interim Variable Rate Base determined for rate relief reimbursement to the provider exceeds the audited Variable Rate Base reimbursement by more than three

percent, the provider will be assessed a penalty equal to 10 percent of the total overpayment amount.

A nursing facility provider receiving rate relief is allowed to participate in any other add-on reimbursement programs at their election. These programs are handled under the Medicaid policy applicable to the program. The costs associated with these add-on programs are not included in the cost settlement of the variable costs for rate relief as previously described.

10.13.G.2. Rate Relief Documentation

It is the provider's responsibility to present supporting documentation with the rate relief petition. Petition from a new provider must include:

- Identification of the criteria under which relief is requested.
- Supporting documentation for the criteria.
- Detail of the circumstances causing the need for the rate relief request.
- The proposed effective date. The actual effective date of the rate relief is based on the date the petition is received by Medicaid. The earliest effective date would be the first day of the next month following the receipt of the request.
- The services time period that is the basis for which rate relief is requested.
- Specific details reflecting how the additional funds will be spent (i.e., staffing, consultants, medical supplies, etc.).
- Plans on how these changes will ensure the required level of resident care.

10.13.H. Rate Relief for a Current Provider or a New Provider in a Medicaid Enrolled Nursing Facility with a Variable Rate Base Between 80 Percent and 100 Percent of the Class Average Variable Cost

A current or new provider in a Medicaid enrolled nursing facility with a Variable Rate Base between 80 percent and 100 percent of the Class Average Variable Cost may request accelerated rebasing.

Rate relief applies only to the nursing facility's Variable Rate Base. The facility's qualification for adjustment of the Plant Cost Component in the Medicaid rate and Nurse Aide Training and Testing costs is handled in accordance with current Medicaid policy.

10.13.H.1. Rate Relief Methodology

Accelerated rebasing is the use of the Medicaid cost report data from the period ending in the current calendar year in the rate setting process, rather than using cost report data from the period ending in the previous calendar year under the standard reimbursement methodology. The nursing facility's allowable variable cost is indexed to October 1 of the year that is one year prior to the rate year being calculated by applying the appropriate cost index.

Example: The provider's cost report for the period ending December 31, 2003 could be used to set the October 1, 2003 rate if approved for rate relief under this policy. The provider would be allowed to participate in any add-on reimbursement programs at their election.

The cost reporting is based on the provider's established fiscal year and must not cover a time period of less than seven months. The cost report period used for accelerated rebasing must have a reporting period end date prior to January 1 of the State rate year.

Example: A cost report time period ending after January 1, 2004 could not be used for accelerated rebasing of a rate effective during the State rate year October 1, 2003 through September 30, 2004.

10.13.H.2. RATE RELIEF DOCUMENTATION

It is the provider's responsibility to submit supporting documentation with the rate relief petition. Petition from the provider must include:

- Identification of the criteria under which rate relief is requested.
- Supporting documentation for the criteria.
- Detail of the circumstances causing the need for the rate relief request.
- A requested effective date (the actual effective date of the rate relief is based on the date that the petition is received by Medicaid). The earliest effective date would be the first day of the next month. For example, a petition received on August 31 may be effective as soon as September 1.
- The services time period that is the basis for which rate relief is requested.
- Detail of the expenses that are not in the base period for the current or subsequent fiscal year Medicaid rate and how these expenditures relate to the provision of resident care.
- Plans on how these changes will ensure the required level of resident care.

SECTION 11 - APPEAL PROCESS

A nursing facility participating in the Medicaid program may appeal an adverse action and certain determinations made by Medicaid. The provider will be given a written notice of the determination or action that outlines the proposed action, the provider's appeal rights, and the appeal process.

Adverse actions include, but are not limited to:

- A suspension or termination of a provider's Medicaid program participation.
- A reduction, suspension, or adjustment of provider payments.
- A retroactive adjustment following an audit or review of a facility's daily reimbursement rate or other services reimbursement.
- The prospective reimbursement rate determination.

Some elements of the Medicaid nursing facility reimbursement determination methodology are not appealed through an administrative process, but may be appealed to a court of appropriate jurisdiction. These are elements where an administrative remedy, if permitted for a single provider, would imply or necessitate a change for all providers or for all providers in a class and include, but are not limited to:

- The formula for the determination of the nursing facility cost factor.
- The Principles of Reimbursement and guidelines that define allowable costs.
- Medicaid Interim Payment (MIP) Program normal payment amount or reconciliation of payments and approved service billings.
- Non-Medicaid issues.
- Cost limits established in program policy.
- Medicaid's determination of allowable items and costs until an audit has been completed.

The review and hearings process for providers has been promulgated in the administrative rules and is explained in MDCH's Administrative Hearings Manual located on the MDCH website. (Refer to the Directory Appendix for website information.)

11.1 AUDIT APPEALS

Each nursing facility cost report is audited to ensure that expenses attributable to allowable cost were reported in adherence with Medicaid policy. Once the audit report is completed, the provider is given a Preliminary Summary of Audit Adjustments Notice. This notice outlines audit results and advises the provider of their appeal rights, including the right to an Area Office Conference.

If the provider or the provider's designee does not respond to the Preliminary Summary of Audit Adjustments within 15 business days of the date of the notice, the provider will receive a Final Summary of Audit Adjustment Notice. The notice advises the nursing facility of subsequent appeal rights, up to and including an administrative hearing. The provider or their designee has 30 calendar days from the date of the Final Summary of Audit Adjustments Notice to request a formal hearing in accordance with MDCH rules for hearings.

If a provider wants an Area Office Conference, the provider or the provider's designee must send a written request to the audit representative(s) within 15 business days of the Preliminary Summary of Audit Adjustments Notice date. The Area Office Conference is a forum for the provider or their designee to present documents and arguments contesting the Preliminary Summary of Audit Adjustments Notice. The audit representative(s) must schedule an Area Office Conference within 15 calendar days of the receipt of the provider's or provider designee's request. Within 15 calendar days after the Area Office Conference, the audit representative(s) must issue a Final Summary of Audit Adjustments Notice to the provider. The notice advises the nursing facility of subsequent appeal rights, up to and including an administrative hearing. The provider or their designee has 30 calendar days from the date of the Final Summary of Audit Adjustments Notice to request a formal hearing in accordance with MDCH rules for hearings.

If a provider does not appeal or does not respond to the Final Summary of Audit Adjustments Notice or other notices or processes related to a conference or hearing within the allotted timeframe, the provider has waived the right to any further administrative review.

11.2 Rate Appeals

Providers are notified in writing of their Medicaid reimbursement rate(s) at least 30 calendar days prior to the rate's effective date. The provider is given an opportunity for informal review of the rate determination by RARSS. The provider may also formally appeal issues of disagreement or dispute regarding the determined reimbursement rate. A notice of appeal rights, with instructions on how to request an appeal, is included in the final settlement Notice of Medicaid Reimbursement.

11.3 Reimbursement Settlement Appeals

A final settlement reimbursement determination is made to determine the aggregate Medicaid reimbursement to the nursing facility for the time period covered by the cost report. Providers are notified in writing of the final reimbursement settlement and given an opportunity for informal review of the settlement determination. The provider may formally appeal issues of disagreement or dispute of the reimbursement settlement determination. A notice of appeal rights, with instructions on how to request an appeal, is included in the final settlement Notice of Program Reimbursement.

11.4 Provisional Rates

A provider will be given a provisional rate for the new rate year if:

- Medicaid is responsible for a delay in determination procedures.
- An Area Office Conference or Administrative Conference is in progress.
- The potential for an Area Office Conference or an Administrative Conference is still open at the beginning of the rate year that begins a year and a day after the end of the rate year that is being processed.

For this purpose, "delay in the procedures" means (if applicable):

- Medicaid failed to issue the Preliminary Summary of Audit Adjustments in a timely manner.
- Medicaid failed to conduct the Area Office Conference in a timely manner.

- Medicaid failed to issue the Final Summary of Audit Adjustments Notice, including a final determination notice, in a timely manner.

11.5 Provider Payment Adjustment Resulting From Appeal Decision

If the appeal result requires a change in a provider's rate or reimbursement level, the change will be made retroactively for service time periods coinciding with the effective dates of the original reimbursement rate notice. Payment adjustments will be made by an aggregate adjustment rather than by individual claim adjustments.

SECTION 12 - MEDICAID INTERIM PAYMENT PROGRAM

A nursing facility has the option of selecting one of two payment methods:

- Payment directly related to claims submitted to and processed by the Invoice Processing system, or
- enrollment in the Medicaid Interim Payment (MIP) Program.

Providers enrolled in MIP receive a pre-determined dollar amount in cycled payments. MIP payments represent the expected dollar amount that Medicaid would have paid to the nursing facility in claims reimbursement during a period of time. The MIP payment calculation is based on historical approved billings, current reimbursement rate and claims data. The Department may perform interim reconciliation(s) if a significant amount is due the program. After the end of the quarter, a comparison is made of the most recent pre-determined payment and the approved days activity billed. The result of the comparison could result in an increase or a decrease to the MIP payment amount. A reconciliation is done at the end of the provider's fiscal year.

12.1 ENROLLMENT IN MIP

To participate in MIP, a Medicaid participating provider must submit a written request to RARSS. New providers must submit the necessary information outlined in the New Provider Information Data format. Established providers may submit a written request. Providers must acknowledge and agree to the terms of participation in the MIP as outlined in this section. Requests to enroll in MIP must be received one month prior to the beginning of the calendar quarter for which enrollment is desired.

If enrollment is approved, RARSS will enroll the provider in MIP in the calendar quarter following the approval of RARSS. Once MIP payments begin, claims approved through the Claims Processing system, regardless of date of service, will not generate a separate or additional payment.

12.2 DISENROLLMENT IN MIP

To disenroll in MIP, the provider must submit a written request to RARSS. The request to disenroll must be received by RARSS one month prior to the end of a calendar quarter. Disenrollment is effective at the beginning of the calendar quarter following the receipt of the request by RARSS.

Providers terminating participation in the Medicaid Program will not receive a MIP payment in the final month of participation.

The final month's MIP payment is subject to reconciliation to determine the status of MIP. Special arrangements may be made where there is guaranteed assurance the State can recover any payment difference that may exist as the result of MIP participation. A provider interested in a special arrangement must contact RARSS for consideration.

Providers interested in re-enrollment in the MIP program must wait at least one full quarter before reapplying.

12.3 Claims Submission

Providers are expected to submit claims for services rendered in a timely manner. Although a provider enrolled in MIP does not receive payment directly from claims submission, future MIP payments are affected by claims submission. MIP payments are calculated for expected days to be reimbursed.

12.4 Calculation of MIP Payment

The MIP amount is recalculated on a quarterly basis. The recalculation is to update the MIP amount to reflect the current Medicaid billing activity for the facility and the provider's Medicaid per diem rate when necessary. A recalculation may occur any time during a calendar quarter due to a change in the provider's per diem rate. The quarterly recalculation is based on the approved claims activity over the most recent twelve months, regardless of the date of service, and Medicaid utilization during the same time period. At the end of each quarter, the recently completed quarter's approved claims are used to update the MIP payment calculation.

The annually projected State liability to the provider (total reimbursement less other insurance and patient payments) will be divided by 24 to determine the regularly scheduled payment amount that will be made twice a month. The other insurance and patient payment amounts are based on the most recent quarter payment data projected to an annual amount.

In the case of major problems to Medicaid data system where a significant change has occurred in the approved claims data for a quarter as a result of Medicaid data system, the MIP amount would continue as previously calculated or the provider may request that RARSS perform a recalculation. If a significant reduction in the MIP amount is due to a problem outside the provider's control, such as a payment system error, the provider may request that RARSS perform a recalculation as a special consideration. RARSS staff will analyze and review the request to determine if special consideration is warranted.

Interim recalculations requests as a result of provider delays in billing must be submitted to RARSS for approval or denial. Providers that have demonstrated repeated occurrences of delays in billing may not receive an interim recalculation.

12.5 Frequency of MIP Payment

The biweekly MIP payment is an estimate of one-half of the Medicaid liability for reimbursable services rendered in the previous month. The MIP payment will be paid on the first and third Wednesday of each month. This means a provider could receive 100 percent of the monthly payment as early as the 15th day of the month and no later than the 21st day. Providers enrolled in MIP will receive six regularly scheduled payments during a calendar quarter.

12.6 Annual Reconciliation

The reconciliation of approved claims and MIP payments is done annually, generally 90 calendar days after the end of the provider's fiscal year. If a provider changes their cost-reporting fiscal year, they must notify RARSS in advance in writing. Any change in a fiscal year could adversely affect a provider in the reconciliation.

If an underpayment has been made, the provider will receive a gross adjustment payment. If an overpayment is determined, recovery will be made by gross adjustment recovery against future payments. The gross adjustment process follows the Initial and Final Settlement practices in the respective subsections of this appendix. A provider may submit a written request to RARSS for an extended repayment schedule to repay the Program. The request must provide adequate justification for the need for extended repayment.

MIP amount determination, reconciliation and adjustments are not subject to appeal under the administrative rules. The MIP Program does not determine the reimbursement rate; it is an interim payment mechanism substituting for Claims Processing payments. The provider is given advance notice of the MIP actions and can request a review with RARSS. The provider's action must be timely and specific to the problem.

12.7 New Providers

New providers, resulting from a change in facility ownership, may request MIP at the time of Medicaid Program enrollment by submitting the information in the New Provider Information Data format to RARSS.

New providers in facilities without historical Medicaid Program billing data are not eligible for MIP.

SECTION 13 – APPRAISAL GUIDELINES

Where historical cost records of a purchased asset are not available or are incomplete, or where fair market value or current reproduction cost must be established, a timely appraisal of the historical costs, fair market value, or depreciated reproduction cost (as appropriate) of the asset made by an independent, recognized expert is acceptable for depreciation and owner's equity capital purposes. The appraisal of the historical cost of assets should produce a value approximating the cost of reproducing substantially identical assets of like type, quality, and quantity at a price level in a bona fide market as of the date of acquisition. The appraisal must be conducted in accordance with "The Principles of Appraisal Practices and Code of Ethics" of the American Society of Appraisers.

For Medicaid program purposes, the term "appraisal" refers primarily to the process of establishing or reconstructing the historical cost, fair market value, or current reproduction cost of an asset. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property.

Appraisal Date	The date selected for establishing the value of fixed assets. For example, if December 31, 2002 was established as the appraisal date and the actual physical inventory of fixed assets was taken on February 1, 2003, any additions or dispositions of fixed assets between December 31, 2002 and February 1, 2003 must be taken into account in the appraisal values.
Appraised Book Value	The book value of an asset's appraised cost as of the date of acquisition less accumulated depreciation computed on an approved basis up to the appraisal date.
Appraisal Expert	An individual or firm that is experienced and specialized in multi-purpose appraisals of plant assets involving the establishment or reconstruction of the historical cost, fair market value, or current reproduction cost of such assets. The appraisal expert must employ a specially trained and well supervised staff with a complete range of appraisal and cost construction techniques; be experienced in appraisals of plant assets used by providers; and demonstrate a knowledge and understanding of the regulations involving reimbursement principles, particularly those pertinent to depreciation.

13.1 APPROVAL

Medicaid does not require the nursing facility representatives to get prior approval before an appraisal is made for Medicaid purposes. Medicaid requirements are that the appraisal be conducted in accordance with the provisions of these guidelines. Questions regarding the appraisal of the nursing facility should be directed to the SMA's LTC Reimbursement and Rate Setting Section. (Refer to the Directory Appendix for contact information.) The provider must make the appraisal agreement and final report available to Agency staff for audit review. The scope of the appraisal must conform to Medicare Principles of Reimbursement as modified by Michigan Medicaid for provider costs in effect on the appraisal date.

13.2 Need for Appraisal

An appraisal for Medicaid purposes should be made only where the nursing facility provider has no historical cost records, has incomplete records of the depreciable fixed assets, or needs to determine an asset's fair market value or depreciated reproduction cost. The appraisal should develop the historical cost and related information that will assist in the construction, reconstruction, or revision of accounting records to enable the provider to make proper distribution of depreciation expense in cost reports. Normally, a proprietary provider will not need a historical cost basis of its assets. Where an appraisal is being performed to determine the current reproduction of an asset, the appraisal should represent the cost to reproduce the actual facility in like kind and should not be inflated by such factors as current or anticipated space needs or different construction types, e.g., masonry versus wood frame. Appraisals must be performed within the time limit specified in the proposed agreement and not on a piecemeal or intermittent basis.

13.3 Purchase of Ongoing Facility

In establishing the historical cost of assets where an ongoing nursing facility is purchased through a bona fide sale after July 1, 1966 and prior to August 1, 1970, the purchase price or portion thereof attributable to the asset must not exceed the fair market value of the asset at the time of the sale. For depreciable assets acquired after July 1970, the cost basis of the depreciable assets must not exceed the lower of the current reproduction cost adjusted for straight-line depreciation over the life of the assets to the time of the sale or the fair market value of the tangible assets purchased.

If the nursing facility was participating in the Medicaid program at the time of sale, the sale price used by the seller in computing gain or loss for the final cost report must agree with the historical cost used by the new facility owner (the purchaser) in computing depreciation. However, where the basis for depreciation to the purchaser for an asset acquired after July 1970 is limited to the lower of current reproduction cost (adjusted for straight-line depreciation from the time of asset acquisition to the time of the sale) or the fair market value, the basis for computing gain or loss to the seller is the sale price. The gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sale price among all the assets sold (including land, goodwill, and any assets not related to resident care) in accordance with the fair market value of each asset as it was used by the seller at the time of sale. If the purchaser and seller cannot agree on an allocation of sale price, or if they do agree but there is insufficient documentation of the current fair market value of each asset, the Agency will require an appraisal by an independent appraisal expert to establish the fair market value of each asset and will make an allocation of the sale price in accordance with the appraisal. In any case, the sale price must be allocated among all the assets sold, even if some of the assets will be disposed of shortly after the sale.

If a purchaser cannot demonstrate that the sale is bona fide, the seller's net book value will be used by the purchaser as the basis for depreciation of the asset. In such cases, the purchaser must record the historical cost and accumulated depreciation of the seller recognized under the Medicaid program, and these must be considered as incurred by the purchaser for Medicaid purposes.

The cost basis for the depreciable assets of a nursing facility purchased in a bona fide sale on or after August 1, 1970 is limited to the lowest of the following:

- The total price paid for the facility by the purchaser as allocated to the individual assets;
- The total fair market value of the facility at the time of the sale as allocated to the individual assets;

- The combined fair market value of the individually identified assets at the time of the sale; or
- The current reproduction costs of the depreciable assets, depreciated on a straight-line basis over the life of the assets to the time of the sale.

The purchaser has the burden of proving that the transaction was a bona fide sale, and if the burden is not met, the cost basis may also not exceed the seller's cost basis less accumulated depreciation.

13.4 Fixed Assets Included in Appraised Values

Fixed asset values established by an appraisal must include all plant assets owned by the nursing facility provider that are used in resident care or in the overall operation and administration of the facility. Fixed assets used in research and other non-allowable cost areas or functions should be included so that depreciation is reflected in those departmental costs to provide a proper basis for allocating administrative and general expense. Fixed assets of a related organization not used by a provider in rendering resident care, assets acquired in anticipation of expansion, and assets held for investment and not used in the plant operation should not be included as a part of the appraised values.

Generally accepted accounting principles relating to improvements or betterments must be followed in determining the asset values established by the appraisal. Repair or maintenance of a nature that restores an asset to its original condition but does not extend its useful life is not betterment or improvement but an expense of that period.

The pricing of assets to establish historical costs is based on such actual supporting documents as vendor invoices and construction contractor completion statements. In the absence of invoices, such other records as revenue stamps, board minutes, contracts of purchase, and deeds recorded with the county's Recorder of Deeds may be used.

Other methods, such as manufacturer's catalogs, libraries of material prices, or techniques involving reverse trending and price indices may be used to establish acquisition costs and dates. Such methods may be used only when actual supporting documents are not available. When these sources and techniques are used, consideration must be given to the manufacturers and to quantity discounts. The determined value should closely approximate the actual historical cost of an asset at the date of acquisition.

13.5 Minor Equipment

Where minor equipment is concerned, the SMA recognizes that the inventory costs of such equipment may not truly reflect the cost of equipment purchased and in use by the nursing facility provider. Differences in the capitalization policies of providers and their desire to limit property record controls over certain classes of small assets cause variations in the recorded costs of assets generally considered depreciable. Medicaid will only recognize an appropriate amount for minor equipment costs where the original equipment acquisition cost was recorded in the accounting records as capital asset cost and had not previously recorded the minor equipment acquisition as current period operations expense.

Minor equipment includes, but is not limited to, such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, and buckets. The general characteristics of this type of equipment are as follows:

- The equipment is in no fixed location and is subject to use by various departments in the nursing facility;
- The items are comparatively small in size and unit cost;
- The equipment is subject to inventory control;
- There is a fairly large quantity of the items in use; and
- The equipment has a useful life of approximately three years or less.

However, where all other depreciable assets are concerned, such as buildings, building equipment, major movable equipment, land improvements, and leasehold improvements, the Medicaid program will not recognize a historical cost of such assets in excess of the historical cost used for federal income tax purposes. Nursing facility providers should be able to support this historical cost by reference to original documents such as contracts, vouchers, checks and other evidence. If the provider does not have such original documentation constituting primary evidence of the historical cost of assets, the Agency will consider the provider's federal income tax returns as secondary evidence to be used in establishing and verifying the historical cost of the assets. Further, it is possible that because of the effects of other provisions within the Medicare Principles of Reimbursement, such as "cost to related organizations," the historical cost under Medicaid might be less than that allowed and used for income tax purposes.

Under the Principles, nursing facility providers may change the useful lives of assets where this can be justified and appropriately adjust the accumulated depreciation applicable to the historical cost of the assets involved. The effect of such adjustments is to change the undepreciated amount of the historical cost for Medicaid purposes. The Principles do not permit providers to increase the historical cost basis of their assets to recognize elements of costs or expenditures that were not capitalized but were considered as expense items.

Example: If a provider determines that a physical modification of the building was a repair, and thus an item of expense not capitalized, and uses the historical cost so determined for federal income tax purposes, the provider may not change the historical cost basis to include that expenditure previously determined a repair and capitalize it, i.e., increase the historical cost basis of the building for Medicaid purposes.

Example: If a provider builds a facility and, in establishing the historical cost of the building, determines that material and labor used were not part of the historical cost of the building and charges the cost of such material and labor into expenses for federal income tax purposes, the provider may not then include such expenditures in the historical cost of the building for Medicaid purposes.

Costs in excess of the cost basis used for federal income tax purposes will not be recognized under Medicaid. Further, for cost reporting periods beginning on or after January 1, 1970, the Agency will also require a redetermination of allowable costs for the reporting period covered to reflect the effects of the adjustment in the historical cost basis of the assets. For cost reporting periods beginning before January 1, 1970, however, no redetermination of such allowable costs need be made for the reporting periods covered. Accumulated depreciation applicable to the depreciable assets under the Medicaid program will include the full amount allowed during those periods in which an increased historical cost basis was used. The net book value will be used for computations of gain or loss on the sale of assets and for any other reimbursement purposes under Medicaid.

13.6 Donated Assets

The fair market value for a donated asset is the price that the asset would bring by bona fide bargaining between well-informed purchasers and sellers at the date of acquisition. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

Exception: In cases where an asset has been used or depreciated under the Medicaid program and then donated to a provider, the basis of depreciation will be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program.

If the nursing facility provider's records do not include the fair market value of the donated assets as of the date of donation, an appraisal of such fair market value by a recognized appraisal expert will be acceptable for depreciation and owner's equity capital purposes.

Where material, labor, and services are donated in the construction of an asset, the asset value is the sum of the appraised cost of the material, labor, or services actually donated and the incurred cost of that part which was not donated. Labor costs should be determined in accordance with both the rates prevailing in the community at the time of construction and the type of labor incurred, i.e., if the labor donated was non-union labor, the cost would be at the non-union labor rate rather than at a union labor rate. If records are not available as to the actual labor, services, or material donated, the fair market value at the time of donation may be determined by the other methods shown in Medicare Principles of Reimbursement. Estimated labor costs provided by an owner or shareholder of a facility are not includable in the historical cost of constructed assets.

13.7 Assets Costing Less Than $100

Individual major movable assets costing less than $100, whether or not purchased in quantity prior to the appraisal date, may be capitalized at the time of appraisal at the purchase cost less accumulated depreciation from the date of acquisition regardless of the provider's past accounting practices. If an election is made to capitalize such assets, this policy must be applied consistently.

Nursing facility providers that have expensed such items while in the Medicaid program may not decide later to capitalize them. This also applies to those providers that eventually decide to have appraisals. The appraisal expert may group major movable equipment with a unit cost of $100 or less. However, the book value assigned to such grouped assets at appraisal may not exceed the book value of the assets if individually appraised. Identification of the individual assets comprising the group must be available.

13.8 Tagging of Equipment

For Medicaid program purposes, tagging of equipment is not mandatory. In the absence of tagging, however, alternate records must be maintained to satisfy audit verification of the existence and location of the assets.

13.9 Appraisal Programs

Since the condition of nursing facility provider asset records varies significantly, an appraisal program may be comprehensive or partial. For instance, a provider may engage an appraisal expert to appraise a part of its facility for which no historical records have been maintained, or a provider may need to have an appraisal made on a particular class of assets in a specific identified location.

Comprehensive appraisal programs are usually appropriate because of such complexities as lump-sum purchases of assets or a complete lack of historical cost records for all assets.

An appraisal program should include:

- A physical inventory and listing of pertinent data for all applicable assets in use or in standby status as of the appraisal date or report date. The physical inventory may be made by the provider or by the appraiser. If made by the provider, the appraiser must verify the inventory.
- The acquisition cost of each item or unit of property including, but not limited to, architect fees, installation costs, and freight.
- A classification of each item or unit of property in accordance with the American Hospital Association (AHA) Health Data and Coding Standards Group, Estimated Useful Lives of Depreciable Hospital Assets. These classifications are:
  - Land improvements;
  - Buildings, including building improvement, fixed equipment, building services equipment and other fixed equipment;
  - Major movable equipment;
  - Minor equipment; and
  - Leasehold equipment.

  Note: Refer to the Cost Classifications and Cost Finding section of this appendix for a comprehensive description for capital assets by category.
- Establishing an estimated useful life for each asset. The estimated useful life for purposes of the appraisal must be consistent with the estimated useful life for each asset used by the provider for depreciation purposes.
- Determining a salvage value for each asset.
- Selecting a depreciation method for each asset.
- Calculating depreciation provisions for the current reporting period.
- Calculating accumulated depreciation using an approved basis, from the date of acquisition to the start of the Medicaid reporting period in which actual depreciation is first claimed.
- Determining square footage for each cost center to identify all rooms on a floor or within a building if the provider did not previously do this. This should be accomplished as explained in the AHA Cost Finding and Rate Setting for Hospitals publication.

- Reconciling appraisal results with provider records. For assets acquired prior to January 1, 1966, the provider's plant asset records, if any, and accounting records must be considered even though they may be inaccurate. This reconciliation must be made for land improvements, buildings, building services equipment and, where possible, for other major asset classifications.

  Where applicable, differences discussed by the reconciliation must be reflected as adjustments in the provider's accounting and plant asset records.

13.10 Appraisal Report

The appraisal expert must prepare a letter of certification. The letter should state that, in the appraisal expert's judgment, the appraisal results were determined in conformity with Medicaid program regulations and requirements. This letter will include such information as:

- Name of the nursing facility provider for which the appraisal was conducted;
- Location(s) of the facility included in the appraisal;
- Appraisal date, the date up to which accumulated depreciation was calculated (if other than the appraisal date), and the period for which current depreciation is calculated;
- Contents of data supplied to the provider, i.e., summaries, schedules, plans, etc.;
- Appraisal program descriptions, including:
  - The extent of asset appraisal, i.e., assets physically inventoried,
  - Pricing basis, and
  - Other pertinent information not readily apparent in the detail results, such as depreciation methods.
- Policy for determining capitalizable assets;
- Depreciation policy in the year of acquisition and disposal; and
- Identification of material items included in the appraisal where the values of such items were obtained from outside sources without independent verification by the appraisal expert.

13.11 Listing of Assets Appraised

If a listing of assets that constitutes the nursing facility provider's Medicaid property records is supplied, it must contain all necessary and pertinent information, even if portions were determined solely by the provider. A listing of assets should include the following information for each asset:

- Building location;
- Cost center or department;
- Asset description, usually including manufacturer's name, model number, serial number, etc.;
- AHA asset classification;
- Historical cost;
- Acquisition date;

- Estimated useful life to provider;
- Salvage value;
- Depreciation provision for current reporting period;
- Accumulated depreciation provision for current reporting period; and
- Pricing method necessary for adequate disclosure, where more than one method was used for various assets.

Reconciliations and comparisons with provider records must also be included, as well as square footage and other allocation basis information for buildings and cost centers within buildings.

13.12 Records

Appraisal work papers must be made available to SMA staff or their designee upon reasonable request.

13.13 Appraisal Expense

The expense of an appraisal to establish plant records for Medicaid program purposes, including the expense for appraisal of research and other non-resident departments incurred by a nursing facility provider after entrance into the program, may be included as an allowable cost. The expenses will be considered as administrative costs in the period incurred, subject to apportionment to the Medicaid program. Appraisal expenses incurred relative to assets not connected with provider operations are not allowable costs.

Where providers have appraisals made for other business purposes, such as insurance coverage, tax values or financing, the incurred expenses for such appraisals may be included in allowable costs as part of administrative and general costs. However, appraisal expenses incurred to establish values for the sale or anticipated sale of the nursing facility or provider organization are not allowable costs.

Where the SMA determines that a provider has incurred appraisal expenses to establish the historical cost of assets which were already adequately reflected in its books, records, or tax returns, the cost of performing the appraisal is not allowable.

SECTION 14 – COST REPORTING AND REIMBURSEMENT DESCRIPTIONS AND CLASSIFICATIONS

14.1 GENERAL

Refer to Cost Classifications and Cost Finding section of this appendix for detailed discussion and description of program cost categories for Plant, Variable Base, Support and Base/Support.

Plant 1	Depreciation cost category generally allocated to operational cost centers on the basis of square footage.
Plant 2	Depreciation cost category generally allocated to operational cost centers on the basis of square footage or asset dollar value.
Plant 3	Interest, real and personal property taxes, allowable lease rental and borrowing-related amortization cost category generally allocated to operational cost centers on the basis of square footage.

14.2 PLANT COSTS - RENT/LEASES

Leases

Underlying Cost – Depreciation ..... Plant 1
Underlying Cost – Interest ..... Plant 3
Underlying Cost – Property Taxes ..... Plant 3
Lease Rental Component ..... Plant 3
Other Nonallowable Costs ..... Support

Interests

Mortgage & Bond ..... Plant 3
Other ..... Plant 3
Paid to Owner(s) ..... Plant 3

Amortization

Interest Related ..... Plant 3

Property Taxes

Property Taxes ..... Plant 3

Depreciation

Building & Improvements (fixed) ..... Plant 1
Equipment (moveable) ..... Plant 2
Vehicles ..... Plant 2

14.3 EMPLOYEE HEALTH & WELFARE

FICA – Employer's Portion ..... Base/Support
Federal Unemployment Tax ..... Base/Support
MESC ..... Base/Support
Workers' Compensation ..... Base/Support

Pension & Profit Sharing ..... Base/Support
Employees Group Insurance ..... Base/Support
Retirement ..... Base/Support
Other ..... Base/Support

14.4 Administrative & General

Salaries & Wages – Officers ..... Support
Salaries & Wages – Administrator ..... Support
Salaries & Wages – Owner/Administrator ..... Support
Salaries & Wages – Clerical & Other ..... Support
Employee Benefits ..... Support
Workers Compensation ..... Base
Payroll Taxes ..... Support
Director's Fees ..... Support
Management Services ..... Support
Central Office Overhead ..... Support
Contracted Services ..... Support
In-service Training ..... Support
Education ..... Support
Advertising ..... Support
Promotion & Public Relations ..... Support
Telephone & Other Communications ..... Support
Dues & Subscriptions ..... Support
Insurance - Officer's Life ..... Support
Insurance – General ..... Support
Malpractice Liability Insurance ..... Support
Copier ..... Support
License Fees ..... Support
Quality Assurance Assessment ..... Support
Provider Donation for Outstationed State Staff ..... Support
Transportation ..... Support
Equipment Repair & Maintenance ..... Support
Vehicles ..... Support
Office Supplies ..... Support
Printing ..... Support
Postage, UPS, Freight ..... Support
Legal & Accounting ..... Support
Utilization Review ..... Support
Income Taxes ..... Support
Other Taxes ..... Support
General Travel ..... Support
Travel & Seminars ..... Support
Data Processing ..... Support
Amortization – Non-interest Related ..... Support
Employment Agency Fees ..... Support

Charitable Contributions.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Security Guard Services.....Support
Penalties.....Support
Miscellaneous.....Support
Bad Debt.....Support

14.5 Plant Operation & Maintenance

Salaries & Wages – Plant Operation & Maintenance.....Support
Employee Benefits.....Support
Workers' Compensation.....Base
Payroll Taxes.....Support
Contracted Services.....Support
In-service Training.....Support
Education.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Deprecation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Repair & Maintenance – Building.....Support
Repair & Maintenance – Equipment.....Support
Repair & Maintenance – Grounds.....Support
Building Insurance.....Support
Supplies.....Support
Miscellaneous.....Support
Trash Removal.....Support
Snow Removal.....Support

14.6 UTILITIES

Gas & Fuel ..... Base
Electricity ..... Base
Water ..... Base
Miscellaneous ..... Base

14.7 LAUNDRY

Salaries & Wages – Laundry ..... Base
Employee Benefits ..... Base
Workers' Compensation ..... Base
Payroll Taxes ..... Base
Contracted Services – Base ..... Base
Contracted Services – Support ..... Support
Contracted Services – Base/Support ..... Base/Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Repair & Maintenance ..... Support
Linen & Bedding ..... Base
Laundry Supplies ..... Base
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.8 HOUSEKEEPING

Salaries & Wages – Housekeeping ..... Support
Employee Benefits ..... Support
Workers' Compensation ..... Base
Payroll Taxes ..... Support
Contracted Services ..... Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3

Repair & Maintenance	Support
Housekeeping Supplies	Support
Miscellaneous	Support

14.9 DIETARY

Salaries & Wages – Dietary	Base
Employee Benefits	Base
Workers' Compensation	Base
Payroll Taxes	Base
Contracted Services – Base	Base
Contracted Services – Support	Support
Contracted Services – Base/Support	Base/Support
In-service Training	Support
Education	Support
Minor Equipment – Less Than $500	Support
Minor Equipment – More Than $500	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Depreciation	Plant 2
Direct Allocation – Interest & Property Taxes	Plant 3
Repair & Maintenance	Support
Raw Food	Base
Miscellaneous – Base	Base
Miscellaneous – Support	Support

14.10 NURSING ADMINISTRATION

Salaries & Wages – Director of Nursing	Base
Salaries & Wages – Other	Base
Employee Benefits	Base
Workers' Compensation	Base
Payroll Taxes	Base
Office Supplies	Support
Contracted Services – Base	Base
Contracted Services – Support	Support
Contracted Services – Base/Support	Base/Support
In-service Training	Support
Salaries & Wages – In-service Training	Support
Employee Benefits – In-service Training	Support
Payroll Taxes – In-service Training	Support
Education	Support
Minor Equipment – Less Than $500	Support
Minor Equipment – More Than $500	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2

Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support.....Support

14.11 Central Supplies

Salaries & Wages – Central Supplies.....Support
Employee Benefits.....Support
Workers' Compensation.....Base
Payroll Taxes.....Support
Supplies.....Support
Contracted Services.....Support
In-service Training.....Support
Education.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous.....Support

14.12 Medical Supplies

Salaries & Wages – Medical Supplies.....Support
Employee Benefits.....Support
Workers' Compensation.....Base
Payroll Taxes.....Support
Supplies.....Base
Contracted Services.....Support
In-service Training.....Support
Education.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous.....Support

14.13 Medical Records & Library

Salaries & Wages – Medical Director	Support
Salaries & Wages – Medical Records	Support
Employee Benefits	Support
Workers' Compensation	Base
Payroll Taxes	Support
Supplies	Support
Contracted Services – Medical Director	Support
Contracted Services	Support
In-service Training	Support
Education	Support
Minor Equipment – Less Than $500	Support
Minor Equipment – More Than $500	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Depreciation	Plant 2
Direct Allocation – Interest & Property Taxes	Plant 3
Miscellaneous	Support

14.14 Social Services

Salaries & Wages – Social Services	Base
Employee Benefits	Base
Workers' Compensation	Base
Payroll Taxes	Base
Supplies	Support
Contracted Services – Base	Base
Contracted Services - Support	Support
Contracted Services – Base/Support	Base/Support
In-service Training	Support
Education	Support
Minor Equipment – Less Than $500	Support
Minor Equipment – More Than $500	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Depreciation	Plant 2
Direct Allocation – Interest & Property Taxes	Plant 3
Miscellaneous – Base	Base
Miscellaneous – Support	Support

14.15 Diversional Therapy

Salaries & Wages - Diversional Therapy ..... Base
Employee Benefits ..... Base
Workers' Compensation ..... Base
Payroll Taxes ..... Base
Supplies ..... Base
Contracted Services – Base ..... Base
Contracted Services - Support ..... Support
Contracted Services – Base/Support ..... Base/Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.16 Ancillary Service Cost Centers

14.16.A. Radiology

Salaries & Wages – Radiology ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Contracted Outside Services ..... Support
Other ..... Support

14.16.B. Laboratory

Salaries & Wages – Laboratory ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support

Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Contracted Outside Services.....Support
Other.....Support

14.16.C. Intravenous Therapy

Salaries & Wages – Intravenous Therapy.....Support
Employee Benefits.....Support
Payroll Taxes.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Contracted Outside Services.....Support
Other.....Support

14.16.D. Inhalation Therapy (Oxygen)

Salaries & Wages – Inhalation Therapy.....Support
Employee Benefits.....Support
Payroll Taxes.....Support
Oxygen – Intermittent Use.....Base
Oxygen – Continuous Use.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3

14.16.E. Physical Therapy

Salaries & Wages – Physical Therapy.....Support
Employee Benefits.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2

Direct Allocation – Interest & Property Taxes	Plant 3
Payroll Taxes	Support
Contracted Outside Services	Support
Other	Support

14.16.F. Speech Therapy

Salaries & Wages – Speech Therapy	Support
Employee Benefits	Support
Payroll Taxes	Support
Minor Equipment – Less Than $500	Support
Minor Equipment – More Than $500	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Depreciation	Plant 2
Direct Allocation – Interest & Property Taxes	Plant 3
Contracted Outside Services	Support
Other	Support

14.16.G. Occupational Therapy

Salaries & Wages – Occupational Therapy	Support
Employee Benefits	Support
Payroll Taxes	Support
Minor Equipment – Less Than $500	Support
Minor Equipment – More Than $500	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Depreciation	Plant 2
Direct Allocation – Interest & Property Taxes	Plant 3
Contracted Outside Services	Support
Other	Support

14.16.H. Electroencephalography

Salaries & Wages – Electroencephalography	Support
Employee Benefits	Support
Payroll Taxes	Support
Electroencephalography	Support
Minor Equipment – Less Than $500	Support
Minor Equipment – More Than $500	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2

Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3

14.16.I. Pharmacy

Salaries & Wages – Pharmacy.....Support
Employee Benefits - Pharmacy.....Support
Payroll Taxes - Pharmacy.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Contracted Outside Services.....Support
Pharmacy - Other.....Support
Drugs – Legend.....Base
Drugs – Non-Legend.....Support
Special Services.....Support

14.16.J. Physician Services

Salaries & Wages – Physician Services.....Support
Employee Benefits.....Support
Payroll Taxes.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Contracted Outside Services.....Support
Other.....Support

14.17 Nursing Service Cost Centers

14.17.A. Medicare SNF Unit

Salaries & Wages – R.N.....Base
Salaries & Wages – L.P.N.....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Workers' Compensation.....Base
Payroll Taxes.....Base

Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.17.B. Medicaid Routine Care Unit #1

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers' Compensation ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.17.C. Medicaid Routine Care Unit #2

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers' Compensation ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support

Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.17.D. Medicaid Special Care Unit #1

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.17.E. Medicaid Special Care Unit #2

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers' Compensation ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2

Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support.....Support

14.17.F. Home For Aged Unit

Salaries & Wages – R.N. .....Base
Salaries & Wages – L.P.N.....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Payroll Taxes .....Base
Nursing Supplies .....Base
Contracted Services.....Base
In-service Training .....Support
Education .....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support.....Support

14.17.G. Non-LTC Apartment/Housing Unit

Salaries & Wages – R.N. .....Base
Salaries & Wages – L.P.N.....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Payroll Taxes .....Base
Nursing Supplies .....Base
Contracted Services.....Base
In-service Training .....Support
Education .....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3

Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.17.H. Non-Medicare And Non-Medicaid Licensed Only

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.17.I. Non-LTC Nursing Services

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.18 Reimbursable / Non-Reimbursable Cost Centers

14.18.A. Non-Available Beds

Medicaid Non-Available Beds ..... Non-Reimbursable

14.18.B. Nurse Aide Training & Testing - LTC

Nurse Aide Training & Testing ..... Pass-Through

14.18.C. Special Dietary

Salaries & Wages – Special Dietary ..... Base
Employee Benefits ..... Base
Workers' Compensation ..... Base
Payroll Taxes ..... Base
Contracted Services – Base ..... Base
Contracted Services – Support ..... Support
Contracted Services – Base/Support ..... Base/Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Repair & Maintenance ..... Support
Raw Food ..... Base
Dietary Supplies (Non-Ingested) ..... Base
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.18.D. Beauty & Barber Shop

Salaries ..... Non-Reimbursable
Other ..... Non-Reimbursable

14.18.E. Gift, Flower, Coffee Shop & Canteen

Salaries ..... Non-Reimbursable
Other ..... Non-Reimbursable

14.18.F. Physician's Private Office

Salaries ..... Non-Reimbursable
Other ..... Non-Reimbursable

14.18.G. Non-Paid Workers

Salaries.....Non-Reimbursable
Other.....Non-Reimbursable

14.18.H. Other

Other Salaries .....Non-Reimbursable
Other.....Non-Reimbursable

OUTPATIENT THERAPY

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION

This chapter applies to outpatient therapy providers enrolled as provider type 40.

The primary objective of Medicaid is to ensure that essential medical/health services are made available to those who would not otherwise have the financial resources to purchase them. The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services, recommended and supported by a pediatric sub-specialist, with care coordination that relates to the CSHCS qualifying diagnosis. Policies are aimed at maximizing the health care services obtained for this population with the limited number of dollars available.

The term Medicaid throughout this chapter refers to both the Medicaid and CSHCS programs.

1.1 SERVICE PROVISION

Outpatient therapy may be provided by any of the following Medicaid-enrolled providers when performed by properly credentialed professionals:

- Outpatient Occupational Therapy (OT) and Physical Therapy (PT)
  - Outpatient Hospital
  - Comprehensive Outpatient Rehabilitation Facility (CORF)
  - Outpatient Rehabilitation Agency (Rehab Agencies)
  - CARF-Accredited Medical Rehabilitation Program
  - Physical Therapist or Occupational Therapist in Private Practice (Medicare coinsurance and deductible amounts only)
- Outpatient Speech Language Pathology (ST)
  - Outpatient Hospital
  - Comprehensive Outpatient Rehabilitation Facility (CORF)
  - Outpatient Rehabilitation Agency (Rehab Agencies)
  - CARF-Accredited Medical Rehabilitation Program
  - CAA-Accredited University Graduate Education Program

1.2 OUTPATIENT THERAPY DATABASE

For specifics regarding Medicaid coverage of the Healthcare Common Procedure Coding System (HCPCS), refer to the Outpatient Therapy Database on the MDCH website. (Refer to the Directory Appendix for website information.) The database includes all covered outpatient therapy codes, their associated maximum fee screens, required modifiers and applicable frequency limits for the Medicaid-enrolled providers listed in this chapter.

1.3 Documentation in Beneficiary File

Outpatient therapy providers must maintain all applicable documentation in the beneficiary's file for six years. For audit purposes, the patient's medical record must substantiate the medical necessity of the item or service supplied.

SECTION 2 – PROVIDER REQUIREMENTS

2.1 OUTPATIENT HOSPITALS

Outpatient OT, PT and ST services may be provided to beneficiaries of all ages in the outpatient hospital.

2.2 COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES AND OUTPATIENT REHABILITATION AGENCIES

Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Rehab Agencies may enroll with Medicaid for reimbursement of outpatient OT, PT and ST provided by qualified professionals. All CORFs and Rehab Agencies must provide proof of Medicare certification when enrolling in Medicaid.

2.3 COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES (CARF) ACCREDITED OUTPATIENT MEDICAL REHABILITATION PROGRAMS

CARF accredited outpatient medical rehabilitation programs may enroll with Medicaid for reimbursement of outpatient OT, PT and ST services provided by qualified professionals. The program must be freestanding and not part of, or owned by, a hospital, CORF or Rehab Agency. All CARF accredited outpatient medical rehabilitation programs must provide proof of their current CARF accreditation when enrolling in Medicaid.

2.4 UNIVERSITY AFFILIATED SPEECH-LANGUAGE PATHOLOGY GRADUATE EDUCATION PROGRAMS

University graduate education programs accredited by the American Speech-Language-Hearing Association's (ASHA) Council on Academic Accreditation (CAA) in Audiology and Speech-Language Pathology may enroll with Medicaid for reimbursement of outpatient ST provided by qualified professionals. The university program must be freestanding and not part of, or owned by, a hospital, CORF or Rehab Agency. All university programs must provide proof of their current ASHA-CAA when enrolling in Medicaid.

2.5 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS IN PRIVATE PRACTICE

Medicaid enrolls physical therapists and occupational therapists in private practice only for reimbursement of the Medicare coinsurance and deductible on behalf of dual Medicaid/Medicare beneficiaries. These providers may not bill for services provided to beneficiaries with Medicaid or CSHCS only.

SECTION 3 - CSHCS REQUIREMENTS

As a condition to participate in the CSHCS program, the beneficiary's assigned pediatric sub- specialist must coordinate treatment and services relating to the beneficiary's CSHCS-qualifying diagnosis. CSHCS beneficiaries must be referred by their pediatric sub-specialist directly to the specified Medicaid-enrolled provider of therapy services. Documentation of this referral must remain in the beneficiary's medical record.

CSHCS diagnostic evaluations authorized by the local health department do not require a referral by the pediatric sub-specialist.

CSHCS-covered outpatient therapy services must be directly related to the CSHCS-eligible diagnosis. Therapists providing or supervising services provided to CSHCS beneficiaries must have obtained at least one year of prior professional experience treating the health care needs of pediatric patients with physical disabilities. Professional resumes documenting pediatric experience, as well as a copy of the facility's program description and mission/vision statement, must be submitted to the MDCH Prior Authorization Division. (Refer to the Directory Appendix for contact information.) CSHCS will make the determination, based on this documentation, of whether the provider is approved to provide therapy services to CSHCS beneficiaries.

Once approved to provide therapy services to CSHCS beneficiaries, the provider may accept referrals from the pediatric sub-specialist. When a CSHCS beneficiary presents for services, the provider must check the beneficiary's CSHCS Client Eligibility Notice. Before billing for therapy services, the enrolled provider must be listed on the beneficiary's CSHCS Client Eligibility Notice. Providers may contact the MDCH Prior Authorization Division to request addition to a Client Eligibility Notice. (Refer to the Directory Appendix for contact information.)

These requirements do not apply to services provided to Medicaid-only or dual Medicaid/CSHCS beneficiaries.

SECTION 4 – PRIOR AUTHORIZATION REQUESTS

PA is required for certain services before the services are rendered. To determine which services require PA, refer to the Standards of Coverage and Service Limitations Section of this chapter or the Outpatient Therapy Database on the MDCH website. (Refer to the Directory Appendix for contact information.)

Requests for PA for all services must be submitted on MSA-115 (Occupational Therapy-Physical Therapy-Speech Therapy Prior Approval Request/Authorization Form). (Refer to the Forms Appendix or the MDCH website for a copy of the form.) Required medical documentation must accompany the form. The information on the PA request form must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Thorough – Complete information, including the appropriate HCPCS procedure codes must be provided on the form. The form and all documentation must include the beneficiary name and Medicaid identification (ID) number, provider name, address and the provider's Medicaid ID number.

PA request forms for all eligible Medicaid beneficiaries must be sent or faxed to the MDCH Prior Authorization Division. To check the status of a PA request, contact the MDCH Prior Authorization Division via telephone. (Refer to the Directory Appendix for contact information.)

4.1. EMERGENCY PRIOR AUTHORIZATION

A provider may contact MDCH to obtain a verbal PA when the physician providing the medical clearance has indicated that it is medically necessary to provide the service within a 24-hour time period.

To obtain verbal PA, providers may call or fax a request. If the provider faxes a request, the request must state, "verbal prior authorization required" . (Refer to the Directory Appendix for contact information.)

If a service is required during nonworking hours, providers must contact the Prior Authorization Division the next working day.

The following steps must still be completed before a PA number is issued for billing purposes:

- The MSA-115 must be submitted to the Prior Authorization Division within 30 days of the verbal authorization.
- Supporting documentation must be submitted along with the PA request.
- The verbal authorization date must be entered on the MSA-115.

The verbal authorization does not guarantee reimbursement for the services if:

- The beneficiary was not eligible when the service was provided.
- The Prior Authorization Division does not receive the completed MSA-115 and required documentation within 30 days of the verbal authorization.
- The required documentation is dated after the date of service.

4.2 Retroactive Prior Authorization

Services provided before PA is requested are not covered unless the beneficiary was not eligible on the date of service (DOS) and a subsequent eligibility determination was made retroactive to the DOS. If MDCH's record does not show that retroactive eligibility was provided, then the request for retroactive PA is denied.

4.3 Beneficiary Eligibility

Approval of a service on the MSA-115 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible. To assure payment, the provider must verify eligibility for fee-for-service (FFS) Medicaid or the CSHCS before initiating services.

4.4 Reimbursement Amounts

Many items have established fee screens that are published in the Outpatient Therapy Database. For NOC codes and all codes without established fee screens, the approved reimbursement amount is indicated on the authorized PA request.

4.5 Billing Authorized Services

After authorization is issued, the information (e.g., PA number, procedure code, modifier, and quantity) that was approved on the authorization must match the information on the claim form. (Refer to the Billing & Reimbursement Chapters of this manual for complete billing instructions.)

The copy of the PA request returned to the provider must be retained in the beneficiary's medical record.

SECTION 5 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

5.1 OCCUPATIONAL THERAPY

MDCH covers Occupational Therapy (OT) Services furnished by a Medicaid-enrolled outpatient therapy provider when performed by:

- An occupational therapist currently registered in Michigan (OTR);
- A certified occupational therapy assistant (COTA) under the supervision of an OTR (i.e., the COTA's services must follow the evaluation and treatment plan developed by the OTR and the OTR must supervise and monitor the COTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the appropriate supervising OTR; or
- A student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) an OTR. All documentation must be reviewed and signed by the appropriate supervising OTR.

OT is considered an all-inclusive charge and MDCH does not reimburse for a clinic room charge in addition to OT services unless it is unrelated. MDCH expects OTR's and COTA's to utilize the most ethically appropriate therapy within their scope of practice as defined by state law and/or the appropriate national professional association. OT must be medically necessary, reasonable and required to:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status; or
- Prevent a reduction in medical or functional status had the therapy not been provided.

For CSHCS beneficiaries	OT must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing care.
For beneficiaries 21 years of age and older	OT is only covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations or participation restrictions.

MDCH anticipates OT will result in a functional improvement that is significant to the beneficiary's ability to perform appropriate daily living tasks (per beneficiary's chronological, developmental, or functional status). Functional improvements must be achieved in a reasonable amount of time and must be maintainable. MDCH does not cover therapy that does not have an impact on the beneficiary's ability to perform age-appropriate tasks.

OT must be skilled (i.e., require the skills, knowledge and education of an OTR). MDCH does not cover interventions provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], family member, or caregiver).

OT may be covered for one or more of the following:	▪ Therapeutic use of occupations*. ▪ Adaptation of environments and processes to enhance functional performance in occupations*. ▪ Graded tasks (performance components) in activities as prerequisites to an engagement in occupations*. ▪ Design, fabrication, application, or training in the use of assisted technology or orthotic devices. ▪ Skilled services that are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers. Routine provision of the maintenance/prevention program is not a covered OT service. * Occupations are goal-directed activities that extend over time (i.e., performed repeatedly), are meaningful to the performer, and involve multiple steps or tasks. For example, doing dishes is a repeated task. Buying dishes happens once; therefore, does not extend over time and is not a repeated task.
OT is not covered for the following:	▪ When provided by an independent OTR**. ▪ For educational, vocational, or recreational purposes. ▪ If services are required to be provided by another public agency (e.g., community mental health services provider, school-based services). ▪ If therapy requires PA and service is rendered before PA is approved. ▪ If therapy is habilitative. Habilitative treatment includes teaching someone how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. This may include teaching a child normal dressing techniques or cooking skills to an adult who has not performed meal preparation tasks in the past. ▪ If therapy is designed to facilitate the normal progression of development without compensatory techniques or processes. ▪ For development of perceptual motor skills and sensory integrative functions to follow a normal sequence. If the beneficiary exhibits severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function, OT may be covered. ▪ Continuation of therapy that is maintenance in nature. ** An independent OTR may enroll in Medicaid if he provides Medicare-covered therapy and intends to bill Medicaid for Medicare coinsurance and/or deductible only.

5.1.A. Duplication of Services

Some therapy areas (e.g., dysphagia, assistive technology, hand therapy) may be appropriately addressed by more than one discipline (e.g., OT, PT, speech therapy) in more than one setting. MDCH does not cover duplication of service (i.e., where two disciplines are working on similar goals/areas). The OTR is responsible to communicate with other therapists and coordinate services. MDCH requires any related documentation to include coordination of services.

5.1.B. Services to School-aged Beneficiaries

School-aged beneficiaries may be eligible to receive OT through multiple sources. MDCH expects educational OT to be provided by the school system, and it is not covered by MDCH or CSHCS. (Example: OT coordination for handwriting, increasing attention span, identifying colors and numbers).

MDCH only covers medically necessary OT when provided in the outpatient setting. Coordination between all OT providers must be continuous to ensure a smooth transition between sources.

Outpatient therapy provided to school-aged children during the summer months in order to maintain the therapy services provided in the school are considered a continuation of therapy services when there is no change in beneficiary diagnosis or function. Prior authorization is required before initiating a continuation of therapy.

5.1.C. Aquatic Therapy

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool would be reimbursed when billed using the HCPCS code describing the covered procedure as long as the service met all Medicaid coverage requirements.

5.1.D. Group Therapy

OT is not covered by Medicaid when provided concurrently to a group of two or more individuals by the same therapist. Covered therapeutic procedures require direct (one-to-one) patient contact by the therapist.

5.1.E. Serial Casting

Serial casting is a process in which a joint or joints, which normally lack full range of motion, are immobilized with a rigid cast. During this procedure, the affected joint or joints are gradually and repeatedly set in more anatomically correct alignment to improve joint alignment and/or to achieve a decrease in abnormal tone and increased muscle length, resulting in an increase in the range of motion.

Casts are applied and removed in succession, usually every week, over a specified period of time. Upon removal of each cast, the limb is stretched and a new cast is applied immediately to hold the limb in place.

Serial casting is a covered Medicaid/CSHCS benefit when performed by or under the direct supervision of a qualified therapist and defined in a treatment plan as medically necessary rehabilitation services for improving range of motion and/or reducing tone. Either the physician referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting or the referring physician must provide written concurrence of any treatment plan including serial casting. For CSHCS beneficiaries without dual Medicaid eligibility, the service must be directly related to the

CSHCS-eligible diagnosis and must be referred by the beneficiary's assigned pediatric sub-specialist.

5.1.F. Prescription Requirements

MDCH requires a physician's prescription for an OT evaluation and preparation of the treatment plan. The prescription must include beneficiary name, prescribed therapy, and diagnosis(es) or medical conditions(s). MDCH requires a new prescription if OT is not initiated within 30 days of the prescription date. An evaluation may be provided for the same medical diagnosis without PA twice in a 365-day period with a physician's prescription. PA is required if an evaluation is needed more frequently.

Evaluations	Evaluations must include standardized tests and/or measurable functional baselines. OT evaluations must be completed by an OTR and include the following: ▪ Treatment diagnosis and medical diagnosis, if different from the treatment diagnosis(es) (e.g., medical diagnosis of cerebral palsy with contractures being treated); ▪ OT provided previously, including facility/site, dates, duration, and summary of change; ▪ Current therapy being provided to the beneficiary in this or other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ Standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension).
Treatment Plan	The OT treatment plan that results from the evaluation must consist of the following: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's life goals; ▪ Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy; ▪ Anticipated frequency and duration of treatment required to meet short- and long-term goals;

	▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs; ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational); and ▪ Physician signature verifying acceptance of the treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring physician.
Initiation of Services	OT may be initiated without PA upon completion of the assessment and development of a treatment plan that is reasonable and medically necessary as documented in the patient record. The outpatient setting allows up to 36 OT services provided in the initial 90-day treatment period. If therapy is not initiated within 30 days of the prescription date, a new prescription is required. PA is not required for the initial period of skilled therapy for the first 90 consecutive calendar days in the outpatient setting for a new treatment diagnosis or new medical diagnosis if: ▪ The beneficiary remains Medicaid-eligible during the period therapy is provided. ▪ A copy of the physician's signed and dated (within 30 days of initiation of services) prescription for OT is on file in the beneficiary's medical record. Providers may initiate services without PA when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability. OT must be provided by the evaluating discipline. (Example: a speech-language pathologist cannot provide treatment under an occupational therapist's evaluation). Co-signing of evaluations and sharing treatments require PA. MDCH does not cover the service when Medicare determines that the service is not medically necessary.
Requirements of Continued Therapy	The OTR must request PA to continue therapy beyond the initial 90 days. When requesting PA, providers must complete the MSA-115. MDCH returns a copy of the PA to the provider, and it must be retained in the beneficiary's medical record. The OTR may request up to 90 consecutive calendar days of continued active therapy in the outpatient setting. Requests to continue active therapy must be supported by the following: ▪ Treatment summary of previous OT period, including measurable progress on each short- and long-term goal. This must include the treating OTR's analysis of the therapy provided during the previous month, rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes. ▪ Progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy. ▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.

	▪ Statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ Statement detailing coordination of services with other therapies (e.g., medical and educational) if appropriate. ▪ A copy of the prescription must be provided with each request. The prescription must be hand-signed by the referring physician and dated within 30 days prior to initiation of the continued service. ▪ A discharge plan.
Maintenance/ Monitoring Services	In some cases, the beneficiary does not require active treatment, but the skills of an OTR are required for training or monitoring of maintenance programs being carried out by family and/or caregivers or continued follow-up for the fit and function of orthotic or prosthetic devices. PA is not required for these types of service for up to four times per 90-day period in the outpatient setting. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required. The OTR must complete an MSA-115 and include the following: ▪ Service summary, including a description of the skilled services being provided (to include the treating OTR's analysis of the rate of progress, and justification for any change in the treatment plan). Documentation must relate to the period immediately prior to that time period that you are requesting PA. ▪ A comprehensive description of the maintenance/activity plan. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (medical and educational) if appropriate. ▪ The anticipated discharge plan. ▪ The anticipated frequency and duration of continued maintenance/monitoring.

5.1.G. Resuming Therapy

PA is required when OT services must be resumed within a 12-month period for the same diagnosis. A discharge summary for the previous therapy or an explanation of the changes in functional or medical status must accompany the PA request. MDCH does not approve PA if this information is not provided with the request. The copy of MSA-115 is returned to the requesting provider and must be retained in the beneficiary's medical record.

Therapy may be resumed within a 12-month period without PA if there are functional changes due to a change in the treatment diagnosis (e.g., decreased active range of motion resulting in an inability to dress the upper extremities).

The LPT must supervise and monitor the CPTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the licensed supervising LPT.

5.2 Physical Therapy

MDCH uses the terms physical therapy, PT and therapy interchangeably. PT is covered when furnished by a Medicaid-enrolled outpatient therapy provider and performed by a Michigan-licensed Physical Therapist (LPT) or an appropriately supervised Certified Physical Therapy Assistant (CPTA).

PT must be medically necessary, reasonable and necessary to return the beneficiary to the functional level prior to illness or disability or to a functional level that is appropriate to a stable medical status within a reasonable amount of time.

For CSHCS beneficiaries	PT must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the beneficiary's care. Functional progress must be demonstrated and documented.
For beneficiaries 21 years of age and older	PT is covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant to the beneficiary's life roles despite impairments, activity limitations or participation restrictions.

MDCH anticipates PT will result in significant functional improvement in the beneficiary's ability to perform mobility skills appropriate to his chronological, developmental, or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). PT making changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks are not covered.

PT must be skilled (i.e., require the skills, knowledge and education of an LPT). MDCH does not cover interventions provided by another practitioner (e.g., teacher, RN, OTR, family member, or caregiver).

MDCH covers the physical therapist's initial evaluation of the beneficiary's needs and design of the PT program. The program must be appropriate to the beneficiary's capacity, tolerance, treatment objectives, and include the instructions to the beneficiary and support personnel (e.g., aides or nursing personnel) for delivery of the individualized treatment plan. MDCH covers infrequent reevaluations, if appropriate.

The cost of supplies and equipment used as part of the therapy program is included in the reimbursement for the therapy. MDCH only covers a clinic room charge in addition to PT if it is unrelated.

PT services may be covered for one or more of the following reasons:

- PT is expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills;
- PT service is diagnostic;
- PT is for a temporary condition and creates decreased mobility; or
- Skilled PT services are designed to set up, train, monitor, and modify a maintenance or prevention program to be performed by family or caregivers. MDCH does not reimburse for routine provision of the maintenance/prevention program.

PT may include:

- Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility);
- Stretching for improved flexibility;
- Instruction of family or caregivers;
- Modalities to allow gains of function, strength, or mobility; and/or
- Training in the use of orthotic/prosthetic devices.

MDCH requires a new prescription if PT is not initiated within 30 days of the prescription date.

PT is not covered for beneficiaries of all ages for the following:

- When PT is provided by an independent LPT. (An independent LPT may enroll in Medicaid if they provide Medicare-covered therapy and intend to bill Medicaid for Medicare coinsurance and/or deductible only.)
- When PT is for educational, vocational, or recreational purposes.
- If PT services are required to be provided by another public agency (e.g., CMHSP services, school-based services [SBS]).
- If PT requires PA and services are rendered prior to approval.
- If PT is habilitative therapy. Habilitative treatment includes teaching a beneficiary how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. For example, teaching a child normal dressing techniques or teaching cooking skills to an adult who has not performed meal preparation tasks previously.
- If PT is designed to facilitate the normal progression of development without compensatory techniques or processes.
- If PT is a continuation of PT that is maintenance in nature.
- If PT services are provided to meet developmental milestones.
- If PT services are not covered by Medicare as medically necessary.

Only medically necessary PT may be provided in the outpatient setting. Coordination between all PT providers must be continuous to ensure a smooth transition between sources.

5.2.A. Duplication of Services

MDCH recognizes some areas of therapy (e.g., dysphagia, assistive technology, hand therapy) may also be addressed appropriately by multiple disciplines (e.g., OT, PT, speech therapy) in more than one setting. MDCH does not cover two disciplines working on similar areas/goals. The LPT is responsible for coordinating/communicating with other therapists and providing documentation in the medical record.

5.2.B. Services to School-Aged Beneficiaries

MDCH recognizes school-aged beneficiaries may be eligible to receive PT through multiple sources. MDCH expects educational PT (e.g., strengthening to play school sports) to be provided by the school system and is not covered by MDCH or CSHCS.

Outpatient therapy provided to school-aged children during the summer months in order to maintain the therapy services provided in the school are considered a continuation of therapy services when there is no change in beneficiary diagnosis or function. Prior authorization is required before initiating a continuation of therapy.

5.2.C. Aquatic Therapy

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool would be reimbursed when billed using the HCPCS code describing the covered procedure as long as the service met all Medicaid coverage requirements.

5.2.D. Group Therapy

PT is not covered by Medicaid when provided concurrently to a group of two or more individuals by the same therapist. Covered therapeutic procedures require direct (one-to-one) patient contact by the therapist.

5.2.E. Serial Casting

Serial casting is a process in which a joint or joints, which normally lack full range of motion, are immobilized with a rigid cast. During this procedure, the affected joint or joints are gradually and repeatedly set in more anatomically correct alignment to improve joint alignment and/or to achieve a decrease in abnormal tone and increased muscle length, resulting in an increase in the range of motion.

Casts are applied and removed in succession, usually every week, over a specified period of time. Upon removal of each cast, the limb is stretched and a new cast is applied immediately to hold the limb in place.

Serial casting is a covered Medicaid/CSHCS benefit when performed by or under the direct supervision of a qualified therapist and defined in a treatment plan as medically necessary rehabilitation services for improving range of motion and/or reducing tone. Either the physician referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting or the referring physician must provide

written concurrence of any treatment plan including serial casting. For CSHCS beneficiaries without dual Medicaid eligibility, the service must be directly related to the CSHCS-eligible diagnosis and must be referred by the beneficiary's assigned pediatric sub-specialist.

5.2.F. Prescription Requirements

MDCH requires a physician's prescription for a PT evaluation and preparation of the treatment plan. It must include the beneficiary's name, prescribed therapy and diagnosis(es) or medical condition. A new prescription is required if PT is not initiated within 30 days of the prescription date.

Evaluation	MDCH does not require PA for evaluations. An evaluation is formalized testing in the early stages of a beneficiary's treatment program followed by periodic testing and reports to indicate the disposition of the beneficiary's treatment. Evaluations may be provided for the same diagnosis without PA twice in a 365-day period with a physician's prescription. PA is required for more frequent evaluations. PT evaluations must be completed by a LPT, include standardized tests and/or measurable functional baselines, and include: ▪ Treatment and medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with gait treatment); ▪ PT previously provided, facility/site, dates, duration, and summary of change; ▪ Current therapy provided in this or other settings; ▪ Medical history as it relates to current PT; ▪ Beneficiary's current functional status (i.e., functional baseline); ▪ Standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory, visual, and comprehensive).
Treatment Plan	MDCH requires a PT treatment plan immediately follow the evaluation. The treatment plan must include: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function and/or mobility; ▪ Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy;

	▪ Anticipated frequency and duration consist of treatment required to meet short-term and long-term goals; ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs; ▪ Statement detailing coordination of services with other therapies (e.g., medical and educational); and ▪ Physician signature verifying acceptance of the treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring specialist physician.
Initiation of Services	MDCH requires PT be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without PA. For the initial period, PT may be provided up to 36 times in the 90-day outpatient setting. PT must be provided by the evaluating discipline (e.g., OTR cannot provide treatment under a PT's evaluation). Co-signing evaluations and sharing treatment requires PA. MDCH does not require PA for the initial period of skilled therapy the first 90 consecutive calendar days in the outpatient setting for a new treatment diagnosis or new medical diagnosis if: ▪ Beneficiary remains Medicaid-eligible during the period therapy is provided; and ▪ A copy of the physician's signed and dated (within 30 days of initiation of services) prescription for PT is on file in the medical record. MDCH does not require PA when PT services are initiated when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.
Continued Active Treatment	MDCH requires providers to obtain PA to continue PT beyond the initial 90 days. Providers must complete the MSA-115. MDCH returns a copy of the PA to the provider after processing the request. The PA must be retained in the beneficiary's medical record. Requests to continue Active Therapy must contain: ▪ A treatment summary of the previous period of PT, including measurable progress on each short-term and long-term goal. This should include the treating LPT's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes. ▪ A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of PT. ▪ Documentation related to the period no more than 30 days prior to that time period for which PA is being requested.

	▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ A copy of the prescription hand-signed by the referring physician and dated within 30 days prior to initiation of continued service must be provided for each request. ▪ A discharge plan.
Maintenance/ Monitoring Services	MDCH recognizes that, in some cases, a beneficiary does not require active treatment but the skills of an LPT are necessary for training or monitoring of maintenance programs being performed by family and/or caregivers. PA is not required for these types of services for up to four times in 90 days for the outpatient setting. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required for up to 90 consecutive calendar days in the outpatient setting. The LPT must complete an MSA-115 and include: ▪ A service summary, including a description of the skilled services being provided (including the treatment LPT's analysis of the rate of progress, and justification for any change in the treatment plan). Documentation must relate to the period immediately prior to that time period for which PA is requested. ▪ A comprehensive description or copy of the maintenance/activity plan. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ A discharge plan.

5.2.G. DISCHARGE SUMMARY

MDCH requires the LPT to document a discharge summary to identify the completion of PT services and the discharge status. This must include:

- Dates of service (i.e., initial and discharge dates);
- Description of services provided;
- Functional status related to treatment areas/goals at discharge;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- Description or copy of follow-up or maintenance program put into place, if appropriate;
- Identification of adaptive equipment provided (e.g., walker) and its current utilization, if appropriate; and
- Recommendations/referral to other services, if appropriate.

5.2.H. Resuming Therapy

MDCH requires PA if PT services must be resumed within a 12-month period for the same diagnosis. Providers must provide a discharge summary for the previous therapy or an explanation of the changes in functional or medical status when requesting PA. Providers must retain a copy in the beneficiary's medical record.

MDCH only covers PT resumed within a 12-month period without PA if there are functional changes due to a change in treatment diagnosis**.**

5.3 Speech Therapy

The terms speech therapy, speech-language pathology, speech-language therapy, and therapy are used to mean speech and language rehabilitation services and speech-language therapy.

MDCH covers speech-language therapy provided in the outpatient setting. MDCH only reimburses services for speech-language therapy when provided by:

- A speech-language pathologist (SLP) with a current Certificate of Clinical Competence (CCC)
- An appropriately supervised SLP candidate (i.e., in their clinical fellowship year [CFY]) or having completed all requirements but has not obtained a CCC. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.
- A student completing his clinical affiliation under direct supervision of (i.e., in the presence of) an SLP having a current CCC. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

MDCH expects that all SLPs will utilize the most ethically appropriate therapy within their scope of practice as defined by Michigan law and/or the appropriate national professional association.

For all beneficiaries of all ages, speech therapy must relate to a medical diagnosis, and is limited services for:

- Articulation
- Language
- Rhythm
- Swallowing
- Training in the use of an speech-generating device
- Training in the use of an oral-pharyngeal prosthesis
- Voice

For CSHCS beneficiaries (i.e., those not enrolled in Medicaid; only enrolled with CSHCS), therapy must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the care of the beneficiary.

Therapy must be reasonable, medically necessary and expected to result in an improvement and/or elimination of the stated problem within a reasonable amount of time (i.e., when treatment is due to a recent change in medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status without therapy).

Speech therapy services must be skilled (i.e., require the skills, knowledge and education of a certified SLP to assess the beneficiary for deficits, develop a treatment program and provide therapy). Interventions that could be provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], registered occupational therapist [OTR], family member, or caregiver) would not be reimbursed as speech therapy by MDCH.

For beneficiaries of all ages, therapy is not covered:

- When provided by an independent SLP.
- For educational, vocational, social/emotional, or recreational purposes.
- If services are required to be provided by another public agency (e.g., PIHP/CMHSP provider, SBS).
- When intended to improve communication skills beyond premorbid levels (e.g., beyond the functional communication status prior to the onset of a new diagnosis or change in medical status).
- If it requires PA but is rendered before PA is approved.
- If it is habilitative. Habilitative treatment includes teaching someone communication skills for the first time without compensatory techniques or processes. This may include syntax or semantics (which are developmental) or articulation errors that are within the normal developmental process.
- If it is designed to facilitate the normal progression of development without compensatory techniques or processes.
- If continuation is maintenance in nature.
- If provided to meet developmental milestones.
- If Medicare does not consider the service medically necessary.

5.3.A. Duplication of Services

Some areas (e.g., dysphagia, assistive technology) may appropriately be addressed by more than one discipline (e.g., OT, PT, speech therapy) in more than one setting. MDCH does not cover duplication of services, i.e., where two disciplines are working on similar areas/goals. It is the treating therapist's responsibility to communicate with other practitioners, coordinate services, and document this in his reports.

5.3.B. Services to School-Aged Beneficiaries

School-aged beneficiaries may be eligible to receive speech-language therapy through multiple sources. Educational speech is expected to be provided by the school system and is not covered by MDCH or CSHCS. Examples of educational speech include enhancing vocabulary, improving sentence structure, improving reading, increasing attention span, and identifying colors and numbers. Only medically necessary therapy may be provided in the outpatient setting. Coordination between all speech therapy providers should be continuous to ensure a smooth transition between sources.

Outpatient therapy provided to school-aged children during the summer months in order to maintain the therapy services provided in the school are considered a continuation of therapy services when there is no change in beneficiary diagnosis or function. Prior authorization is required before initiating a continuation of therapy.

5.3.C. Physician Referral for Speech Therapy

A physician referral is required for Medicaid coverage of speech therapy. A physician referral for speech therapy must be documented in the beneficiary's medical record and must include the following:

- Beneficiary name;
- Beneficiary date of birth;
- Diagnosis for referral (for CSHCS beneficiaries, this must be the CSHCS-qualifying diagnosis); and
- A statement indicating that the beneficiary is being referred for speech therapy.

If therapy is not initiated within 30 days of the referral date, a new referral is required. A new physician referral must be made at least annually for continuing treatment lasting longer than 12 months. Whenever a beneficiary is discharged from speech therapy treatment, a new referral must be made and an evaluation and treatment plan must be completed before therapy may resume.

A copy of the physician referral must be attached to all PA requests for speech therapy.

Evaluation	Does not require PA. This is formalized testing in early stages of a beneficiary's treatment program followed by periodic testing and reports to indicate measurable functional change resulting from the beneficiary's treatment. These may be provided for the same diagnosis without PA twice in a 365-day period with a physician's referral. If an evaluation is needed more frequently, PA is required. Evaluations must include standardized tests and/or measurable functional baselines. The speech-language evaluation must be completed by an SLP and include: ▪ The disorder and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with dysphasia as the speech disorder being treated).

	▪ Speech therapy provided previously, including facility/site, dates, duration and summary of measurable change. ▪ Current rehabilitation services being provided to the beneficiary in this or other settings. ▪ Medical history as it relates to the current course of therapy. ▪ Beneficiary's current functional communication status (functional baseline). ▪ Standardized and other evaluation tools used to establish the baseline and to document progress. ▪ Assessment of the beneficiary's functional communication skill level, which must be measurable. ▪ Medical, physical, intellectual deficits that could interfere with the beneficiary's improvement in therapy. Evaluations must include, but are not limited to: ▪ Articulation – standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication and a medical diagnosis. ▪ Language – standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es). ▪ Rhythm – standardized tests that measure receptive and expressive language, mental age, oral motor skills, measurable assessment of dysfluency, current means of communication and a medical diagnosis. ▪ Swallowing – copy of a video fluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment and a standardized cognitive assessment. ▪ Voice – copy of the physician's medical assessment of the beneficiary's voice mechanism and medical diagnosis.
Treatment Plan	Is the immediate result of the evaluation and consists of: ▪ Time-related short-term goals that are measurable, functional and significant to the beneficiary's communication needs. ▪ Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from speech-language therapy services. ▪ Anticipated frequency and duration of treatment required to meet short-term and long-term goals. ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs. ▪ Statement detailing coordination of services with other therapies (e.g., medical and educational).

	▪ Documentation of physician acceptance of stated treatment plan. The treatment plan must be accepted by the referring specialist physician for CSHCS beneficiaries. Physician acceptance of the speech therapy treatment plan must be documented by one of the following processes: ▪ Phone call to the referring physician (document date and time) ▪ Copy of the plan to the referring physician (document date sent and method sent) ▪ Referring physician sign-off on the treatment plan Documentation of the physician acceptance of the speech therapy treatment plan must be placed in the beneficiary's medical record.
Initiation of Services	Therapy may only be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without PA. For the initial period, speech may be provided up to a maximum of 36 times during the 90 consecutive calendar days in the outpatient setting. If therapy is not initiated within 30 days of the referral, a new referral is required. No more than one encounter for individual speech therapy and one encounter for group speech therapy may be billed on the same date of service. Each encounter must represent a minimum of 25 minutes of therapy provided on the date of services. Therapy must be provided by the evaluating discipline. (An OTR cannot provide treatment under a SLP's evaluation.) Co-signing of evaluations and sharing treatments require PA. PA is not required for the initial period of skilled therapy for the first 90 consecutive calendar days in the outpatient setting for a new treatment diagnosis or new medical diagnosis if: ▪ Beneficiary remains Medicaid-eligible and enrolled during the period services are provided; and ▪ A copy of the physician's signed and dated (within 30 days of initiation of services) referral for speech-language therapy is on file in the beneficiary's medical record. Providers may also initiate services without PA when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.

Continued Active Treatment	MDCH requires providers to request PA for therapy beyond the initial 90 days. The SLP must complete the MSA-115. MDCH returns a copy of the PA to the provider after processing the request. The PA must be retained in the beneficiary's medical record. The SLP may request up to 90 consecutive calendar days of continued active therapy in the OPH setting. Requests to continue active treatment must be accompanied by: ▪ Treatment summary of the previous service period, including measurable progress on each short-term and long-term goal. This must include the treating SLP's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes. ▪ A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy. ▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested. ▪ A statement of the beneficiary's treatment response, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and education), if appropriate. ▪ Anticipated frequency and duration of maintenance/monitoring. ▪ A discharge plan. ▪ A copy of the referral hand-signed by the referring physician and dated within 30 days prior to initiation of continued service must be provided with each request.
Maintenance/ Monitoring Services	A beneficiary may not require active treatment, but the skills of an SLP are required for training or monitoring of maintenance programs that are being carried out by a family member and/or caregiver. In the outpatient setting, these types of service may be provided without PA up to four times per 90-day period. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required. The SLP must complete the MSA-115 and include: ▪ A service summary including a description of the skilled services being provided. This should include the treating SLP's analysis of the rate of progress and justification for any change in treatment plan. Documentation must relate to the period immediately prior to that time period for which PA is requested and can cover up to three months. ▪ A comprehensive description or copy of the maintenance/activity plan. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of service with other therapies (e.g., medical and educational) if appropriate. ▪ The anticipated frequency and duration of continued maintenance/monitoring. ▪ A discharge plan.

5.3.D. Discharge Summary

When the beneficiary is discharged from therapy services, the SLP must maintain a discharge summary on file as a mechanism for identifying completion of services and beneficiary status at discharge. The discharge summary should include:

- Dates of service (initial and discharge);
- Description of services provided;
- Functional status related to treatment areas/ goals at discharge;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- Description or copy of follow-up or maintenance program put into place, if appropriate;
- Identification of adaptive equipment provided and its current utilization, if appropriate; and
- Recommendations/referral to other services, if appropriate.

5.3.E. Resuming Therapy

If services must be resumed within a 12-month period for the same diagnosis, PA is required. A discharge summary of the previous therapy or an explanation of the changes in functional or medical status must accompany the PA request.

5.3.F. Evaluations and Follow-Up for Speech-Generating Devices

Up to six hours of face-to-face time spent by the SLP evaluating or re-evaluating a beneficiary to determine the need for a specified Speech-Generating Device (SGD) may be billed in three years without PA. The results of this evaluation must be shared with the prescribing physician.

SGD follow-up care that requires the skills of an SLP as is identified by the evaluating SLP may be billed up to two times per year before PA is required. This service includes training or set-up services (including programming and modification) that are **not** provided by the SGD vendor.

An SLP evaluation for the use and/or fitting of a voice prosthetic device to supplement oral speech is only to be billed to determine the need for an electro-larynx. This service may be billed once in 3 years without PA.

PA is required for all SGDs. An additional PA form for SGDs, the Augmentative Communication Device (ACD) Evaluation form (MSA-1653-C) must be completed by the evaluating SLP and must accompany the PA request. Additional information regarding SGDs may be found in the Medical Supplier Chapter of this manual

5.3.G. Supplies and Equipment

The cost of supplies and equipment used as part of the speech therapy is included in the reimbursement for the therapy services.

PHARMACY

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SECTION 1 – GENERAL INFORMATION [CHANGE MADE 4/1/06]

Michigan Department of Community Health (MDCH) administers the fee-for-service (FFS) programs for Medicaid, Children's Special Health Care Services (CSHCS), Maternity Outpatient Medical Services (MOMS), and Adult Benefits Waiver (ABW). This chapter and the Michigan **(corrected 4/1/06)** Pharmaceutical Product List (MPPL) comprise program policies and explain coverage and reimbursement for the services dispensed and billed by enrolled pharmacies (Provider Type 50).

Throughout this chapter the terms Medicaid and MDCH are used to refer to the Michigan Medicaid FFS, CSHCS, MOMS, and ABW programs unless otherwise noted.

1.1 MDCH PHARMACY BENEFITS MANAGER AND OTHER VENDOR CONTRACTORS

MDCH retains all decisions for policy, coverage, and reimbursement. However, MDCH contracts with First Health Services Corporation (FHSC) as its pharmacy benefits manager (PBM). PBM services provided include pharmacy claims payment (paper and electronic), claims instruction, prior authorization (PA), prospective drug utilization, retrospective drug utilization, clinical consultation, provider enrollment, provider information lines, and provider audits. (Refer to the Directory Appendix for PBM contact information.)

The PBM website contains the:

- Pharmacy Claims Processing Manual for Michigan Medicaid
- Michigan Pharmaceutical Product List (MPPL)
- Preferred Drug List (PDL)
- Drug Utilization Review (DUR) Meeting Notices
- Dose Optimization Program
- Pharmacy and Therapeutics (P&T) Committee Meeting Notices
- Pharmacy Forms
- Maintenance Drug List

Pharmacies may call the PBM for questions or concerns. Beneficiaries may call the PBM Beneficiary Helpline. (Refer to the Directory Appendix for contact information.)

MDCH contracts with other vendors to perform financial, program or provider audits on behalf of the State of Michigan. (Refer to the Pharmacy Resources portion of the Directory Appendix for additional information.)

1.2 DEFINITIONS

The following definitions have specific meaning in the Pharmacy program:

Average Wholesale Price (AWP)	The price of a product as published by First Data Bank.

Bingo Cards	Bingo cards are cards, sheets, or blister packs of medications that are not separable into single tamper-evident unit packages and do not have each individual dose of the drug identified with the drug name, manufacturer, lot number, and expiration date of the drug, so that the drug can be legally used by the patient.
Brand-Name Drug	A single-source drug, a cross-licensed drug or an innovator drug for which a lower-cost generic equivalent is available.
Compounded Prescription	The combination of two or more ingredients extemporaneously mixed in usually accepted therapeutic doses. This requires the pharmacist's skill in weighing, measuring, levigating, etc., at the time of dispensing. The allowable compounding fee applies to the preparation of an individual prescription. It does not apply to prescriptions dispensed from a previously prepared stock supply (i.e., premaking a special lotion, cream, or ointment in gallons or pounds).
Dispensing Fee	Payment for filling a prescription and all related services performed by a pharmacist.
Drug Efficacy Study Implementation (DESI) Drugs	FDA designations related to "substantial evidence" of effectiveness. These products are also known as proposed less than effective.
Drug Utilization Review (DUR)	A process designed to ensure that prescriptions are appropriate, medically necessary and not likely to result in adverse medical outcomes.
Drug Utilization Review Board (DUR Board)	An advisory board to the State's Medicaid Program that includes physicians and pharmacists.
Federal Drug Rebate Program	Program established by the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which requires Labelers to sign a rebate agreement with the CMS in order to have their products covered for Medicaid beneficiaries. State Medicaid agencies administer the program and collect rebates from the Labelers.
Fraud	Deliberate, intentional, and willful act with the specific purpose of deceiving MDCH with respect to any material fact, condition, or circumstance affecting eligibility or need.
Generic	Refers to a nonproprietary drug or class of drugs. The generic name refers to the official chemical composition of the drug as published in the latest edition of a national recognized pharmacopoeia or drug compendium. Generics do not refer to a particular brand name product.
Labeler	Any firm that manufactures, replaces or distributes a drug product.
Legend Drug	A drug bearing the statement: "Caution – Federal Law Prohibits Dispensing without a Prescription."

Long Term Care Pharmacy	Refers to pharmacies specializing in provision of drugs and services in an institutional setting such as a nursing home, medical care facility or hospital long term care unit.
Maximum Allowable Cost (MAC)	The maximum cost allowed by MDCH for certain multiple source brands, generics, cross-licensed drugs and sometimes for sole-source drugs or classes.
Multiple Source Drug (Multi-Source)	A drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name and without such a name.
National Council for Prescription Drug Programs (NCPDP)	Develops standards for electronic pharmacy transactions (Point of Sale claims transactions).
National Drug Code (NDC)	The eleven-digit code assigned to all prescription and over-the-counter products by the labeler/manufacturer of the product under Federal Drug Administration (FDA) regulations.
Out of State Pharmacy	An entity not housed within the state of Michigan but registered by the Michigan Board of Pharmacy. An Out of State Pharmacist is required to be licensed in the state the pharmacy is located in.
Over-the-Counter (OTC)	A drug that can normally be purchased without a physician's prescription, although may require a prescription if covered by Medicaid.
Pharmacist	A person licensed under Michigan statutes to provide services within the scope of pharmacy practice.
Pharmacy	An entity registered by the Michigan Board of Pharmacy.
Point-of-Sale (POS)	Real-time on-line adjudication of pharmacy claims to the PBM. Point-of Sale provides participating pharmacies real-time access to beneficiary eligibility, drug coverage, pricing information, guidelines for drug use, and dispensing fees.
Prescribed Drug	A drug, either legend or over-the-counter, that is ordered by a prescriber to be used by a patient to treat a disease or condition.
Prospective Drug Utilization Review (ProDUR)	Detection, evaluation, and counseling components of pre-dispensing drug therapy screening. ProDUR is required at the point of sale before each prescription is delivered to a Medicaid beneficiary. ProDUR screening is the responsibility of each Medicaid participating pharmacy and is a requirement of Medicaid participation.

Retrospective Drug Utilization Review (RetroDUR)	Program that analyzes and interprets patterns of prescribing and dispensing beneficiary drug usage through periodic examinations of claims data to identify patterns of fraud and abuse, gross overuse, and inappropriate or medically unnecessary care.
Return to Stock	Prescriptions filled but not dispensed or picked up by the beneficiary, and unit dose medication not administered.

1.3 Children's Special Health Care Services

Pharmacy coverage for beneficiaries who only have CSHCS coverage is limited to those pharmaceutical products that are required for the treatment of the CSHCS qualifying diagnoses. The beneficiary's CSHCS qualifying diagnosis are listed on his eligibility letter by International Classification of Diseases-9 (ICD-9) code. Pharmacies may not bill for pharmaceutical products not required for the treatment of the CSHCS qualifying diagnosis. Also, the MPPL specifies other coverages unique to this program.

1.4 Place of Service

Coverage and payment policies for products dispensed in the settings listed below are not contained in this chapter or the MPPL. Healthcare providers should refer to the provider-specific chapters for Hospital, Practitioner, Nursing Facility, or Laboratory in this manual for these services:

- Physician's office or clinic: Injectable products used in physician offices or clinics are reimbursed to the healthcare provider administering the drug, not a pharmacy. If a pharmacy sells injectable products to a physician or clinic, a pharmacy must obtain payment directly from the purchasing provider and not MDCH. Injectable products are not to be dispensed to the beneficiary for the purpose of administration at the physician's office.

  Exception: Beneficiaries with a level of care (LOC) 02 can receive injectable drugs as a pharmacy benefit due to the relationship between the nursing facility and its contracted providers.
- Inpatient hospital.
- Mental health, hospital long term care, and medical care facilities with in-house pharmacies.
- Laboratory.

1.5 Outpatient Hospital

Outpatient hospitals with pharmacies enrolled with MDCH as pharmacy providers must bill for take-home pharmaceutical products in compliance with policies of this chapter and the MPPL. Such services cannot be billed under the outpatient hospital's ID number.

Injectable drugs and single doses given on the premises, including products used in conjunction with lab, radiology, and other medical procedures, must be billed using the outpatient hospital's provider type, not as a pharmacy provider.

1.6 Hospice

Services, including drugs and nutritional supplements related to a beneficiary's terminal illness, are provided by the hospice (Level of Care [LOC] 16). The hospice reimburses pharmacies for these services. Coverage, payment amounts, and billing procedures of the particular hospice must be followed. To confirm that a product is not related to the terminal illness, the pharmacist must contact the hospice regarding coverage before billing. A pharmacy must not bill MDCH for prescription services related to the terminal illness.

MDCH's PBM messages back to the pharmacy when claims are submitted for beneficiaries with a LOC 16. It is the pharmacy's responsibility to assure that the claim submitted is not related to the beneficiary's terminal illness. If billings contrary to this policy are found in post-payment review, MDCH will recover inappropriate payment.

1.6.A. Exception for Selected HIV Drugs

MDCH separately reimburses a pharmacy for selected HIV drugs that the beneficiary had previously used to prevent the terminal illness. These HIV drugs include Protease Inhibitors, Nucleoside/-tide Reverse Transcriptase Inhibitors, and Non-Nucleoside Reverse Transcriptase Inhibitors, even though the product is related to the terminal illness.

1.6.B. Products Not Related to the Terminal Illness

Covered drug products not related to the terminal illness may be separately billed by the pharmacy. For example: A hospice beneficiary has leukemia and a lifelong condition of diabetes. Products related to the diabetes can be separately billed, as a pharmacy provider.

1.7 Medicaid Health Plans and ABW County Health Plans

Coverage criteria (including PA) and reimbursement limits for members of MDCH contracted Medicaid Health Plans (MHPs) and ABW County Health Plans (CHPs) may not follow the policies specified in this chapter applicable to FFS.

Each health plan enrolls its own providers, structures its own billing system, and sets up its own drug list. Providers must contact the contracted plan for information regarding reimbursement issues.

To determine if a beneficiary is enrolled in a MHP or CHP, providers should access the Eligibility Verification System (EVS). (Refer to the Beneficiary Eligibility Chapter of this manual for additional information and to the Directory Appendix for contact information.)

Pharmacy Aspects of MHP & CHP: Quick Reference

Level of Care	07 (MHP) or 11 (CHP)
Provider Enrollment	Pharmacies must follow the MHP or CHP procedures for enrollment to ensure payment.

Pharmaceutical Coverage	Approved MHP or CHP pharmaceutical products may differ from Medicaid FFS, CSHCS and ABW Programs.
Co-payment	Co-payments may differ.
Payment and Billing	Payment levels and billing methods are set by the MHP or CHP not MDCH.
Prior Authorization (PA)	Follow the MHP and CHP PA procedures.
Questions	For general managed care questions, call MDCH's Provider Inquiry or Beneficiary Helpline. (Refer to the Directory Appendix for contact information.) Contact the individual MHP or CHP for specific coverage questions.

1.8 Intermediate Care Facility for Mentally Retarded

Beneficiaries residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) are identified by a level of care (LOC) 08. For Medicare/Medicaid dually-eligible beneficiaries, pharmacy services will be covered by Medicare Part D. Drugs not covered by Medicare Part D are included in the ICF/MF per diem rate.

1.9 Medicare Part D Benefit [Changes Made 4/1/06]

Medicare Modernization Act of 2003 provides a prescription drug benefit to Medicare beneficiaries. The benefit is commonly referred to as Medicare Part D. Dually eligible Medicare/Medicaid beneficiaries must obtain all Part D covered drugs through their Medicare Part D Plan (PDP or MA-PD) **(corrected 4/1/06)**.

Drugs covered by Medicare Part D, but not included in the beneficiary's Medicare Part D Plan's formulary will not be covered by Medicaid.

Drugs excluded from coverage by Medicare Part D will not be covered by Medicaid, except for the following:

- Benzodiazepines
- Barbiturates
- Over-the-counter (OTC) drugs listed on the MPPL

- Over-the-counter **(added for clarification 4/1/06)** agents used to promote smoking cessation
- Select group of vitamins and minerals prescribed at therapeutic doses for deficiency diagnoses that meet Medicaid coverage criteria

Questions concerning the Medicare Part D benefit must be directed to Medicare. (Refer to the Directory Appendix for contact information.)

SECTION 2 – PRESCRIBER REQUIREMENTS

All MDCH-covered legend and over-the-counter drugs (OTCs), except condoms, require a written or oral prescription by a licensed prescriber.

Coverage of pharmaceutical products is based on limitations stated in this chapter, the MPPL, and medical necessity. Determination of medical necessity and appropriateness of service is the responsibility of the prescribing physician/provider (prescriber) within the scope of currently accepted medical practice and MDCH limitations. Participating providers must observe applicable State and Federal laws, rules, regulations, and policies. MDCH may impose additional constraints to reduce misuse.

2.1 SCOPE OF PRACTICE

MDCH only reimburses for products prescribed by a licensed prescriber that are within the prescriber's scope of currently accepted medical practice and MDCH limitations.

2.2 PRESCRIBER DRUG ENFORCEMENT AGENCY NUMBER

Pharmacy providers must provide the prescriber's Drug Enforcement Agency (DEA) number on the submitted claim. If the prescriber does not have a DEA number, pharmacies must use ZZ1111119.

2.3 SANCTIONED PRESCRIBERS

MDCH does not reimburse for pharmaceuticals prescribed by providers sanctioned by the Federal Government, the State of Michigan, or for prescribers having a limited or revoked license. A list of sanctioned providers is provided through the MDCH bulletin process, and is posted on MDCH website. (Refer to the Directory Appendix for website information.)

2.4 OTHER PERTINENT SECTIONS

Prescribers should refer to other pertinent sections in this chapter for policies and procedures related to Drug Utilization Review, Prior Authorization, and the MPPL.

SECTION 3 – PHARMACY REQUIREMENTS

3.1 COMPLIANCE WITH APPLICABLE STATE, FEDERAL, AND MDCH PROVISIONS

A provider who complies with all licensing and regulation laws applicable to the practice of pharmacy in Michigan may enroll as a Medicaid provider. Applicable State and Federal laws, rules, regulations, and policies must be observed by participating pharmacies. MDCH does not enroll dispensing physicians as Medicaid providers for pharmacy services. (Refer to the General Information for Providers Chapter of this manual for additional information.)

3.2 ENROLLMENT

The PBM enrolls pharmacies on behalf of MDCH. The PBM also sends newly enrolled pharmacies the Pharmacy Claims Processing System Manual for Michigan Medicaid. The Pharmacy Provider Enrollment and Trading Partner Agreement (MSA-1626) is available online at the PBM's website. (Refer to the Directory Appendix for website information.)

SECTION 4 – COUNSELING REQUIREMENTS

Pharmacies must follow the counseling requirements mandated in State and Federal statutes and regulations. These requirements do not apply to drugs dispensed in nursing facilities that are in compliance with the drug regimen review procedures specified by the licensing authority.

4.1 OFFER TO DISCUSS

For every new prescription presented by the beneficiary, the pharmacy's representative must offer the beneficiary the opportunity to discuss/receive counseling from the pharmacist regarding the new prescription. The offer for counseling must be in a positive helpful manner. If practical, the offer to counsel must be face-to-face and verbal. Otherwise, it is permissible for the offer to be made in writing or by telephone. Pharmacies are required to provide toll-free access for beneficiary inquiries related to products dispensed. A pharmacist is not required to provide counseling when a beneficiary or representative refuses the offer for counseling.

4.2 DISCUSSION

When the beneficiary (or representative) accepts the offer for counseling, it must be provided by the pharmacist in person (whenever practical) or by telephone and may include written materials. Information must be in a language that can be understood by the beneficiary (or representative) and must include an opportunity for questions.

In addition to discussing interactions with drugs previously dispensed by the pharmacist, the discussion should also include the potential interaction with any other drugs the beneficiary indicates he is taking. The beneficiary (or representative) must be counseled in a confidential manner, consistent with any State or Federal regulations. Federal law requires that the pharmacist must discuss all the items indicated below, and any others deemed significant in the pharmacist's professional judgment. If an interpreter is required, the provider must provide one free of charge.

- The name and description of the medication.
- The dosage form, dosage, route of administration, and duration of drug therapy.
- Special directions and precautions for preparation and use by the beneficiary.
- Common side effects or interactions and therapeutic contraindications that may be encountered, including their avoidance and the action required if they occur.
- Techniques for self-monitoring drug therapy.
- Proper storage.
- Prescription refill information.
- Action to be taken in the event of a missed dose.

SECTION 5 – SIGNATURE LOG, DATA COLLECTION AND DOCUMENTATION

5.1 SIGNATURE LOG

Pharmacy providers must maintain a log containing the following information:

- Beneficiary's name;
- The signature of the beneficiary or that of his representative; and
- The date of receipt of the prescription.

The log must effectively differentiate between prescriptions received by a beneficiary for which counseling was accepted and provided, and those for which counseling was offered and was declined. This log must be retained for review by MDCH or MDCH's agent for six years and is subject to audit.

The signature log serves as verification of the beneficiary receiving the prescription billed. The absence of the appropriate signature indicates the beneficiary did not receive the prescription, and funds will be recouped from the pharmacy.

5.2 BENEFICIARY INFORMATION AND DATA COLLECTION REQUIREMENTS

To meet specified State and Federal requirements, pharmacies must make a reasonable effort to obtain, record, and maintain on file at least the following information:

- Name, address, telephone number, date of birth (or age), and gender of the beneficiary.
- Pharmacist notes on the beneficiary's drug therapy.
- Beneficiary history when significant, including:
  - Disease state(s);
  - Known allergies and drug reactions; and
  - Comprehensive list of drugs and relevant devices.
- Whether the offer to counsel was made and whether this offer was accepted or rejected by the beneficiary or the beneficiary's representative.

5.3 DOCUMENTATION REQUIREMENTS

To assure that pharmacy counseling and other data collection requirements were performed, pharmacies must record the information required in the beneficiary's manual or electronic profile, in the prescription signature log, or any other system of records. Regardless of the format used, the associated documentation must be kept for at least six years and be readily accessible.

SECTION 6 – GENERAL NONCOVERED SERVICES

This section specifies general coverage restrictions. However, drugs in other classes may not be covered. Pharmacies should review the MPPL for specific coverage. When possible, pharmacies are encouraged to suggest alternative covered therapy to the prescriber if a product is not covered.

The following drug categories are **not covered** as a benefit:

- Agents used for anorexia or weight loss.
- Agents used for weight gain.
- Agents used for cosmetic purposes or hair growth.
- Agents used for symptomatic relief of cough and colds.
- Experimental or investigational drugs.
- Agents used to promote fertility.
- Agents used to promote smoking cessation not on the MPPL.
- Vitamin/Mineral combinations not for prenatal care, end stage renal disease or pediatric fluoride supplementation.
- Covered outpatient drugs that the Labeler seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the Labeler or its designee.
- Covered outpatient drugs where the Labeler limits distribution.
- Proposed less-than-effective (LTE) drugs identified by the Drug Efficacy Study Implementation (DESI) program.
- Over-the-counter drugs not on the MPPL.
- Drugs of Labelers not participating in the Rebate Program.
- Drugs prescribed for "off label" use if there is no generally accepted medical indication in peer reviewed medical literature (Index Medicus), or listing of such use in standard pharmaceutical references such as Drug Facts and Comparisons, AMA Drug Evaluations, American Hospital Formulary Service Drug Information, or DRUGDEX Information Systems.
- Drugs prescribed specifically for medical studies.
- Drugs recalled by Labelers.
- Drugs discontinued (past one year).
- Lifestyle agents.
- Standard Infant Formulas.
- Drugs used to treat gender identity conditions, such as hormone replacement.
- Drugs covered by the Medicare Part D benefit.

SECTION 7 - MICHIGAN PHARMACEUTICAL PRODUCT LIST

The Michigan Pharmaceutical Product List (MPPL) identifies the pharmaceutical products that are covered by MDCH. The MPPL pharmaceutical product coverages may vary by MDCH program or be limited by age, clinical parameters, and/or gender. The Point of Sale pharmacy claim adjudication also provides coverage information related to a specific beneficiary or prescription.

The MPPL is posted on the PBM's website. (Refer to the Directory Appendix for website information.) Providers must refer to the MPPL for the additions and deletions of drug products. Specific notification of changes will not be issued.

7.1 NOTIFICATION OF NEW OUTPATIENT DRUGS

MDCH receives weekly, comprehensive new information about outpatient drugs from First DataBank. Manufacturers are not required to submit notification of new drug products. (Refer to the Directory Appendix for website information.)

7.2 APPROVED LABELERS

MDCH reimburses MPPL products distributed by approved Labelers who have signed rebate agreements with the Centers for Medicare and Medicaid Services (CMS). A list of these approved Labelers is located on the CMS website and are identified by the first five digits of a National Drug Code (NDC). (Refer to the Pharmacy portion of the Directory Appendix for CMS website information.)

Alcohol swabs, condoms, diaphragms, lancets, syringes, aerochambers, spacers, and peak flow meters provided by a pharmacy are covered regardless of the manufacturer rebate agreement.

SECTION 8 – PRIOR AUTHORIZATION

8.1 PRIOR AUTHORIZATION PROCESSOR [CHANGE MADE 4/1/06]

The MDCH PBM processes prior authorizations (PAs). Refer to PBM's Pharmacy Claims Processing Manual for PA procedures. (See Directory Appendix for contact information.) Authorization to override denial edits must be obtained from the PBM.

Do **not** call the PBM's Call Centers for:

- Supplies billed by Medical Suppliers, including enteral formula and Total Parenteral Nutrition (TPN), **(modified 4/1/06)** since these are only reimbursed to a Medical Supplier Provider. Contact the MDCH Prior Authorization Division for PA. (Refer to the Directory Appendix for contact information.)
- Information about the member's MHP or CHP. The provider must contact the MHP or CHP to obtain their policies.

8.2 PRIOR AUTHORIZATION REQUIREMENTS

PA is required for:

- Products as specified in the MPPL. Pharmacies should review the information in the remarks, as certain drugs may have PA only for selected age groups, gender, etc. (e.g., over 17 years).
- Payment above the Maximum Allowable Cost (MAC) rate.
- Prescriptions that exceed MDCH quantity or dosage limits.
- Medical exception for drugs not listed in the MPPL.
- Medical exception for noncovered drug categories.
- Acute dosage prescriptions beyond MDCH coverage limits for H2 Antagonists and Proton Pump Inhibitor medications.
- Dispensing a 100-day supply of maintenance medications that are beneficiary-specific and not on the maintenance list.
- Pharmaceutical products included in selected therapeutic classes. These classes include those with products that have minimal clinical differences, the same or similar therapeutic actions, the same or similar outcomes, or have multiple effective generics available.

8.3 RESPONSIBILITY FOR OBTAINING AUTHORIZATION

8.3.A. PHARMACY RESPONSIBILITY

Pharmacies may call the PBM Technical Call Center for exceptions on:

- Quantity;

- Early refills; and
- 72-hour supply of medication for emergency needs only when the prescriber is not available to obtain PA.

Pharmacies may call the PBM Clinical Call Center for exceptions on payment for brand name over the MAC.

The PBM's Technical Call Center is available 24 hours per day/seven days a week.

Refer to the Directory Appendix for PBM's Call Center contact information.

8.3.B. Prescriber Responsibility

Prescribers or their designees may call the PBM's Clinical Call Center for any PA, but must call for any request that falls outside the categories noted above as applying to pharmacies.

The PBM Clinical Call Center is available after hours by telephone and by pager. The PBM may also be contacted by fax or in writing via the US mail.

Refer to the Directory Appendix for the PBM's Clinical Call Center contact information, PA contact information and hours of operation.

8.4 Documentation Requirements

For all requests for PA, the following documentation is required:

- Pharmacy name and phone number;
- Beneficiary diagnosis and medical reasons why another covered drug cannot be used;
- Drug name, strength, and form;
- Other pharmaceutical products prescribed;
- Results of therapeutic alternative medications tried; and
- MedWatch Form or other clinical information may be required.

8.5 Additional Documentation [Change Made 4/1/06)

Depending on the specific drug being prescribed, additional medical documentation may be required. The most common categories requiring additional documentation are:

8.5.A. Brand Override

Provide documentation of the therapeutic trial and failure reasons of the generic.

8.5.B. Medication for Erectile Dysfunction **[per bulletin MSA 06-02, coverage of ED drugs terminated effective 2/1/06)**

8.5.B. Weight Loss [Renumbered 4/1/06]

- Current medical status, including nutritional or dietetic assessment.
- Current therapy for all medical conditions, including obesity.
- Documentation of specific treatments, including medications.
- Current accurate Body Mass Index (BMI), height, and weight measurements.
- Confirmation that there are no medical contraindications to reversible lipase inhibitor use, no malabsorption syndromes, cholestasis, pregnancy and/or lactation.
- Details of previous weight loss attempts and clinical reason for failure (at least two failed, physician supervised, attempts are required).

8.6 Prior Authorization Denials

PA denials are conveyed to the requester. PA is denied if:

- The medical necessity is not established.
- Alternative medications are not ruled out.
- Evidence-based research and compendia do not support it.
- It is contraindicated, inappropriate standard of care.
- It does not fall within MDCH clinical review criteria.
- Documentation required was not provided.

SECTION 9 – H2 ANTAGONIST AND PROTON PUMP INHIBITOR POLICY

For high dose use greater than 102 days in a 365-day period, PA is required for H2 Antagonists and Proton Pump Inhibitors (PPIs). The MDCH defines high dose use as:

H2 Receptor Antagonists	Proton Pump Inhibitors
Cimetidine: 800 mg per day or more	Omeprazole: 40 mg per day or more
Famotidine: 40 mg per day or more	Esomeprazole (Nexium): 40 mg per day or more
Nizatidine: 300 mg per day or more	Lansopazole (Prevacid): 30 mg per day or more
Ranitidine: 300 mg per day or more	Rabeprazole (Aciphex): 20 mg per day or more
	Pantoprazole (Protonix): 40 mg per day or more

Nonpreferred H2 Antagonists or PPIs require PA for both high and low dose use. Compliance with the H2 Antagonists and PPI Policy is monitored with POS or post-payment review.

Prescribers may request PA for high dose therapy over the 102 days through the PBM Clinical Call Center. (Refer to the Directory Appendix for contact information.). The following information is required for PA determination:

- Diagnosis;
- Drug and dose for which PA is requested;
- Date and results of GI testing;
- All alternative H2 Antagonists and PPIs tried, including dose and duration;
- Other prescribed medications relating to this diagnosis;
- Reason patient cannot endure testing; and
- Health education or other counseling employed for this condition.

SECTION 10 – DRUG UTILIZATION REVIEW

10.1 PROSPECTIVE DRUG UTILIZATION REVIEW

MDCH utilizes Prospective Drug Utilization Review (ProDUR) edits in its Point of Sale (POS) system. ProDUR encompasses drug therapy screening, including problem detection, evaluation, and counseling components of pre-dispensed drugs.

In the POS system, MDCH limits the number of messages to providers that concern potential drug problems to those that are critical to quality of care and appropriate dispensing. It is the provider's responsibility to provide ProDUR screening and to adhere to beneficiary information and data collection requirements.

10.1.A. PRODUR SCREENING REQUIREMENT

Before prescriptions are filled or delivered, pharmacists must review the consequences of the drug therapy based on the appropriate standards and guidelines.

The review must screen for potential therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications (to the extent diagnosis information is available)
- Drug-drug interactions (including interactions with known over-the-counter drugs)
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse
- Under-utilization or over-utilization

10.1.B. PRODUR ALERT MESSAGES

The PBM's POS system provides online assistance for the dispensing pharmacist. Incoming drug claims are compared to a beneficiary's pharmacy claims history file to detect potential therapeutic problems. ProDUR alert messages are returned to the pharmacist when significant problems are discovered by this review.

10.2 RETROSPECTIVE DRUG UTILIZATION REVIEW

Medicaid utilizes pharmacy data for retrospective drug utilization review (RetroDUR) as required by Federal law and the following compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopoeia-Drug Information
- DRUGDEX Information System

- American Medical Association Drug Evaluations
- Peer-reviewed medical literature

RetroDUR is intended to be an educational tool to reduce costs resulting from drug-induced illnesses and hospitalizations. The purpose of retrospective drug utilization review is:

- To identify high-risk cases for drug-induced illness.
- To communicate risk factors to prescribers and dispensing pharmacists for evaluation.
- To improve patient healthcare outcomes and quality of care.

RetroDUR alerts providers to a beneficiary's medical condition and total drug usage from all prescribers and pharmacies. MDCH's PBM reviews utilization data on a monthly basis and makes recommendations to the Michigan DUR Board for interventions and educational seminars.

10.3 Michigan Drug Utilization Review Board

The Michigan Drug Utilization Review (DUR) Board includes both physicians and pharmacists. After post-payment review, the DUR vendor sends appropriate intervention letters to pharmacies and prescribers. Based on the DUR intervention information, prescribers may choose to modify therapy. However, prescribers or pharmacists also may choose to correct beneficiary negative patterns by counseling, or provide background for re-evaluation by the DUR vendor or the DUR Board.

As needed, the PBM or DUR Board follows up on re-occurring patterns that have not been justified. Provider education or academic detailing may be provided to address re-occurring patterns.

10.4 Clinical Consultation

MDCH provides feedback to providers through its academic detailing program. Administered by PBM, Medicaid targets topics related to drug therapy where direct educational intervention to medical providers may prove beneficial in improving outcomes. The Michigan DUR Board approves the topics for academic detailing. Clinical consultants are Michigan-licensed pharmacists who are recruited and trained through the Michigan Pharmacists' Association under the direction of PBM. Whenever possible, clinical consultants are assigned to call on medical providers who practice in the same geographical area as the detailing pharmacist to provide a personal and professional connection between the healthcare providers. Providers are encouraged to give the clinical consultants feedback on both topics presented and the overall program.

SECTION 11 – DISPENSING POLICY

11.1 DAYS SUPPLY

Prescription quantities are limited to the units specified by the prescriber. MDCH covers up to a 34-day supply for acute medications, and up to a 100-day supply for maintenance medications.

The pharmacy must submit accurate days supply information. Submitting incorrect days supply information can cause false ProDUR messages and claim denials. It could also result in a pharmacy being targeted for a post-payment audit.

11.2 ACUTE AND MAINTENANCE SUPPLIES

Providers must bill and dispense as follows:

- For acute illness: The amount dispensed must be limited to the quantity required for the desired therapy during that episode of illness or up to a 34-day supply.
- For chronic illness:
  - Maintenance drugs must be dispensed in quantities as ordered by the physician and to achieve optimum therapy and economy of dispensing, or up to a 100-day supply.
  - If a prescription for a product on the maintenance list is for more than a month's supply and less than a 100-day supply, only one dispensing fee is allowed.
  - A maximum of 13 dispensing fees are paid for the same drug dispensed to the same beneficiary within a 365-day billing period.

A list of maintenance medication is posted on the PBM's website. (Refer to the Directory Appendix for website information.) This list does not exclude medications from other standard therapeutic class codes from being supplied in maintenance quantities. PA is necessary when a maintenance quantity of other medications is required for specific beneficiaries.

11.3 REFILLS

Refills must conform to the current Administrative Rules of the Michigan Board of Pharmacy, Michigan Public Health Code, state and federal statutes, rules, regulations, and policies. Claims will deny at point-of-sale if the utilization requirements have not been met.

11.4 RETURNED TO STOCK PRESCRIPTIONS

MDCH does not reimburse for prescriptions returned to stock and does not allow restocking fees. For prescriptions returned to stock/not picked up, pharmacies must claim adjust or reverse the claim for any payments received, including the dispensing fee. The pharmacy should reverse claims in a timely manner. However, MDCH policy allows claim adjustments or reversals to be submitted up to six months after the original date of service. For example, if Medicaid beneficiary does not pick up a prescription from the pharmacy within 14 calendar days from the date the prescription claim was submitted by the pharmacy, the prescription claim should be reversed on the 15th calendar day and must have been reversed by the 180th day. For audit purposes, a record of processed reversals must be retained by the pharmacy for six years.

SECTION 12 – QUANTITY AND BILLING UNITS

MDCH uses standard metric billing units and the provider may not round fractions. For example, if the product is 2.500 ml, it must be billed as 2.500 ml, not 3 ml. The PBM's processing allows a quantity entry up to 999,999.999.

12.1 QUANTITY LIMITS

Dispensing quantities are limited according to accepted standards of practice, Food and Drug Administration (FDA)-approved Labeler recommendations and the recommendations of the Michigan DUR Board.

12.2 COMMON UNIT BASES

Quantities are based on the amount dispensed for the unit of the product. Thus, quantity field entries must be based on the amount dispensed for the unit specified in the MPPL. The most common unit bases are EACH, ML, or GM. Following are examples.

Drug Name	Drug Strength	Dosage Form	Unit	Billing Quantity Based On:
Alphanate		Vial	EA	AntiHemophilic Factor Units
Amoxicillin Trihydrate	125 mg/5 ml	Susp Recon	ML	Reconstituted Milliliters
Cefazolin Sodium	1 gm	Vial	EA	Vials (Powdered-Filled)
Chemstrip BG		Strip	EA	Strips
Gentamicin Sulfate	40 mg/ml	Vial	ML	Milliliters (Liquid-Filled)
Humulin-N	100 U/ml	Vial	ML	Milliliters (Liquid-Filled)
Indocin 50 mg Supp.	50 mg	Supp Rect	EA	Suppositories
Prolastin		Vial	EA	Milligrams
Proventil Inhaler		Aerosol	GM	Grams in each canister
Zantac 300 mg Tab	300 mg	Tablet	EA	Tablets

SECTION 13 – REIMBURSEMENT, CO-PAYMENTS, AND COORDINATION OF BENEFITS

13.1 USUAL AND CUSTOMARY CHARGE

Reimbursement is the lower of the usual and customary (U&C) charge or MDCH's product cost payment limits and a dispensing fee minus the beneficiary co-payment, with the exception of condoms. If a beneficiary has other insurance or Medicare coverage, the related other insurance or Medicare payments are subtracted from MDCH's payment.

U&C charge is defined as a pharmacy's charge to the general public. The sum of charges for both the product cost and dispensing fee must not exceed a pharmacy's U&C charge for the same or similar service. The U&C charge must reflect all advertised discounts, special promotions, or other programs initiated to reduce prices for product costs available to the general public or to a special population.

If a pharmacy discounts prescriptions to an inclusive category of customers (e.g., over 60 years), the pharmacy must reflect this discount in its billings for MDCH program beneficiaries in the same category.

13.2 OVER-THE-COUNTER DRUGS

The U&C charge for prescription-ordered OTC drugs may be different, but not greater, than the retail pharmacy's shelf price of the same product sold without a prescription.

13.3 SALES TAX

Sales tax must not be added to a pharmacy's U&C charge. The MDCH does not reimburse for sales tax.

13.4 PRODUCT COST PAYMENT LIMITS

Product Cost Payment Limits are based on the NDC the pharmacy identifies as the product that was dispensed. Reimbursement is the lower of the Average Wholesale Price (AWP) minus a discount, the MAC, or the provider's charge. Misrepresentation of the product's NDC results in denied payment and fraud/abuse sanctions subject to applicable Federal and State laws.

Entities or their contracted pharmacies that participate in the Federal 340B program must bill the 340B price.

13.4.A. DISCOUNTED AVERAGE WHOLESALE PRICE

Medicaid's discounted AWP is as follows:

Pharmacy Group	Discount Used for Payment
Pharmacies with 1-4 stores	AWP minus 13.5%
Pharmacies with 5 or more stores	AWP minus 15.1%

Pharmacy Group	Discount Used for Payment
Pharmacies who serve beneficiaries with a level of care (LOC) 02.	AWP minus 15.1%

13.4.B. Maximum Allowable Cost

Maximum Allowable Cost (MAC) reimbursement levels for Michigan Medicaid are established and managed by an MDCH contractor. MAC reimbursement levels are generally applied to multi-source brand and generic products. However, MAC reimbursement may also be applied to single source drugs or drug classifications where appropriate. New or changed MAC prices are posted on the contractor's website the next business day after they are determined. A monthly online MAC list is also available on the contractor's website. MAC reimbursement reviews will take place on an on-going basis. In addition to the website, specific MAC reimbursement levels are also available by contacting the MAC vendor by US mail, e-mail, fax or telephone. (Refer to the Directory Appendix for the MAC vendor website and contact information.)

All requested MAC price reviews require the following information:

- The brand and generic name, strength, form, and NDC requested for review
- Reason for requested review (availability, price, or other)
- Supporting documentation that the MAC is below cost or the product is not available (wholesaler invoice to support a request)
- Date of service to identify the difference between reimbursement and actual cost
- Prescription number
- Company or pharmacy name, NAPB number, telephone number, and contact person

13.4.C. MAC Overrides

Specific brand products have a MAC reimbursement level. To receive payment above the MAC reimbursement level, PA through the PBM is required. (Refer to the Directory Appendix for contact information.)

13.5 Dispensing Fees

Dispensing Fee is defined as the fee charged for filling a prescription and all related services performed by a pharmacy. MDCH's dispensing fee is described below.

Other sections of this chapter describe dispensing fee policies for condoms, compounded drugs, infusion therapy, and re-packaged unit dose prescriptions.

Dispensing Type	Dispensing Fee
Standard Fee for Long Term Care Pharmacy Standard Fee for Non Long Term Care Pharmacy	$2.75 $2.50
IV Admixtures	$7.50 (single all-inclusive fee) plus standard dispensing fee
Compounded Capsules, Powder, and Suppositories	$10.00
Other Compounded Prescriptions	$6.00

13.6 BENEFICIARY CO-PAYMENTS [CHANGE MADE 4/1/06]

13.6.A. MEDICAID CO-PAYMENTS [CHANGE MADE 4/1/06]

Medicaid FFS beneficiaries age 21 and older have a $1 co-payment for each generic drug dispensed, and a $3 co-payment for each brand name drug dispensed, unless the beneficiary meets one of the exemptions from co-payment stated below. For information regarding ABW co-payments, refer to the Adult Benefits Waiver Chapter of this manual.

Co-payments cannot be discounted for promotional purposes. (added 4/1/06)

Providers may not refuse to render service if a beneficiary is unable to pay the co-payment amount at the time the service is provided. However, the uncollected co-payment is considered a bad debt which allows the provider to refuse to provide future services according to Michigan's State Plan. Providers who elect not to provide services based on a history of bad debt, including unpaid co-payments, must give beneficiaries appropriate verbal notice and a reasonable opportunity for payment.

Co-Payment Exemptions	
Over Age 21 Exclusions	▪ The pharmaceutical product is a family planning or pregnancy-related product. ▪ The beneficiary is in a nursing facility (level of care 02, 55, or 56). (Refer to the Nursing Facility Section of this chapter for additional information.) ▪ The beneficiary is enrolled in a hospice program (level of care 16).
Other Exclusions	▪ Medicaid beneficiaries who are under the age of 21 are excluded from the co-pay requirement. ▪ All CSHCS and MOMS beneficiaries are excluded, including those over age 21.

13.6.B. Medicare Part D Co-Payments [Added 4/1/06]

Medicaid will not reimburse:

- Co-pays, deductibles, or co-insurance for Medicare Part D drugs.
- Commercial insurance drug co-pays, deductibles, or co-insurance for Medicare/Medicaid beneficiaries who chooses to retain their creditable drug coverage offered by the commercial insurance in place of joining a Medicare Part D plan.
- Co-pays, deductibles, or co-insurance that exceed the standard Medicare Part D benefit for Medicare/Medicaid beneficiaries. **(added for clarification 4/1/06)**

13.7 Nonallowable Charges to the Beneficiary

A pharmacy must not charge a beneficiary for a prescription if the pharmacy or prescriber fails to request prior authorization (PA). For all products listed in the MPPL indicating PA is required, the pharmacy may contact the PBM for PA or notify the prescriber that a PA is needed.

A pharmacy may charge the beneficiary its U&C charge for a product requiring PA only if the pharmacy has written documentation that the beneficiary was informed of the attempt and failure to obtain PA and of the resultant desire to purchase the drug privately. The pharmacy must not charge any portion of this claim to Medicaid.

The beneficiary must be made aware that PA and reimbursement cannot be obtained later.

13.8 Allowable Charges to the Beneficiary

A pharmacy may only charge a beneficiary MDCH's established co-payment for covered services. A beneficiary may not be charged for any cost of the prescription above MDCH's reimbursement level. A pharmacy may only charge a beneficiary its usual and customary charge if the service is a noncovered service, or if MDCH has denied the service based on lack of medical necessity and the beneficiary has indicated a desire to purchase the service privately. Furthermore, a beneficiary may not be charged for a prescription in lieu of the pharmacy accepting the reimbursement paid by MDCH, or in lieu of obtaining PA when indicated.

13.9 Advertising

Advertisements must convey only participation in Medicaid. Advertising must not be used to influence the free choice of a pharmacy by a beneficiary. Promotions offering beneficiaries free goods, gift certificates, or shopping sprees in exchange for filled prescriptions are prohibited. No pharmacy may discount the co-payment for promotional purposes.

13.10 Coordination of Benefits

Coordination of benefits (COB) (also referred to as Third Party Liability [TPL]) requires providers to bill other insurances, including Medicare Part B, before billing MDCH. Regardless of participation by the pharmacy provider with the other insurance and/or Medicare, MDCH only reimburses for the coinsurance and deductible amounts up to the Medicaid allowable fee screen. If the other insurance's (including Medicare) reimbursement exceeds the reimbursement level of Medicaid, no additional monies are paid.

Providers must submit the charge as the amount allowed by the other insurance, indicating the other insurance payment (including the dispensing fee) and the other insurance co-payment. In addition, the provider is to use the drug list established by the beneficiary's other insurance carrier. If the other carrier's drug list covers a drug not on the MPPL, the prescriber must obtain PA from MDCH. (For complete information on MDCH's policy regarding other insurance, refer to the Coordination of Benefits Chapter of this manual.)

If a provider receives payment from another insurance and/or Medicare after MDCH has made full payment, the payment must be returned to MDCH through a claim adjustment. Failure to reimburse MDCH may be construed as fraud under the Medicaid False Claim Act.

13.10.A. COB Edit Override

When billing Medicaid for a beneficiary who has other insurance, providers must enter the appropriate National Council for Prescription Drug Program (NCPDP) code based on the status of the other insurance. See the PBM's Pharmacy Claims Processing System Manual for Michigan Medicaid for a complete list of codes.

13.10.B. COB Edit Exceptions

In the following situations, providers may override the COB edit using the NCPDP code indicated in parentheses:

- The beneficiary indicates, or the pharmacy is aware, that the beneficiary no longer has the other insurance on the date the prescription is dispensed (1).
- The beneficiary's other insurance requires the beneficiary to pre-pay for the drug (4).
- The beneficiary is in a nursing facility, and the dispensing pharmacy is not a part of the insurance carrier's network (except if the beneficiary is enrolled in the Medicare Part D benefit) (4).

13.10.C. COB Edit Override Exclusions

In the following situations, providers may not override the COB edit.

- The beneficiary has other insurance and the pharmaceutical product is covered and would be paid to the provider if the insurance carrier's rules (e.g., obtain PA, use of a network provider, or proper claim submission) had been followed.
- The other insurance requires a generic instead of the brand equivalent covered by Medicaid. The provider must bill the other insurance for the generic.
- The pharmacy is not part of the carrier's network and is not able to obtain authorization from the carrier to provide the drug. The pharmacy should instruct the beneficiary to have the prescription filled at a participating pharmacy. If the beneficiary is not familiar with the carrier's network, the pharmacy should instruct the beneficiary to contact their carrier for a list of network pharmacies.
- The beneficiary is required to pre-pay, but only because the pharmacy is not part of the carrier's network. The beneficiary should be instructed to have the prescription filled at a participating pharmacy.

13.10.D. Billing Information

For billing information, including NCPDP codes, refer to the PBM's Pharmacy Claims Processing Manual, the PBM's website, or contact the PBM Technical Call Center. (Refer to the Directory Appendix for contact information.)

13.10.E. Non-COB with Medicare Part D

Medicaid does not coordinate benefits with Medicare Part D.

SECTION 14 – SPECIAL PRODUCT COVERAGE

14.1 AMPHETAMINE

Some drugs used to treat narcolepsy or hyperkinesis may be covered for beneficiaries over 17 years of age. The prescriber or designee must obtain PA before the pharmacy dispenses these products.

14.2 ANTIHEMOPHILIC DRUGS

Billing quantities for antihemophilic drugs must be based on antihemophilic factor units. The PBM's quantity field allows quantities up to 999,999.999.

A Medical Supplier must bill for infusion kits necessary for administration. (Refer to the Medical Supplier Chapter of this manual for additional information.)

Antihemophilic drugs are a Medicare Part B benefit. For beneficiaries who are eligible for both Medicare and Medicaid, the pharmacy must bill Medicare prior to billing Medicaid as explained in the Coordination of Benefits Chapter of this manual.

14.3 ANTINEOPLASTIC DRUGS

Covered chemotherapeutic agents are listed in MPPL. Most injectable chemotherapy forms are not listed in the MPPL as reimbursement is made to the administering healthcare provider (e.g., physicians, outpatient hospitals). A dosage intended for parenteral infusion (continuous or intermittent), perfusion, or intracavity administration in an office, clinic, or outpatient hospital is not a reimbursable Medicaid benefit to a pharmacy. The pharmacy should bill the ordering provider of service.

Injectable chemotherapy and topical uses for these products may be reimbursed to a pharmacy for home use. Some of these agents may require PA. Refer to the MPPL for verification of PA requirements.

14.4 COMPOUNDED DRUGS

Medicaid defines a compounded drug as the combination of two or more ingredients not available from any Labeler in the combination prescribed. Compounded prescriptions must contain at least one product manufactured by an approved Labeler. The following compounded policies do not apply to infusion therapy.

14.4.A. EXCLUSIONS

Compounded drugs are not covered if active ingredients include:

- A noncovered legend drug or drug class (e.g., cough/cold, DESI);
- Only OTC drugs; or
- Reconstitution of a product only.

A compound prescription is not covered if it contains noncovered products and is prescribed solely to circumvent Program limitations.

14.4.B. Dispensing Fees

Dispensing fees for compounded drugs are based on the schedule below. To receive the compounded fee, a prescription must involve extemporaneous compounding and dispensing prepared only when orders for specific beneficiaries are received.

Medicaid monitors its compounded drug policy on a pre- and post-payment basis.

Compounded Drug Dispensing Fee	Final Dosage Forms
$6.00	Creams, Emulsions, Nasal Drops, Ointments, Ophthalmics, Optic Drops, etc.
$10.00	Capsules, Suppositories, Powder Papers

14.5 Condoms

Condoms do not require a prescription. A pharmacy may provide condoms at the beneficiary's request. Both males and females are eligible to receive condoms. Condoms are **not** a covered benefit for participants in the CSHCS program.

- **Payment Limit** – Payment is the lesser of the pharmacy's retail price or the MAC listed in the MPPL. A dispensing fee is not paid for condoms.
- **Dispensing Limits** – The following quantity requirements are monitored by pre- and post-payment reviews. A pharmacy is not reimbursed for more than:
  - 12 condoms at one time to a beneficiary; or
  - 36 condoms in 30 days to a beneficiary.
- **Documentation** – Pharmacies are responsible for maintaining adequate documentation to substantiate which beneficiaries received condoms. Documentation can be collected on a prescription blank or a log entry. Either form of documentation must contain:
  - An assigned control number (e.g., prescription number);
  - Beneficiary name;
  - Beneficiary Medicaid ID number;
  - Brand name of condom dispensed;
  - Quantity dispensed; and
  - Date dispensed.

14.6 Clozapine

Clozapine may be billed in weekly cycles. A dispensing fee may be reimbursed each week when billed in accordance with other MDCH and FDA product licensure guidelines.

14.7 Infusion Therapy

Infusion therapy, except for Total Parental Nutrition (TPN) used in the home setting, is covered to a pharmacy. If a specific drug is not listed in the MPPL, PA must be obtained. A Medical Supplier must bill for infusion-related expendable supplies and durable medical equipment, such as pumps or IV stands and TPN.

MDCH will reimburse an additional single all-inclusive fee, above the standard dispensing fee, for the diluent and vehicle that is administered with the active ingredient. Refer to the Dispensing Fee subsection for current fee information.

Daily billing for infusion therapy is not allowed. Drugs for infusion therapy must not be billed more frequently than seven days.

14.8 Inhalers

Depending on the beneficiary's condition, several inhalers per month may be necessary. If dispensing limitations allow and the prescriber writes accordingly, the beneficiary may obtain more than one inhaler per prescription.

14.9 Methadone

Methadone is only covered when used as an analgesic for severe intractable pain such as that produced by some types of terminal illnesses.

14.10 Oral Contraceptives

Prescriptions for oral contraceptives may be dispensed for a three-month supply when the prescriber writes the prescription accordingly.

14.11 Over-the-Counter Drugs

Covered OTC drugs are listed in the MPPL. A prescription is required. The refill policy is the same as for legend drugs.

14.11.A. OTC Drugs for End Stage Renal Disease

Certain OTC drugs are covered only for End Stage Renal Disease (ESRD) (that is, prescribed for the treatment of a beneficiary with a kidney transplant or one undergoing maintenance dialysis). Documentation must be kept on file by the pharmacy to substantiate the beneficiary's ESRD condition and must include:

- The date of the transplant (month and year); or
- The name of the facility performing dialysis; or
- An indication that the beneficiary is on Continuous Ambulatory Peritoneal Dialysis (CAPD).

14.11.B. OTC Drugs for Nursing Facilities

The MPPL designates when a covered OTC drug is included in the NF per diem. These products and noncovered OTC drugs are included in the per diem rate paid to a NF. It is the responsibility of the NF to provide these products for its beneficiaries. Reimbursement must be obtained from the NF.

Covered OTC drugs, such as insulin (except if covered by the Medicare Part D benefit) and those not designated as included in the NF rate, are reimbursable to a pharmacy for NF beneficiaries.

14.12 Peak Flow Meters, Spacers, and Aerochambers

Peak flow meters, spacers, and aerochambers listed in the MPPL may be billed by pharmacies. Coverage is limited to four (4) peak flow meters per year, and four (4) spacers and/or aerochambers combined total per year.

Spacers and aerochambers cannot be billed by the pharmacy for NF beneficiaries. These items are included the NF per diem rate.

14.13 Unit Dose

Medicaid only reimburses for unit dose packaging in three specific situations:

- When the drug entity is available only in unit dose packaging.
- When the pharmacy cost of the unit dose packaged product is lower than, or equal to, the Michigan Medicaid MAC.
- The pharmacy is enrolled as a Long Term Care pharmacy provider. Unit dose for oral solids is encouraged for NF beneficiaries, but not mandated.

SECTION 15 – NURSING FACILITY

Because of the uniqueness of pharmacy services provided in the nursing facility (NF) setting, separate billing policies were established. Other policies listed in this chapter also apply to NF beneficiaries.

15.1 LEVEL OF CARE

NF beneficiaries typically reside in a nursing home, hospital long term care (LTC) unit, or county-operated medical care facility (MCF). The levels of care indicated below are available through the EVS and identify NF beneficiaries.

Level of Care	Description
02	Beneficiary of NF services.
55, 56	Beneficiary is not eligible for NF services, but is eligible for pharmacy services.

15.2 UNIT DOSE POLICY

Unit dose for oral solids is encouraged for NF beneficiaries, but not mandated. MDCH does not reimburse pharmacies for unit dose liquids. MDCH monitors these policy requirements for unit dose and those listed below on a pre- and post-payment basis.

Long Term Care pharmacies who have unit dose agreements may be reimbursed for unit dose when the pharmacies adhere to all of the following:

- Bills for the actual quantity consumed by the beneficiary, not the quantity dispensed.
- Returns unit dose product dispensed but unused to the pharmacy's inventory for re-use.
- Maintains documentation of the quantity dispensed and consumed by the beneficiary, showing a credit to MDCH for drugs not consumed.
- Bills for only beneficiaries with level of care (LOC) 02.

The PBM will enter a Unit Dose specialty and effective date on the pharmacy enrollment record. The Unit Dose Pharmacy Agreement (MSA-0590) is available on the PBM's website. (Refer to the Directory Appendix for website information.)

15.3 RE-PACKAGED UNIT DOSE

If a pharmacy re-packs traditional containers (bottles of 500, 1000, etc.) into unit dose packages, MDCH will pay a flat unit dose fee of $0.03 per capsule or tablet for NF beneficiaries. To qualify for this fee, in addition to the five guidelines under Unit Dose Policy, the re-packaged unit dose system used must:

- Be individually packaged and labeled. MDCH does not reimburse for "bingo cards".
- Include only capsules and tablets.

- Conform to the physical standards of the US Pharmacopoeia/National Formulary, FDA Current Good Manufacturing Practices and methods in compliance with the Administrative Rules of the Michigan Board of Pharmacy.

15.4 Dispensing Fee

A pharmacy may receive a maximum of one dispensing fee for the same drug entity per month.

15.5 Co-Payment

Medicaid beneficiaries residing in NFs have no pharmacy co-payment.

15.6 Pharmacy Consultant Services

Medication reviews and other pharmacy consultant services are the responsibility of the facility and are included in the facility's per diem rate. The pharmacy must make arrangements with the facility for reimbursement of such services.

15.7 Products Included in the Nursing Facility Per Diem Rate

MDCH does not directly reimburse a pharmacy for items included in a facility's per diem rate. If provided, no additional or separate charges may be made to a beneficiary, a member of the beneficiary's family, or other beneficiary representative. If a pharmacy is requested to dispense any of the following, arrangements for payment must be between the pharmacy and the facility.

- Medical Supplies - Examples of medical supplies included in the facility's per diem rate are insulin syringes, reagent strips, aerochambers, spacers, peak flow meters, etc.
- Enteral Formulas – Enteral Formulas are included in the facility's per diem rate.
- OTC products not listed in the MPPL as in the NF's per diem rate may be paid directly to a pharmacy by MDCH. Noncovered OTCs are included in the NF's per diem rate. Examples of OTCs in the per diem include, but are not limited to:

Analgesics	▪ Acetaminophen ▪ Aspirin ▪ Buffered Aspirin ▪ Enteric-coated aspirin
Cough/Cold Preparations	▪ Guaifenesin with and without Dextromethorphan ▪ Pseudoephedrine/Chlorphen/Dextromethorphan ▪ Pseudoephedrine/Chlorpheniramine ▪ Pseudoephedrine HCl

Ointments	▪ Vitamins A & D Ointment ▪ White Petroleum ▪ Zinc Oxide
Oral Antiseptics	▪ Mouthwash
Topical Antiseptics	▪ Chlorhexidine Gluconate Wash and Solution ▪ Hydrogen Peroxide ▪ Isopropyl Alcohol ▪ Povidone-Iodine Solution/Wash
Vitamins/Minerals	▪ Calcium Carbonate, Calcium Gluconate, Calcium Lactate ▪ Daily Multiple Vitamin with and without Minerals ▪ Oyster Shell Calcium with and without Vitamin D ▪ Vitamin B1, Vitamin B6 ▪ All other OTC vitamins and minerals
Miscellaneous	▪ Epsom Salts (external use) ▪ Glycerin Suppositories ▪ Milk of Magnesia ▪ Mineral Oil or Emulsions of Mineral Oil ▪ Povidone Douches ▪ Sterile Lubricant ▪ Vinegar Douches ▪ Stool Softeners and stool softeners/laxative combinations

15.8 Returned To Stock Prescriptions

MDCH does not reimburse for prescriptions filled but not dispensed to the beneficiary.

SECTION 16 – PUBLIC HEALTH SERVICE AND DISPROPORTIONATE SHARE HOSPITALS

With enactment of Section 602 of the Veterans Healthcare Act of 1992, Public Health Service (PHS) covered entities and selected disproportionate share hospitals became eligible for contract drug prices from Labelers (340B Program). A list of participating entities is located on the Bureau of Primary Health Care - Health Resources and Services Administration (HRSA) website. (Refer to the Directory Appendix for website information.)

In addition to these product cost discounts, entities participating in this contract drug program are required by Federal policies to bill drugs covered in the PHS program using the actual acquisition cost for a drug plus a dispensing fee. Actual acquisition cost is defined as the actual invoice cost for a drug product to the pharmacy or company, organization, corporation, or affiliate with which it is associated.

Except for a two percent cash allowance, actual acquisition cost must reflect trade and quantity discounts, rebates, free goods, and price concessions.

On a post-payment basis, MDCH reviews billings from PHS participating entities to track compliance with this requirement.

Covered entities or their contract pharmacies, or disproportionate share hospital participating entities that are enrolled as Medicaid pharmacies must contact the MDCH Rebate Specialist for PHS and DSH 340B prices so their claims can be excluded from the Drug Rebates. (Refer to the Directory Appendix for contact information.)

SECTION 17 – DRUG REBATE PROGRAM

17.1 APPROVED LABELERS AND MPPL

MDCH only covers those drugs produced by Labelers who have signed rebate agreements with the federal government. Products distributed by companies or a division within a company that did not enroll are not covered.

Approved Labelers are located on the CMS website and are identified by the specific five-digit labeler code (the first five digits of the NDC). (Refer to the Directory Appendix for CMS website information.)

17.2 NATIONAL DRUG CODE ACCURACY

MDCH invoices pharmaceutical Labelers for rebates quarterly from the pharmacy paid claims history. Pharmacies must bill the actual NDC for a product dispensed. Pharmacies may be contacted periodically to verify product utilization and cost. Contact can include phone or written verification requests. Documentation requirements for verification can include, but are not limited to:

- Copies of the product invoice
- Copies of original prescriptions
- Compounding records

SECTION 18 – BENEFICIARY MONITORING PROGRAM

The purpose of the Beneficiary Monitoring Program (BMP) is to monitor and control inappropriate utilization of prescribed drugs and physician and emergency room services. (Refer to the Beneficiary Eligibility Chapter for additional information regarding the BMP.)

SECTION 19 – PHARMACY AUDIT AND DOCUMENTATION

Continued violations of Medicaid claims processing policies may result in recoupment and referral to the Michigan Attorney General's Office for investigation of fraud.

The following information serves as a general guide for policy compliance that is reviewed on a post-payment basis. Although the list is not all-inclusive, it covers a large proportion of discrepancies found through on-site audits, desk audits, and mail audits.

Auditing	MDCH monitors for compliance with Medicaid Policy the Administrative Rules of the Michigan Board of Pharmacy, the Public Health Code, applicable federal and state regulations, and makes referrals when appropriate. MDCH will recover inappropriate payments made for noncompliant claims identified in post payment review.
Changing Claim Information	The Claims Processing System recognizes and denies exact duplicates. Providers may not falsely alter the NDC number, date of service, prescription number, days supply, or any other claim requirement that would allow payment. Payment is recouped for inappropriate payments for billings found in violation of policy.
Compounds	The compounding of prescription products to gain coverage of noncovered OTC, noncovered legend drugs, or other noncovered categories is prohibited (e.g., the use of injectable Sodium Bicarbonate to compound a Sodium Bicarbonate foot irrigation). Medicaid recovers inappropriate payments for billings found in violation of policy.
CSHCS Only	Pharmaceutical products must relate to the qualifying diagnosis. Payment is recouped for billings for products not related to the qualifying diagnosis.
Days Supply	Accurate days supply information is required. Altering days supply information for purposes of payment will be considered fraud and will be reported to the appropriate unit for investigation.
Dispensing Fees	Pharmacies may not bill in a pattern that would lead to more than 13 dispensing fees in a year for the same drug entity. Splitting prescriptions to increase the number of fees paid is considered fraud and reported to the appropriate unit for investigation. Payment is recouped for inappropriate payments for billings found in violation of policy.
Drug Rebate	Dosages outside the normal dosage range based on the days supply submitted may prompt a verification request of product usage on reported utilization.
Hospice	Pharmacies must not bill MDCH for prescription services related to the terminal illness except for selected HIV drugs (see the General Information Section of this chapter for additional information). Payment is recouped for inappropriate payments for billings found in violation of policy.

Inaccurate Billing	The NDC number of the product actually dispensed must be billed. The NDC number is package size and Labeler specific. A noncovered, repackaged product intentionally billed under the brand NDC constitutes fraud. Payment is recouped for inappropriate payments for billings found in violation of policy.
Other Insurance Payments	Pharmacies must bill other insurances before billing Medicaid This also applies to Medicare Part B eligible beneficiaries. Failure to bill Medicaid the total due less the amount paid by another insurance or by Medicare Part B may be construed as fraud under the Medicaid False Claim Act.
Medicare Part D	Pharmacies cannot bill Medicaid for drugs covered by Medicare Part D. The Medicaid Program does not coordinate benefits with Medicare Part D.
Prescription Documentation	Original written prescription and those created from phone, fax, or electronic transmissions must be created and maintained in written form. Physician affidavits will not be accepted for pharmacy documentation. Notation on a pharmacy's database is not considered a written form of the prescription. For originals and all refills, accurate prescription documentation must be readily accessible and maintained for six years. All of the following information for each prescription must be entered in the record: ▪ prescription number ▪ patient's name and address ▪ prescriber's name ▪ prescriber's federal DEA number (if appropriate) ▪ number of refills authorized ▪ "dispense as written" instructions (if indicated) ▪ date of issuance of the prescription ▪ name, strength, dosage form, and quantity of the drug prescribed and the drug dispensed originally and for each refill Payment is recouped for inappropriate payments for billings found in violation of policy.
Prescriber Information	Accurate prescriber information must be provided as required by MCL 400.111b(21). Submitting incorrect prescriber identification numbers can cause false ProDUR messages and claim denials. It could also cause a pharmacy to be targeted for post-payment audit. Pharmacies are audited for inappropriate identification of prescribers. Pharmacies identified through the audit process as misidentifying prescribers receive a warning letter. Continuation of incorrectly identifying prescriber's results in payment being recouped for those claims.
Public Health Service and Disproportionate Share Hospitals	The actual acquisition cost must be billed. Payment is recouped for inappropriate payments for billings found in violation of policy.

Return to Stock	Providers must reverse claims for products billed but not dispensed to a beneficiary. A record of the reversals log must be maintained for audit purposes for six years. Restocking fees are not allowed.
Signature Requirement	Providers must maintain and have accessible the signature log indicating beneficiary's pick-up of prescription and acceptance or denial of beneficiary counseling. Missing signatures indicate the prescription was not picked-up or the beneficiary was not offered counseling as required. Pharmacies are required to maintain this log for six years. Payment is recouped for inappropriate payments for billings found in violation of policy.
Unit Dose	Pharmacies that serve NFs must bill the actual quantity consumed by the beneficiary, not the quantity dispensed. Payment is recouped for inappropriate payments for billings found in violation of policy.
Usual & Customary (U&C) Charge	For specified products, the submitted charge is compared to the cash price to the general public. Payment is recouped for inappropriate payments for billings found in violation of policy.

SECTION 20 – MEDICAL SUPPLIER [CHANGE MADE 4/1/06]

Covered medical supply items payable to a Pharmacy are listed in the MPPL. A prescription is required for medical supplies. Covered products include insulin syringes, alcohol swabs, etc.

MDCH does not separately reimburse a pharmacy for medical supplies dispensed to beneficiaries in nursing homes, hospital long term care units, or medical care facilities. These items are considered a part of the facility's per diem rate. If provided, no additional or separate charges may be made to a beneficiary, a member of the beneficiary's family, or other beneficiary representative. If a pharmacy is requested to dispense any of these items, arrangements for payment must be between the pharmacy and the facility.

Except for those items listed in the MPPL, medical supplies and equipment are covered only when billed by a Medical Supplier or Orthotist/Prosthetist. These items include equipment (e.g., canes), orthotics (e.g., arch supports), prosthetics, oxygen dispensers, wound care dressings (e.g., transparent film, hydrocolloid absorptive dressings, alginate and gel dressing), splints, ace bandages, TPN, enteral and oral nutritional supplements, **(updated 4/1/06)** etc.

When billing as a Medical Supplier or Orthotist/Prosthetist, refer to the Medical Supplier and Billing & Reimbursement for Professionals Chapters of this manual for additional information.

To enroll as a Medical Supplier, contact the MDCH Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

PRACTITIONER

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SECTION 1 - GENERAL INFORMATION

This chapter applies to physicians (MD, DO), Oral Surgeons, Doctors of Podiatric Medicine (DPM), Medical Clinics, Physical Therapists (PTs), Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs) and Nurse Practitioners (NPs) (Provider Types 10, 11, 13, 77).

Generally, medically necessary services provided to a Medicaid beneficiary by an enrolled practitioner are covered. The services addressed in this chapter include services that require explanation or clarification, have special coverage requirements, require prior authorization (PA), or must be ordered by a physician (MD or DO).

Information is included to assist the practitioner in determining how the Michigan Department of Community Health (MDCH) covers specific services. This information should be used in conjunction with the Billing & Reimbursement for Professionals Chapter of this manual, as well as the Practitioner Medical Clinic and related procedure databases located on the MDCH website. (Refer to the Directory Appendix for contact information.)

1.1 ADMINISTRATIVE SERVICES

Services of physicians, medical staff or other licensed or certified health professionals functioning in an administrative or teaching capacity for a hospital or nursing facility (including physician-owners or other staff paid by the physician) are not covered separately as physician services.

Pathology services or interpretive studies done for hospital or nursing facility quality improvement purposes or other reasons which do not directly assist with the specific care of a specific beneficiary are considered to be administrative services and are not separately covered as physician services. These services are included in the facility's allowable costs and are paid to the facility.

1.2 BILLING FOR DELEGATED SERVICES

Physician services provided by the physician's employees or employees of the same legal entity that employs the physician are billed under the delegating physician's identification (ID) number as if he performed the services personally. Services performed by a physician's assistant may be billed to MDCH only by the physician who has complied with all requirements for utilizing physicians' assistants per Public Act 368 of 1978, as amended, and any related rules promulgated by the State of Michigan or its Departments.

1.3 COMPONENT SERVICES

Many physician services are covered as global services. A global service includes all resources necessary to perform the procedure (e.g., office overhead, equipment, supplies, and staff) and the services provided by the physician (e.g., interpretation of results and preparation of a report of findings).

Some services are divided into a professional component and a technical component for coverage purposes. The professional component includes the services provided by the physician while the technical component includes equipment, supplies, and technical staff.

Coverage for the professional component or the technical component generally depends on where the service is provided and who provides that portion of the service. Services for which the professional

component is covered for the physician are identified in the Practitioner Medical Clinic Database on the MDCH website by the modifier that designates a professional component. If this modifier is not present in the databases for a specific procedure code, the professional component is not covered for the physician.

Global services are covered for the physician in nonhospital settings and the professional component is covered for the physician in any setting. The technical component is only covered when the service is provided in a hospital setting and is payable to the hospital. The global service and its professional component service cannot both be covered for the same service since the professional component is included in the global service.

1.4 Co-Payments

The applicable co-payments that a beneficiary is required to pay for certain services (e.g., podiatry services to beneficiaries age 21 and over) are identified in the appropriate section of this manual. The physician should note that a co-payment is not required for:

- Beneficiaries under age 21.
- Beneficiaries in a nursing facility.
- Beneficiaries having Medicare when Medicare covers the service.
- Pregnancy-related drugs. (The pharmacy has a list of these drugs.)

Providers may not refuse to render service if a beneficiary is unable to pay the co-payment amount at the time the service is provided. However, the uncollected co-payment is considered a bad debt which allows the provider to refuse to provide future services according to Michigan's State Plan. Providers who elect not to provide services based on a history of bad debt, including unpaid co-payments, must give beneficiaries appropriate verbal notice and a reasonable opportunity for payment.

1.5 Facility and Nonfacility Reimbursement

Medicaid reduces payment for specified procedures provided in a facility setting. This policy is consistent with the Centers for Medicare and Medicaid Services (CMS) facility and nonfacility reimbursement determination. When a provider performs services in a facility setting, costs for certain procedures are reduced because the practitioner does not incur certain overhead expenses (such as clinical staff, supplies, equipment) necessary to provide the service. When a service is performed in a nonfacility setting, the payment rate is based on the nonfacility relative value units (RVUs). When the service is provided in a facility setting, the payment rate is based on the facility RVUs. The payment difference takes into account the higher expenses for the provider in the nonfacility setting. For the purpose of this payment policy, a facility includes the following:

- Hospital inpatient and outpatient facilities;
- Psychiatric facilities;
- Skilled nursing facilities;
- Ambulatory surgery centers; and
- Rehabilitation facilities.

1.6 Hospital-Based Provider

Medicaid covers services by hospital-based providers (HBPs). A hospital-based provider is employed by the hospital. Each HBP is assigned his own Medicaid ID number.

For purposes of Medicaid, a HBP includes physicians (MD, DO, DPM). Some nonphysician practitioners, such as certified registered nurse anesthetists (CRNAs), nurse practitioners (NPs), and certified nurse midwives (CNMs) can also be considered HBPs under certain circumstances.

Medicaid follows Medicare guidelines for the coverage of HBP services provided by physicians. Generally, professional services provided by nonphysician providers that are employed by a hospital are included in the hospital cost report and are reimbursed to the hospital.

(The HBP should refer to their provider-specific chapter of this manual for policies, procedures, and coverage information.)

1.7 Medicare Related Services

MDCH reimburses physicians for the coinsurance and deductible amounts subject to Medicaid reimbursement limitations on all Medicare approved claims even if Medicaid does not normally cover the service. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual for additional information.)

1.8 Physician Delegation and Supervision

All physician services covered by Medicaid must be performed by the physician personally, the physician's employee, or an employee of the same legal entity that employs the physician, under the physician's delegation and supervision. Only persons currently licensed/certified in an appropriate health occupation/profession (e.g., physician's assistant, NP, CNM) as authorized by Public Act 368 of 1978, as amended, may provide direct patient care under the delegation and supervision of a physician when the physician is not physically present on the premises. The delegating/supervising physician must be continuously available through direct communication such as telephone, radio, or telecommunication when not on the premises.

In the physician's absence, licensed persons who are under the physician's delegation and supervision at the medical care site where the physician regularly sees beneficiaries may provide medical services. Records must demonstrate that the licensed physician is regularly available and provides medical care to beneficiaries at the site on a routine basis. This does not preclude licensed persons under the physician's delegation and supervision from making calls or going on rounds to private homes, public institutions, hospitals, or other health care facilities, as long as the care is a supplement to and does not replace the physician's personal services.

Care and treatment of Medicaid beneficiaries may only be delegated to unlicensed/certified persons when the physician is physically present and providing direct supervision.

1.9 Physician Responsibility

Determination of medical necessity and appropriateness of services is the responsibility of the physician within the scope of currently accepted medical practice and Medicaid limitations. The physician is held responsible if he orders excessive or unnecessary services (e.g., diagnostic tests, prescriptions) regardless of who actually renders or who receives payment for the service. The physician may also be subject to any corrective action related to these services, including recovery of funds.

Services generally must be ordered by a physician to be covered by Medicaid. Some services provided by other providers, such as medical supplies, lab services, and prescriptions, may require the physician to provide written documentation to support the need for the service. If the practitioner is not certain whether a service is a covered benefit, he can refer to the Practitioner Medical Clinic Database posted on the MDCH website or contact MDCH for coverage information. (Refer to the Directory Appendix for contact information.)

1.10 Prior Authorization

Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:

- Procedures identified as requiring PA on the procedure code databases on the MDCH website;
- Procedures that are normally noncovered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery); and
- Referrals for elective services by out-of-state nonenrolled providers.

1.10.A. To Obtain Prior Authorization

Providers must submit a letter to the MDCH Prior Authorization Division to obtain PA. (Refer to the Directory Appendix for contact information.) The letter and materials submitted requesting PA must include:

- Beneficiary's name and Medicaid ID number.
- Provider's name, address, Medicaid provider ID number.
- Contact person and phone number.
- A complete description, including Current Procedural Terminology (CPT)/Health Care Financing Administration Common Procedure Coding System (HCPCS) procedure codes as appropriate, of the procedure(s) that will be performed.
- The beneficiary's past medical history, including other treatments/procedures that have been tried and the outcome, diagnostic test results/reports, expectations and prognosis for the proposed procedure, and any other information to support the medical need for the service.

Providers receive a written response from MDCH. If the authorization is granted, the provider receives a nine-digit authorization number to report on the claim. The physician obtaining PA must make the PA number available to other providers, such as other practitioners or the hospital, for billing purposes.

If the beneficiary has Medicare and Medicare covers the service, the provider does not have to obtain PA from Medicaid. If Medicare denies a service as not medically necessary, Medicaid does not cover the service even if a PA has been obtained. If Medicare identifies a service as an excluded benefit under Medicare and Medicaid requires PA, the provider must pursue PA from Medicaid and a coverage determination is made. If the beneficiary has commercial insurance that covers the service and the provider reports the coverage correctly on the claim, the provider does not have to obtain PA from Medicaid. If a primary insurer covers a service but requires PA and the provider does not follow the primary insurance PA process, Medicaid does not make payment for the service either.

1.10.B. Special Authorizations

Special authorization requirements must be met for selected surgeries performed in the inpatient setting, all elective inpatient admissions, all readmissions within 15 days, and all transfers to an inpatient hospital/unit. Physicians should refer to the Hospital Inpatient Physician Services and the Surgery Sections of this chapter for specific information.

Some beneficiaries may need authorization of services because they are enrolled in special programs, such as the Beneficiary Monitoring Program. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

1.11 Services in a Teaching Setting

Administrative costs associated with teaching physician services, as well as payment for direct patient care services provided by a resident (including interns or fellows) in a teaching setting and supervised by a teaching physician, are subject to guidelines and conditions developed and published by CMS for Medicare. Services covered by Medicaid under these guidelines must be identified with the appropriate modifier.

Teaching institutions and teaching physicians within those institutions must abide by the CMS teaching physician guidelines which explain when services provided in teaching settings can be covered by Medicaid or must be included as allowable medical education costs in the hospital's cost report.

Guidelines require the presence of the teaching physician during the key portion of the performance of the service in which a resident is involved and the teaching physician seeks payment (or the hospital on the behalf of the physician). The medical record must fully support the physician's presence and participation in the service provided. There are exceptions and other considerations that may apply; therefore, the full text of the guidelines must be consulted to ensure compliance. Any services that meet the teaching physician criteria must be reported with the appropriate modifier.

CMS provides an exception to the physician presence requirement for some low- and mid-level Evaluation and Management (E/M) services furnished in certain primary care centers when specified conditions are met. For Medicaid, the preventive medicine E/M visits are also included under the "presence" exception

for services provided in the primary care centers by residents. The appropriate modifier must be reported using the "presence" exception when residents provide E/M services. The E/M services that can be reported with this modifier include office or other outpatient visits requiring straightforward or low complexity medical decision making and comprehensive preventive medicine visits. For higher-level services and all invasive procedures, the teaching physician must be present.

Services of residents or physicians/medical staff functioning in an administrative, teaching or learning capacity in the hospital or long term care facility that are covered as individual physician services are subject to post payment review and recovery of funds unless the provider can present proof that the services were not included in the allowable facility costs.

1.12 Services to Newborns

Physician services provided to newborns are covered under the newborn's Medicaid ID number. The mother's Medicaid ID number cannot be used.

If the delivering physician performs the newborn's care and circumcision during the mother's inpatient stay, these services can be covered under the mother's Medicaid ID number if they are billed on the same claim as the services to the mother.

1.13 Uniform Reporting of Services

MDCH uses the Medicare Correct Coding Initiative (CCI) policy as a guideline for determining when services are covered in addition to, or are included in, other services provided on the same day. The CPT/HCPCS procedure code descriptions are based upon current medical practice. In order to submit a CPT/HCPCS code to Medicaid, providers must have performed all of the services included in the code description. Providers must not submit codes describing components of a comprehensive code in addition to the comprehensive code (unbundling). Components are individual services necessary to accomplish the more comprehensive procedure/service.

Mutually exclusive code pairs represent services or procedures that would not or could not be reasonably performed on one beneficiary during the same session by the same provider based on standard medical practice. Codes representing these services cannot be submitted together.

Certain codes are identified as separate procedures. These are commonly carried out as an integral part of another service and are not covered separately. However, at times, these services may be provided independently, or unrelated or distinct from other procedures on the same day. It may be appropriate to report a separate procedure with the distinct procedural service modifier in these instances. The addition of this modifier to a procedure code indicates that the procedure represents a distinct procedure or service from others billed on the same date of service. This may represent a different session, different surgery, different anatomical site, different agent, different lesion, or a different injury or area of injury (in extensive injuries).

When CPT/HCPCS descriptions designate several procedures of increasing complexity, only the code describing the most extensive procedure actually performed is covered. Certain CPT/HCPCS descriptions designate procedures performed with or without other services. Providers must submit only the code(s) describing the service(s) actually performed. When the descriptions identify procedures requiring a designation for male or female, submit the appropriate code for the gender of the patient.

SECTION 2 - ANESTHESIA SERVICES

Medicaid covers anesthesia services provided by qualified practitioners in conjunction with covered surgeries and other procedures. (Refer to the Anesthesia Services Database on the MDCH website for specific covered anesthesia services.) Medicaid does not cover any anesthesia service related to the treatment of infertility.

2.1 MEDICALLY DIRECTED ANESTHESIA SERVICES

Medicaid covers anesthesia services provided by physicians and CRNAs for medically directed anesthesia services consistent with anesthesia team practice. (Refer to the Certified Registered Nurse Anesthetist Section of this chapter for additional information). Medicaid recognizes medical direction of general anesthesia, regional anesthesia, and reasonable and medically necessary Monitored Anesthesia Care (MAC). Physicians cannot medically direct more than four concurrent anesthesia cases at one time and cannot perform any other services during the same period of time except as outlined below. In all cases in which medical direction is furnished, the physician must be physically present in the operating suite.

All of the following conditions must be met for medically directed anesthesia services to be reimbursed to the physician. For each beneficiary, the physician must:

- Perform a pre-anesthetic examination and evaluation;
- Prescribe the anesthesia plan;
- Personally participate in the most demanding procedures in the anesthesia plan including, if applicable, induction and emergence;
- Ensure that a qualified individual performs any procedures in the anesthesia plan that he does not personally perform;
- Monitor the course of anesthesia administration at frequent intervals;
- Remain physically present and available for immediate diagnosis and treatment of emergencies; and
- Provide indicated post-anesthesia care.

A medical direction service furnished by a physician is not covered if the physician directs a nonqualified individual. A qualified individual is a CRNA, a student anesthetist, an anesthesiologist's assistant, or an intern or resident.

Physicians must document in the beneficiary's medical record that he performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and present during the most demanding procedures, including induction and emergence, where indicated. Total anesthesia time must be documented in the medical record.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another physician member fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. The medical record must indicate the services were furnished by physicians and identify the physician(s) who rendered them.

A physician who is directing the concurrent administration of anesthesia to four or fewer surgical patients should not be involved in furnishing additional services to other patients. If the physician is addressing an emergency of short duration in the immediate area, or administering an epidural or caudal anesthetic to ease labor pain, or providing periodic rather than continuous monitoring of an obstetrical patient, it does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. A physician may also receive patients entering the operating suite for subsequent surgeries, may check on or discharge patients from the recovery room, and may handle scheduling matters while directing concurrent anesthesia procedures without affecting coverage for medical direction.

If the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case, or is not available to respond to the immediate needs of the surgical patients, the physician's services are considered supervisory and are not covered as medical direction.

Medically directed anesthesia services are covered when provided by an anesthesiologist who is monitoring more than four concurrent anesthesia procedures, or who is performing other services while directing the concurrent procedures, in select instances. The physician must personally provide the pre-anesthesia exam and evaluation, prescribe the anesthesia plan, and be in the operating suite during the entire procedure. A flat rate payment is made to cover the physician's involvement in pre-surgical anesthesia services. Medically supervised CRNA services are covered and are reported with the appropriate modifier.

Medicaid covers anesthesia services consistent with Medicare guidelines when provided under an attending physician relationship in a teaching hospital and/or in accordance with the coverage guidelines established by the Medicare policies for teaching physicians.

2.2 Nonmedically Directed Anesthesia Services by the CRNA

Anesthesia services provided by a CRNA under the supervision of the surgeon or another physician who is immediately available if needed are covered as nonmedically directed anesthesia services. MDCH reimburses CRNAs for these services if all of the following conditions are met:

- The facility in which the services are rendered ensures that the anesthesia services are provided in a well-organized manner under the supervision of a physician (MD or DO).
- The facility is responsible for all anesthesia administered in the facility.
- A physician (MD or DO) or a CRNA under the supervision of a physician provided a pre-anesthetic exam and evaluation within 48 hours prior to the surgery.
- An intra-operative anesthesia record identifies the CRNA providing the anesthesia service and the supervising physician.
- For inpatients, the person administering the anesthesia writes a post-anesthesia follow-up report within 48 hours after surgery.
- For outpatients, a post-anesthesia evaluation for proper anesthesia recovery is performed in accordance with the policies and procedures approved by the medical staff.

There is no separate coverage for physicians for any portion of nonmedically directed anesthesia services. The physician's supervisory service is covered as part of the facility charge where the surgery is performed. The pre-anesthetic exam and post-anesthesia evaluation is included in the anesthesia coverage for the nonmedically directed CRNA care and is not separately covered. Payment for the nonmedically directed anesthesia service provided by the CRNA is made to the CRNA or the legal entity employing the CRNA.

There is no separate coverage for anesthesia services performed by physicians who are also performing the medical or surgical service requiring the anesthesia. Any anesthesia service provided personally by the surgeon is included in the coverage for the surgical procedure itself.

2.3 Monitored Anesthesia Care

Monitored Anesthesia Care (MAC) is covered on the same basis as other anesthesia services as long as it is reasonable and medically necessary. MAC involves intra-operative monitoring by a physician, or by a qualified anesthesia provider under the medical direction of a physician, or by a CRNA under the supervision of a physician of the beneficiary's vital physiological signs, in anticipation of the need for administration of general anesthesia or the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., Atropine, Demerol, Valium) and provision of indicated post-operative anesthesia care.

2.4 Medical and Surgical Services Furnished in Addition to Anesthesia Services

2.4.A. Allowable Services

Separate coverage is available for certain medical or surgical services furnished by a physician while furnishing anesthesia services to the beneficiary. The services may be furnished in conjunction with the anesthesia procedure to the beneficiary or as single services (e.g., the day of or the day before the anesthesia service). These services include insertion of a Swan Ganz catheter, insertion of central venous pressure lines, emergency intubation, and critical care. Separate coverage is not available for medical or surgical services, such as the pre-anesthetic examination of the beneficiary, pre- or post-operative visits, or usual monitoring functions, that are ordinarily included in the anesthesia service.

2.4.B. Post-Operative Pain Management

Post-operative pain management is the responsibility of the surgeon (except in special circumstances) and is covered as part of the global service provided by the surgeon.

Placement of a continuous epidural to manage post-operative pain is separately covered under the appropriate CPT/HCPCS code for a continuous epidural when the physician (or CRNA under a physician's supervision) performed the service for post-operative pain management and the procedure was not used as the mode of anesthesia for the surgery. Daily management of a continuous epidural on subsequent post-operative days is covered under the appropriate procedure code.

2.5 Anesthesia Time

Anesthesia time means the time during which the anesthesia provider (physician providing anesthesia or the CRNA) is furnishing continuous anesthesia care to the beneficiary. It starts when the anesthesia provider begins to prepare the beneficiary for induction of anesthesia and ends when the beneficiary may be safely placed under post-operative supervision and the anesthesia provider is no longer in personal attendance. In counting anesthesia time when an interruption in the anesthesia service occurs, only the actual anesthesia time is counted. The anesthesia start and stop times must be documented in the medical record.

2.6 Electro-Convulsive Therapy

Anesthesia services related to electro-convulsive therapy are covered by the beneficiary's Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) or Medicaid Health Plan (MHP). The attending physician must obtain authorization from the PIHP/CMHSP or the MHP. Payment is made by the PIHP/CMHSP or MHP that authorized the service.

2.7 Prior Authorization for Anesthesia Services

If a surgical procedure requires PA, the operating surgeon is responsible for obtaining the authorization to perform the service. The anesthesia provider is not responsible for providing proof that the surgical procedure was authorized.

2.8 Hysterectomies and Sterilization Procedures

By federal statute, all services, including anesthesia services related to hysterectomies or sterilization procedures, must be supported by an informed consent that meets Medicaid's consent requirements before the service can be covered. It is the responsibility of the operating surgeon to obtain this consent.

2.9 Using Modifiers

Anesthesia services must be coded using the appropriate CPT/HCPCS anesthesia codes with the appropriate modifiers. Anesthesia services for multiple surgeries are reported under the anesthesia procedure code with the highest base unit value with the total anesthesia time, in minutes, including all surgical procedures. (Refer to the MDCH website for specific modifiers required for use with anesthesia services.)

2.10 Anesthesia Add-On Codes

Anesthesia add-on codes are covered in addition to the primary anesthesia code. Coverage for anesthesia add-on codes is based on the anesthesia base units (ABUs) established by CMS for the specific anesthesia add-on code.

Obstetrical anesthesia add-on codes are covered based on the ABUs assigned by CMS plus the anesthesia time units associated with the anesthesia add-on code.

2.11 Labor and Delivery

Coverage of anesthesia services associated with labor and delivery is based on the type of anesthesia provided. If anesthesia is provided by placement of an epidural catheter, it is covered under the appropriate anesthesia code depending on the type of delivery. The coverage for this service includes any needle placement, drug injection, and any replacement of the epidural catheter during labor. If endotracheal or general anesthesia is provided for the delivery, it is covered under the appropriate anesthesia code. If an epidural catheter is inserted for labor and delivery but it is later necessary to provide endotracheal anesthesia for the delivery, the surgical code for the epidural insertion is covered in addition to the anesthesia service code for the delivery. The medical record must fully document the circumstances requiring both types of anesthesia.

SECTION 3 - EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) to eligible Medicaid beneficiaries under 21 years of age; however, beneficiary participation is voluntary. The intent of EPSDT is to find and treat problems early so they do not become more serious and costly. Accordingly, EPSDT visits and any needed follow-up services are covered.

The main parts of the EPSDT program that providers are responsible for are:

- Well child visits, including immunizations.
- Referrals for:
  - Other preventive health care;
  - Medically necessary follow-up services to treat detected conditions; and
  - Transportation and reporting.

Well Child Visits	MDCH supports the concept of a medical home for each Medicaid beneficiary. A medical home is a primary care provider who assumes responsibility for assuring the overall care of a beneficiary, and for the maintenance of a beneficiary's medical record. When a physician or other primary care provider accepts a child in a primary care relationship, the provider takes responsibility for arranging or providing well child/EPSDT visits and updating the child's medical record at each visit. Well child visits are the health checkups, newborn, well baby, and well child exams represented by appropriate CPT preventive medicine services procedure codes if they are used in conjunction with the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes V20.0 - V20.2, V70.0, and/or V70.3 - V70.9 The EPSDT periodicity schedule (located later in this section) indicates all components and age-specific indicators for performing the various components.
Outreach	MDCH provides outreach to beneficiaries through various means, including informational publications and other beneficiary contacts. When the **mihealth card** is issued, it is mailed with the MDCH publication "Michigan Free Health Check-Ups" (containing English, Spanish, and Arabic text). The publication explains the benefits of a well child visit, indicates the recommended periodicity schedule, describes procedures included in the free health checkup, and presents information about transportation. Soon after the **mihealth card** is issued, the case is included in a monthly outreach list and the grantee receives a letter that stresses the importance of well child visits and provides transportation information.

	▪ **Fee-for-Service (FFS):** For beneficiaries under two years of age, the letter is sent every six months. The grantee is encouraged to schedule the visits recommended during those six months with the child's provider. For beneficiaries two years of age and older, if a claim for a well child visit has not processed through the Medicaid system by the time the child is halfway to his next due date according to the periodicity schedule, the grantee receives the letter again. The letters generate a list of FFS beneficiaries that goes to the local health department (LHD). LHDs may assist in informing beneficiaries of the EPSDT program, scheduling appointments, and explaining transportation options. ▪ **Medicaid Health Plan (MHP):** Each MHP is able to download an electronic monthly outreach list of enrollees due or overdue. The health plan must either notify the grantee directly or may have the LHD assist in notification, scheduling appointments, and explaining transportation options. Once each year, "Michigan Free Health Check-ups" is mailed to the grantee of each Medicaid case.
Transportation	Transportation is available (free of charge to the beneficiary) for travel to and from well child visits, if requested by the family. ▪ For those enrolled in an MHP, the family needs to make arrangements directly through that plan or with the assistance of the LHD. ▪ Beneficiaries not enrolled in an MHP need to contact their local Department of Human Services (DHS) directly or with the assistance of the LHD to make transportation arrangements for the EPSDT visit. It may take some time to make these arrangements, so the DHS needs to be contacted as soon as the date and time of the appointment are known.

3.1 Periodicity Schedule and Components

The table titled EPSDT Components By Age of Beneficiary in the EPSDT Periodicity Schedule subsection (later in this section) indicates the periodicity schedule and components for well child visits.

Head Start agencies are directed by federal regulation to meet state EPSDT standards for health screening. MDCH urges providers to cooperate with these agencies. Results of well child visits may be shared if requested, since Head Start agencies are bound by confidentiality standards.

Providers must complete all testing components at the specific ages indicated on the periodicity schedule. Well child visits may be performed more frequently than the periodicity schedule indicates if required by court order, foster care standards, or if considered medically necessary. The child's medical record must reflect documentation of the circumstances.

The following sections are meant to provide further guidance to providers when following the EPSDT Components By Age of Beneficiary table.

3.2 HISTORY

Immunization Review	A review shall be performed at each visit, with immunizations administered according to current recommendations and standards of practice recognized by the American Academy of Pediatrics (AAP) and the US Public Health Service Advisory Committee Immunization Practices (ACIP). Providers are reminded that all immunizations should be reported to the Michigan Childhood Immunization Register (MCIR).
Initial/Interval History	An initial history must be obtained for each new patient at the first well child visit, with an update (interval history) at each subsequent well child visit.

Sample history forms from other states are located on the MDCH website. (Refer to the Directory Appendix for contact information.)

3.3 MEASUREMENTS

Blood Pressure	Providers must obtain a blood pressure reading at each well child visit beginning at three years of age.
Head Circumference	This measurement is required at each well child visit through 24 months of age.
Height and Weight	Height and weight must be measured each time the provider conducts a well child visit, with good practice requiring graphing of the measurements. A suitable graphing document may be found on the Centers for Disease Control (CDC) website. (Refer to the Directory Appendix for contact information.).

3.4 SENSORY SCREENING

3.4.A. HEARING [CHANGE MADE 4/1/06]

Newborn	All newborns must be screened using evoked otoacoustic emissions (EOAE) and/or auditory brainstem response (ABR) methods. This screening must be accomplished in one of the following ways: ▪ If the hospital delivered 15 or more Medicaid-covered babies between October 1, 1997 and September 30, 1998, the hospital must provide newborn hearing screenings for Medicaid-covered newborns using the policies and procedures recommended by the AAP. If the newborn fails the first screening, another shall be conducted prior to the newborn's discharge. Coverage for the EOAE and ABR newborn hearing screenings is included within the applicable diagnosis related group (DRG) payment for the newborn's inpatient stay.

	▪ If the hospital delivered fewer than 15 Medicaid-covered babies between October 1, 1997 and September 30, 1998, the following options are available: ➢ The hospital may obtain the appropriate equipment and train staff to perform newborn hearing screenings using policies and procedures recommended by the AAP. If the newborn fails the first screening, another shall be conducted prior to the newborn's discharge. Coverage for the EOAE and ABR newborn hearing screenings is included within the applicable DRG payment for the newborn's inpatient stay. ➢ FFS Beneficiaries: If the hospital is not equipped for EOAE and/or ABR, the child's physician, nurse-midwife, or nurse practitioner shall be made aware of this fact by the hospital so the newborn can be referred to a Medicaid-enrolled hearing and speech center for screening prior to one month of age. Beneficiaries Enrolled in an MHP: If the hospital is not equipped for EOAE and/or ABR, the child's primary care provider (physician, CNM, or NP) shall be made aware of this fact by the hospital so the child can receive an appropriate referral for screening prior to one month of age
Preschool	Subjective hearing screening (i.e., by history) must be performed at each well child visit. Objective hearing screening may be performed on eligible Medicaid preschool-aged children (ages 3-6 years) by qualified LHD staff. LHDs may provide objective hearing screening services and accept referrals for screening from physicians and from Head Start programs. In an effort to promote communication with the child's medical home, the objective hearing screening results must be reported to the child's primary care provider (PCP). In the event the LHD is unable to report the objective hearing screening results to the child's PCP, the LHD must clearly document why this could not be accomplished. The results must also be shared with the Head Start agency if that agency was the referral source. **(per bulletin MSA 06-08 effective 4/1/06)**
School Age	Subjective hearing screening (i.e., by history) must be performed at each well child visit. Children with symptoms or risk factors should be referred to a hearing and speech center, an otologist, or CSHCS-sponsored otology clinic at a LHD for further objective testing or diagnosis.
All Ages	For children of any age, a subjective hearing screening (i.e., by history) must be performed at each well child visit. Referral to a hearing and speech center, an otologist, or CSHCS-sponsored otology clinic at a LHD should be made if there are symptoms (e.g., parent or caregiver has suspicions about poor hearing in the child), risk factors (e.g., exposure to ototoxic medications, family history of hearing deficits), or other medical justification.

3.4.B. VISION [CHANGE MADE 4/1/06]

Providers must perform a subjective vision screening (i.e., by history) at each well child visit. For asymptomatic children three years of age and older, objective screening must occur as indicated on the periodicity schedule. For children of any age, referral to an optometrist or ophthalmologist must be made if there are symptoms or other medical justification.

Preschool	Since most children cannot cooperate prior to three years of age, the standard screening is subjective. Objective screening should begin at age three. Objective vision screening may be performed on eligible Medicaid preschool-aged children (ages 3-6 years) by qualified LHD staff. LHDs may provide objective vision screening services and accept referrals for screening from physicians and from Head Start programs. In an effort to promote communication with the child's medical home, the objective vision screening results must be reported to the child's primary care provider (PCP). In the event the LHD is unable to report the objective vision screening results to the child's PCP, the LHD must clearly document why this could not be accomplished. The results must also be shared with the Head Start agency if that agency was the referral source. **(per bulletin MSA 06-08 effective 4/1/06)**
School Age	Subjective vision screening must be performed at each visit; objective screening shall be performed as indicated on the periodicity schedule.

3.5 Developmental/Behavioral Assessment

Screening for development and behavior is accomplished by observation, history, and appropriate physical examination. The provider may administer a:

- Standardized developmental instrument, such as the Developmental Screening Test II or Bayley Scales of Infant Development.
- Mental health screening.
- Substance abuse screening.

If suspected problems are observed, specific objective testing must be administered either directly by the primary care provider or referred as appropriate.

3.6 Inspections

Dental	The dental health of beneficiaries depends a great deal on the child's primary care provider. Therefore, MDCH requires providers to stress the importance of preventive and restorative dental care and adhere to the following: ▪ The oral cavity must be inspected at each well child visit regardless of whether teeth have erupted. ▪ Beginning at three years of age (younger if the individual child exhibits needs) it is extremely important that the child see a dentist every six months for prophylaxis and other preventive care. If the child does not have his next preventive dental appointment scheduled, the provider must make a referral. When restorative dental care is needed, the child must be referred for treatment.
Physical Examination	A complete physical examination must be performed at each well child visit. Infants are to be totally unclothed; all other children must be undressed and suitably draped.

3.7 PROCEDURES - GENERAL

Anticipatory Guidance	Anticipatory guidance explains any and all changes that will most likely occur before the next recommended well child visit, and offers strategies for dealing with the anticipated changes. This applies to all aspects of the child's life (e.g., physical, developmental, nutritional, psychosocial).
Hematocrit or Hemoglobin	The child's hematocrit or hemoglobin must be tested according to the periodicity schedule.
Hereditary/ Metabolic Screening	As required by law, hospitals must test newborns for biotinadase, congenital adrenal hyperplasia, galactosemia, hemoglobinopathies, hypothyroidism, maple syrup urine disease, phenylketonuria (PKU), and sickle cell. If sickle cell testing is appropriate (as explained on the periodicity schedule), a capillary blood sample may be mailed to the Sickle Cell Detection and Information Center. (Refer to the Directory Appendix for contact information.) Tubes, forms, and envelopes may be obtained from the Center.
Injury Prevention	Injury prevention must be discussed at each well child visit.
Interpretive Conference	The interpretive conference explains the results of the well child visit. Depending on the age and/or family status of the beneficiary, the conference may be held directly with the beneficiary, the beneficiary and parent/guardian, or only with the parent/guardian. If a beneficiary has a potential or apparent abnormality, the provider is responsible for providing or referring for follow-up diagnostic services and treatment.
Nutritional Assessments	Nutritional assessments must be based on height, weight, and their relatedness; the most recent hematocrit/hemoglobin value; physical examination; and health history. Age appropriate nutrition counseling must be provided at each visit.
Sleep Position Counseling	Positioning of infants through six months of age for sleep must be discussed at each visit. Healthy infants should be placed on their backs; side positioning is a reasonable alternative but has a slightly higher risk of Sudden Infant Death Syndrome (SIDS).
Urine Testing	A urinalysis (at a minimum, via dipstick) must be performed for all beneficiaries at five years of age and for sexually active male and female adolescents.
Violence Prevention	Prevention of violence must be discussed at each visit.

3.8 Procedures - Children At High Risk

3.8.A. Cholesterol

High-risk children should be tested according to current AAP guidelines. Beginning at two years of age, children must be screened if:

- Parents or grandparents, at <55 years of age, underwent diagnostic coronary arteriography and were found to have coronary atherosclerosis. This includes those who have undergone balloon angioplasty or coronary artery bypass surgery. Perform a fasting lipoprotein analysis.
- Parents or grandparents, at <55 years of age, had a documented myocardial infarction, angina pectoris, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death. Perform a fasting lipoprotein analysis.
- A birth parent has an elevated blood cholesterol level. Perform a random serum cholesterol.

If a family history cannot be ascertained and other risk factors exist, testing is at the provider's discretion.

3.8.B. Diabetes (Type 2)

High-risk children must be tested according to the current AAP guidelines.

Beginning at age 10 (or at the onset of puberty, if it occurs at a younger age), a risk assessment must be performed at each well child visit. Children at risk should be tested using the fasting plasma glucose, two-hour oral glucose tolerance, or two-hour plasma glucose tests.

A child is considered high risk if he is overweight (i.e., body mass index >85th percentile for age and sex, weight for height >85th percentile, or weight >120 percent of ideal for height) and has any two of the following factors:

- A family history of Type 2 diabetes in first- and second-degree relatives;
- Belongs to a certain race/ethnic group (American Indian, African-American, Hispanic, Asian/Pacific Islander); and
- Signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, polycystic ovarian syndrome).

3.8.C. Pelvic Exams, Pap Smears, Breast Exams, Counseling and Risk Factor Interventions

Beginning at puberty, all females must receive clinical breast exams and be taught self-breast examination.

All sexually active females must have a pelvic, Pap smear, and breast exam as indicated on the periodicity schedule. Pelvic exams and Pap smears must be offered to all females 18 years of age and older. Whenever a pelvic exam is provided, a breast exam, counseling, and risk factor interventions must be provided.

3.8.D. Sexually Transmitted Diseases

All sexually active patients must be screened for sexually transmitted diseases (STDs) according to the periodicity schedule.

3.8.E. Tuberculosis Testing

CMS recommends that children be tested for tuberculosis (TB) according to the guidelines of the AAP, which is based on risk. A risk assessment must be completed at each visit. For assistance in determining high risk and testing, providers may refer to the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases, or contact MDCH's Communicable Disease and Immunization Division. (Refer to the Directory Appendix for contact information.)

Based on current standards of good practice, Mantoux testing is the preferred testing method.

3.8.F. Blood Lead

All Medicaid-covered children are considered at high risk for blood lead poisoning. The CMS has mandated that these children be tested at 12 and 24 months of age. In addition, CMS mandates that if a Medicaid-covered child is between the ages of 36 and 72 months of age and has not previously been tested for blood lead, he must be tested. If the parent or guardian is unsure if the child was previously tested, he must be tested.

For children who have been tested, the following questions are intended to assist physicians and nurse practitioners in determining if further testing is necessary in addition to that completed at the mandated ages:

- Does the child live in (or often visit) a house built before 1950 with peeling or chipping paint? This could include day care, preschool, or home of a relative.
- Does the child live in (or often visit) a house built before 1978 that has been remodeled within the last year?
- Does the child have a brother or sister (or playmate) with lead poisoning?
- Does the child live with an adult whose job or hobby involves lead? (The chart following these questions presents examples.)
- Does the child's family use any home remedies that may contain lead? (The chart following these questions presents examples.)

Possible Means of Exposure

Occupational	Hobbies	Environmental
▪ Auto repair ▪ Battery manufacturing or repair ▪ Bridge reconstruction worker ▪ Chemical manufacturing ▪ Construction worker ▪ Glass manufacturing ▪ Industrial machine operator ▪ Migrant farm worker ▪ Plastics manufacturing ▪ Plumber, pipe fitter ▪ Police officer ▪ Printing ▪ Radiator repair ▪ Rubber products manufacturing ▪ Steel welding and cutting	▪ Brass/copper/aluminum processing ▪ Car or boat repair ▪ Casting lead figures (e.g., toy soldiers) ▪ Furniture refinishing ▪ Jewelry and pottery making ▪ Lead soldering (e.g., electronics) ▪ Making lead shot, fishing sinkers, bullets ▪ Painting ▪ Stained glass making ▪ Target shooting at firing ranges	▪ Burning lead-painted wood ▪ Ceramic ware/pottery ▪ Lead crystal ▪ Lead-soldered cans (imported) ▪ Lead paint ▪ Lead-painted homes ▪ Living near lead-related industries ▪ Renovating/remodeling older homes ▪ Soil/dust near industries and roadways ▪ Use of water from lead pipes
Other	▪ Asian cosmetics ▪ Folk remedies and/or food additives (e.g., Greta, Azarcon, pay-loo-ah, ghasard, Hai ge fen, Bali Goli, Kandu, Kohl, X-yoo-Fa, Mai ge fen, poying tan, lozeena)	

Publications and other materials concerning blood lead may be obtained from the MDCH Childhood Lead Poisoning Prevention Program. The MDCH Blood Lead Laboratory can also be contacted. (Refer to the Directory Appendix for contact information.)

There are pediatricians in all areas of the state who have expertise in the treatment of blood lead and are available to discuss blood lead issues with other providers. Providers with questions concerning blood lead testing or treatment should call the Childhood Lead Poisoning Prevention Program to obtain the names and telephone numbers of these pediatricians. (Refer to the Directory Appendix for contact information.)

For blood lead analysis, the blood sample may be obtained via the capillary method (i.e., heel prick or finger stick) or venipuncture. The sample may be sent to the MDCH Blood Lead Laboratory or to any laboratory qualified to do blood lead testing. If the MDCH Blood Lead Laboratory is used, blood lead supplies may be obtained. (Refer to the Directory Appendix for contact information.)

Michigan has established a statewide blood lead registry. This requires that certain information accompany each blood lead specimen (or request, if the specimen is drawn elsewhere) to the laboratory.

- Before providers begin sending blood lead samples to the MDCH Blood Lead Laboratory, they must obtain a Submitter Clinic Code. If providers send blood lead samples to the MDCH Blood Lead Laboratory, the Blood Lead Sampling Request (DCH-0696) must be used. Providers may obtain a Submitter Clinic Code and a supply of the DCH-0696 forms by calling the MDCH Blood Lead Laboratory. (Refer to the Directory Appendix for contact information.)
- If blood lead samples are sent to a private laboratory or if the private laboratory draws and tests the sample, copy the MDCH Blood Lead Analysis Report (DCH-0395) for use or develop a form that includes all of the information from the DCH-0395. When testing is completed, the laboratory completes the information contained in Part III of the form and submits it to the registry.

Primary care providers must draw blood in their offices for all children needing blood lead testing. There may be instances when a blood draw is not accomplished. If this occurs and the child resides in a jurisdiction where the LHD agrees to obtain a blood sample for blood lead testing, the primary care provider may refer a child to the LHD for the service.

The MDCH Blood Lead Laboratory reports all results to the child's ordering provider if information about the ordering provider is included. When ordering provider information is not available, results are sent to the appropriate LHD.

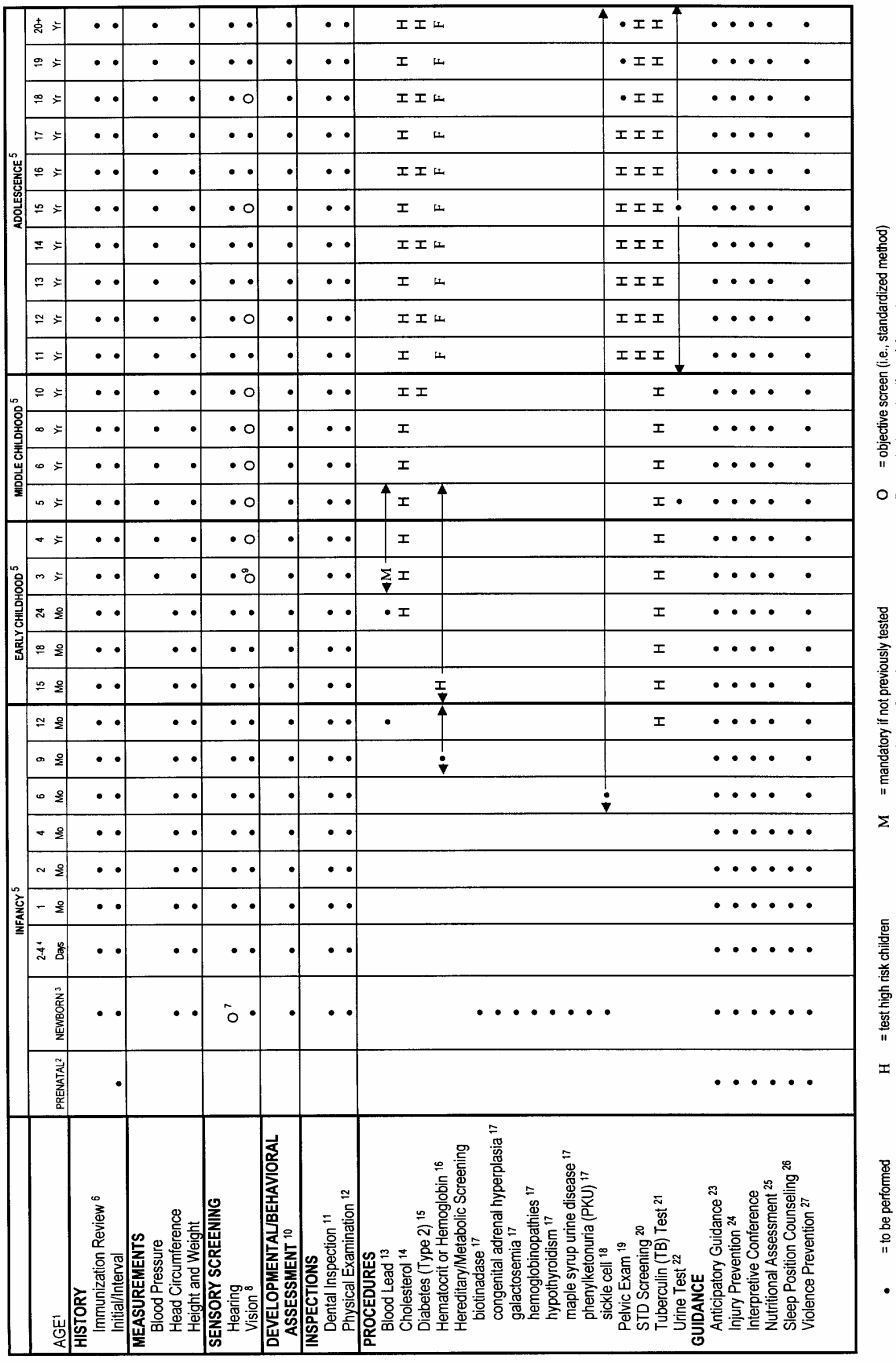
If the results of a capillary blood lead sample indicate an elevated value, a confirmatory venous sample must be obtained. The capillary and venous blood lead value/action charts follows.

Blood Lead (Pb) Interpretation			
Capillary (Microblood) Samples		**Venous (Macroblood) Samples**	
PB Result (micrograms per deciliter of blood)	Action	**PB Result** (micrograms per deciliter of blood)	Action
≤ 9	No action needed.	≤ 9	No action needed.
10 – 14	Obtain venous sample within one month. Emphasize the importance of the venous confirmation.	10 – 19	Refer within one month for medical evaluation and retesting. The provider shall contact the LHD to determine if resources are available to provide follow-up services for this Pb range.
15 -19	Obtain venous sample within two weeks. Emphasize the importance of the venous confirmation.		
20 - 44	Obtain venous sample within one week. Emphasize the importance of the venous confirmation.	20 – 44	Refer within five working days for a complete medical evaluation. Refer to the LHD within ten working days for blood lead poisoning follow-up services.
45 – 69	Obtain venous sample within 48 hours. Emphasize the importance of the venous confirmation.	45 – 69	Refer within 48 hours for medical intervention. Refer to the LHD within five working days for blood lead poisoning follow-up services.
≥ 70	Obtain venous sample immediately. Emphasize the importance of the venous confirmation.	≥ 70	Refer immediately for a complete medical evaluation. Refer to the LHD within 24-48 hours for blood lead poisoning follow-up services.
N.R. (no results-insufficient or clotted blood)	Repeat capillary sample one time or obtain venous sample.	N.R. (no results-insufficient or clotted blood)	Repeat venous sample.
For values above 9, the provider shall always provide general health education to the parents regarding nutrition, house-cleaning techniques, and lead poisoning prevention. (This is considered part of the interpretive conference and is not separately reimbursable.)		For values above 9, the provider shall always: ▪ Emphasize the importance of following through with any retesting, evaluation, or intervention. ▪ Provide general health education to the parents regarding nutrition, house-cleaning techniques, and lead poisoning prevention. This is considered part of the interpretive conference and is not separately reimbursable.	
KEY: ≤ = Less than or equal to ≥ = Greater than or equal to			

3.9 EPSDT PERIODICITY SCHEDULE

FRONT

EPSDT COMPONENTS BY AGE OF BENEFICIARY



Back

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include pertinent medical history, injury prevention, and anticipatory guidance. The benefits of breastfeeding should be discussed as well as the planned method of feeding per AAP statement "The Prenatal Visit" (RE0053), Pediatrics, Volume 107, Number 6, June 2001, pp. 1456-1458.
3. Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged and instruction and support offered. Every breastfeeding infant should have an evaluation 48-72 hours after discharge from the hospital to include weight, formal breastfeeding evaluation, encouragement, and instruction as recommended in the AAP statement "Breastfeeding and the Use of Human Milk" (RE9729), Pediatrics, Volume 100, Number 6, December 1997, pp. 1035-1039.
4. For newborns discharged within 48 hours of delivery, per AAP statement "Hospital Stay for Healthy Term Newborns" (RE9539), Pediatrics, Volume 96, Number 4, October 1995, pp. 788-790.
5. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
6. An immunization review shall be performed at each appointment, with immunizations being administered at appropriate ages, or as needed. See schedules published annually in the January edition of Pediatrics.
7. **ALL** Medicaid-covered newborns must be screened using evoked otoacoustic emissions (EOAE) and/or auditory brainstem response (ABR) methods per AAP statement "Newborn and Infant Hearing Loss: Detection and Intervention" (RE9846), Pediatrics, Volume 103, Number 2, February 1999, pp. 527-530.
8. A subjective vision screening (i.e., by history) shall be performed at each appointment. For asymptomatic children three years of age and older, objective screening shall occur as indicated. For children of any age, a referral to an optometrist or ophthalmologist shall be made if there are symptoms or other medical justification.
9. If the patient is uncooperative, rescreen within six months.
10. By history and appropriate physical examination and/or via a screening instrument. If suspicious, by specific objective developmental, mental health, or substance abuse testing. Parenting skills should be fostered at every visit.
11. A dental inspection should be performed at each screening. Provide reinforcement of routine preventive dental care, stressing the recommended schedule of the American Academy of Pediatric Dentistry. If the next preventive dental visit is not scheduled, if the beneficiary does not have a dentist, or if restorative dental care is needed, a referral shall be made.
12. A complete physical examination shall be performed at each appointment. Infants should be totally unclothed, older children undressed and suitably draped.
13. Medicaid children are considered high risk and shall be tested accordingly. Information relative to testing, treatment, and referrals may be obtained by calling the Childhood Lead Poisoning Prevention Program at (517) 335-8885.
14. Test high risk children per AAP statement "Cholesterol in Childhood" (RE9805), Pediatrics, Volume 101, January 1998, pp. 141-147. If a family history cannot be ascertained and other risk factors are present, testing is at the discretion of the provider.
15. Test high risk children every two years beginning at ten years of age (or at onset of puberty if it occurs at a younger age). Refer to the AAP statement "Type 2 Diabetes in Children and Adolescents, Consensus Statement of the American Diabetes Association" in Pediatrics, Volume 105, March 2000, pp. 671-680.
16. See AAP *Pediatric Handbook of Nutrition* (1998) for a discussion of universal and selective screening options. Consider earlier screening for high risk infants (premature infants, low birth weight infants). Also see "Recommendations to Prevent and Control Iron Deficiency in the United States" *MMWR*, 1998; 47 (RR-3):1-29.
17. By law, these newborn tests should be initiated before the child is discharged from the hospital.
18. If the child was born in a Michigan hospital on or after October 1, 1987, the test should have been performed on the newborn. For other children with all or some black heritage, the test is required prior to the child's 21st birthday unless electrophoresis for sickle cell was done when the child was at least six months of age and the results are known to the parent.
19. All sexually active females (high risk) shall have a pelvic exam and Pap smear. A pelvic exam, breast exam, and Pap smear should be offered to all females beginning at 18 years of age.
20. All sexually active patients (high risk) shall be screened for sexually transmitted diseases (STDs).
21. Test high risk children according to the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. Based on standards of good practice, Mantoux testing is the preferred method.
22. A urinalysis (at a minimum, via dipstick) for all children at five years of age and for sexually active male and female adolescents.
23. Age-appropriate discussion and counseling should be an integral part of each visit per the AAP "Guidelines for Health Supervision III" (1994).
24. From birth to 12 years of age, refer to the AAP injury prevention program as described in *A Guide to Safety Counseling in Office Practice* (1994).
25. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP *Pediatric Handbook of Nutrition* (1998).
26. Parents and caregivers shall be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of Sudden Infant Death Syndrome (SIDS). Consult the AAP statement "Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position" (RE9946), Pediatrics, Volume 105, Number 3, March 2000, pp. 650-656.
27. Violence prevention and management per AAP statement "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level" (RE9832), Pediatrics, Volume 103, Number 1, January 1999, pp. 173-181.

If any problems are detected or suspected, a referral should be made.

If a test is contraindicated at the time of appointment, it need not be performed; if the provider wishes to perform certain tests more frequently (e.g., take blood pressure at each visit, test an older child for blood lead), they may be provided; or if the child requires more frequent health checkups, they may be provided. If additional tests are required, they may be performed or referred, as appropriate.

3.10 REFERRALS

If a problem is found or suspected during a well child visit, the (suspected) problem must be diagnosed and treated as appropriate. This may mean referral to another provider or a self-referral for further diagnosis and treatment. Referrals must be made based on standards of good practice and MDCH's established periodicity schedule or presenting need, if outside the normal schedule.

When a FFS provider performs medically necessary treatment involving diagnostic or therapeutic procedures beyond examination of the child (e.g., wart removal) for a condition found during a well child visit, these procedures are covered in addition to the well child visit. For information regarding billing a well child E/M visit and other E/M visits occurring on the same date of service, refer to the Evaluation and Management Services Section of this chapter. If the provider cannot perform the needed treatment, a referral must be made to an appropriate provider. If providers are not familiar with other providers in the area, the LHD can be of assistance with referrals.

MHP providers must follow the referral procedures for the specific plan in which the beneficiary is enrolled.

Psychiatric (e.g., suspected behavioral disorder)	Limited psychiatric services are available for Medicaid FFS beneficiaries under 21 years of age with mild/moderate mental health conditions through the FFS program. (Refer to the Psychiatric and Substance Abuse Services Section of this chapter for specific coverages.) The MHP contracts include a limited mental health benefit coverage for beneficiaries with mild/moderate mental health conditions. PIHPs/CMHSPs are responsible for the provision of covered specialty mental health services necessary for the treatment of Medicaid beneficiaries with more significant, persistent, complex, and/or serious psychiatric conditions.
Women, Infants and Children (WIC)	The Women, Infants and Children (WIC) program located at LHDs, Tribal Health Centers, and federally-funded clinics is a special supplemental feeding program that provides food coupons and nutritional education to eligible children under five years of age and pregnant women. The provider is expected to make referrals to a WIC site for eligibility determination.
Other Programs	There are other programs that could benefit Medicaid beneficiaries, such as Head Start, intermediate school district services, genetics counseling, nutrition programs, and public health nursing. Providers are encouraged to become familiar with available programs and make full use of them whenever referrals are appropriate.

Blood Lead Poisoning Follow-Up Services	Many LHDs provide blood lead poisoning follow-up services which consist of environmental investigations and nursing assessment/investigation visits. Providers must contact the LHD to determine if services are available in the area and the blood lead levels at which referrals are accepted. LHDs may provide blood lead poisoning follow-up services provided to any Medicaid-covered child, regardless if the child is enrolled with an MHP or is in the FFS program. Authorization for these services is not required by the MHP; however, LHDs must notify the plan of the service(s) provided and provide the plan with a summary of each. Documentation of the child's blood lead poisoning level that initiated service must be maintained, as well as documentation of all environmental investigations and nursing assessment/investigation visits.
Environmental Investigations	Environmental investigations are covered for the LHD if the health officer from the LHD completes a copy of the Blood Lead Poisoning Follow-Up Services Assurance of Provision form (DCH-1530). The form must be mailed to Medicaid Payments Division. (Refer to the Directory Appendix for contact information.) If more than one child in the home has blood lead poisoning, the LHD must select one child's Medicaid ID Number and report a single initial and a single follow-up environmental visit.
	Initial - A risk assessor certified by the State of Michigan's Lead Hazard Remediation Program must conduct the investigation of the child's home. If necessary, an investigation may be covered at a second site if the child spends time regularly at that site and it is a possible source of lead exposure. MDCH covers a maximum of two such investigations per episode of blood lead poisoning. The investigation must follow the Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels and risk assessment activities per the Lead Abatement Act of 1998. The investigation must include testing of appropriate potential sources of paint, house dust, soil, water, and other household risk factors such as pottery and home remedies. Education must be provided regarding known and potential sources of lead poisoning, reduction of future exposures, and suggestions for specialized cleaning techniques. Risk assessors must prepare a risk assessment report per rule R325.9916 promulgated pursuant to the Lead Abatement Act that includes lead hazard control recommendations and the potential relocation of the child depending upon the severity of the lead hazards found. Discussion with the family must include agencies that may be able to provide assistance with lead hazard control recommendations provided in the risk assessment report. An episode includes a venous blood sample indicating the child is at risk according to recommendations of the Centers for Disease Control and Prevention (CDC), and also includes resulting treatment and follow-up services.

	Follow-up - MDCH covers one follow-up environmental investigation per episode of poisoning to determine if lead hazard control interventions were performed satisfactorily and verified by a visual inspection and dust wipe clearance sampling. If a second site was investigated as the possible source of lead exposure and had lead hazard control interventions performed, MDCH also covers a follow-up environmental investigation performed at that second site.
	Resource Documents - Providers may obtain the Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels, a list of certified risk assessors, applications for training and certification, and education materials from the MDCH Lead Hazard Remediation Program. (Refer to the Directory Appendix for contact information.)
Nursing Assessment / Investigation Visits	MDCH covers up to two nursing assessment/investigation visits per episode of blood lead poisoning. If more than one child in the home has blood lead poisoning, the nursing assessment/investigation visits are covered for each child. Blood lead nursing visits must be provided in the child's home. For FFS beneficiaries, an enrolled home health agency, a LHD or other medical clinic, or a physician may conduct the visits. This procedure is not covered for Maternal Infant Health Program (MIHP) providers. Blood lead nursing visits provided through a MHP are covered by the individual MHP. The first nursing assessment/investigation visit focuses on: ▪ Assessment of the growth and developmental status of the child, including any symptomatology that may be present in the child. ▪ Behavioral assessment of the child, including any aggressiveness and/or hyperactivity. ▪ Nutritional assessment of the child. ▪ Assessment of typical family practices that may produce lead risk (e.g., hobbies, occupation, cultural practices). ▪ Limited physical identification of lead hazards within the dwelling. ▪ Identification and planning for testing for any other family member at risk for sequelae of lead hazard exposure. ▪ Education and information regarding lead hazards and ways to minimize those risks in the future. ▪ Development of a family plan of care to increase the safety of the child from lead hazards. The second blood lead nursing visit focuses on: ▪ Reinforcement of the educational information presented to the family during the first visit. ▪ Validation of the family's ability to carry out activities to minimize risks of continued lead exposure. ▪ Modifications of the plan to minimize lead risks, as needed.

Blood Lead Resource Documents	Providers are encouraged to review Guidelines for Environmental and Nursing Investigations for Children with Elevated Venous Blood Lead Levels and apply these standards. This publication, plus other materials concerning blood lead poisoning, may be obtained from the MDCH Childhood Lead Poisoning Prevention Program. (Refer to the Directory Appendix for contact information.)

SECTION 4 - GENERAL PRACTICE

4.1 ALLERGY TESTING AND IMMUNOTHERAPY

Medicaid covers allergy testing and immunotherapy services. Testing is covered under the appropriate CPT/HCPCS code with the appropriate quantity as indicated by the code description. A visit is covered in addition to the testing. Coverage of the testing includes the interpretation of the test results in relation to the history and physical examination of the beneficiary.

Immunotherapy services are covered under the appropriate CPT/HCPCS component codes. The services of the provider who actually prepares and provides the antigens/venoms are covered on a per dose basis. Services of the provider who parenterally administers the antigen/venom are covered under the appropriate injection codes. The injection and the antigen/venom preparation services are covered separately.

Allergy injection services are not covered in addition to the visit unless the visit represents another significant, separately identifiable service above and beyond the antigen/venom immunotherapy and the appropriate modifier is reported.

MDCH assumes antigens are prepared for administration over a period of time in increasing doses. Antigens are covered at the same rate per dose regardless of whether multiple or single dose vials are used. Medicaid covers the dose administered and the preparation of the dose administered.

Any allergy testing and treatments that have not been proven to be effective are not covered.

4.2 AMBULANCE SERVICES

Coverage for ambulance services is restricted to medically necessary and appropriate services when medical/surgical or psychiatric emergencies exist or no other effective or less costly mode of transportation for medical treatment can be used because of the beneficiary's medical condition.

Emergency ambulance services do not require a physician's order.

The physician must order all nonemergency, medically necessary ambulance transportation and the order must contain the following information:

- Beneficiary's name and Medicaid ID number;
- Medical necessity of an ambulance transport; and
- Physician's signature and Medicaid Provider ID number.

Physicians are responsible for providing documentation of the medical necessity for ambulance transport to the ambulance provider for their files. A physician may write a single prescription for nonemergency ambulance transport of a beneficiary with a chronic condition to planned treatments for a period up to one month. The prescription must include the type of transport necessary, why other means of transport could not be used, the frequency of needed transport, origin, destination, diagnosis, and medical necessity for the transport. For all other nonemergency transport, a separate physician's order is required for each individual transport.

(Refer to the Ambulance Chapter of this manual for additional information.)

4.3 Audiological and Hearing Services

Medicaid covers hearing evaluations and other audiological function testing by a physician. Hearing evaluations are covered when they include pure-tone audiometry, speech audiometry, and a report of findings.

A hearing aid is covered if all of the following criteria are met:

- The physician performs an evaluation within six months prior to the beneficiary obtaining a hearing aid.
- The evaluation reveals that the beneficiary needs a hearing aid and that there is no contraindication to the use of a hearing aid.
- The physician prescribes a hearing aid.
- The beneficiary presents the prescription and a written statement of the evaluation to an enrolled hearing and speech center.
- The enrolled hearing and speech center determines the type of hearing aid that is needed.
- The beneficiary is referred to an enrolled hearing aid dealer for provision of the aid.

4.3.A. Newborn Hearing Screening Examination

MDCH requires that all Medicaid-covered newborns be screened using the automated auditory brainstem response (ABR) method and/or the automated evoked otoacoustic emissions (EOAE) method.

Results must be reported to the child's primary care provider in a timely manner.

If the birthing hospital has the appropriate equipment, the screening must be done at the hospital. When this occurs, the screening is covered as a part of the inpatient stay.

If the hospital is not equipped for ABR or EOAE, the child's physician, CNM, or NP must refer the newborn to a Medicaid enrolled hearing and speech center for screening prior to one month of age.

4.3.B. Local Health Department Screenings

The primary care provider or Head Start agency (with approval from the child's primary care provider) may refer preschool-aged children to the local health department (LHD) for objective hearing screening. The results of the screening must be reported to the child's primary care provider. The results must also be shared with the Head Start agency if that agency was the referral source.

MDCH monitors the number of MHP referrals reported by LHDs, and may initiate charge-backs to the plans.

4.4 Care of Abused Children

Medicaid covers physician services related to the diagnosis and treatment of suspected abused or neglected children. When the physician has reasonable cause to suspect that a child may have been abused or neglected, he must immediately contact the appropriate Protective Services Unit of the local DHS office to report his suspicions.

Medicaid covers the inpatient stay of an abused or neglected child when, upon admission, the attending physician determines that the child requires further assessment and treatment which is best provided on an inpatient basis.

Physicians cannot admit a child to the hospital for the sole purpose of custodial or protective care.

4.5 Childbirth/Parenting Education

Medicaid covers childbirth/parenting education for pregnant women when referred in writing by the prenatal care provider and provided by qualified educators in a Medicare certified outpatient hospital or by a certified Maternal Infant Health Program (MIHP) program provider.

This service is not covered if rendered by the prenatal care provider in the office setting.

4.6 Communicable Disease Treatment

Medicaid covers the diagnosis and treatment of communicable diseases, including tuberculosis (TB), hepatitis, meningitis, and enteric disease. Cases of communicable disease must be reported to the LHD. Providers may obtain additional information regarding communicable disease prevention and control from the LHD.

4.7 Diabetes Patient Education

Medicaid covers diabetes self-management education when ordered by a physician and provided by diabetes educators (e.g., nurse, dietitian) in a Medicaid enrolled outpatient hospital or a LHD which has been certified by MDCH Public Health Administration.

This service is not covered if rendered by a physician in the office setting, rendered by a nonenrolled provider, or rendered by a non-CPH certified provider.

4.8 Diagnostic Tests

Medicaid covers tests to diagnose a disease or a medical condition. Diagnostic testing must be directly related to the presenting condition of the beneficiary.

4.9 Family Planning

Medicaid covers family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis). A visit for family planning typically includes a complete physical examination, including a pelvic examination.

Separately identifiable services provided in addition to the examination are covered separately. Counseling for family planning services, including sterilization, is covered as a part of the family planning visit.

Medicaid covers contraceptives including:

- Oral contraceptives (must be prescribed by a physician and dispensed by an enrolled pharmacy or Family Planning Clinic)
- Diaphragms
- Intrauterine devices
- Condoms (available from a pharmacy without a prescription, or from a family planning clinic)
- Foams, gels, sponges (must be prescribed by a physician and dispensed by a pharmacy or family planning clinic.)

4.10 Foot Care, Routine

Medicaid covers these services when provided by a physician or podiatrist and when the beneficiary manifests signs and symptoms from a specific systemic disease of sufficient severity that care by a nonprofessional would be hazardous. The medical necessity for these services must be documented in the beneficiary's medical record and the beneficiary must be receiving regular care from a physician for the systemic disease.

4.11 Fracture Care

Medicaid covers medically necessary fracture care. Coverage includes the initial traction, cast application and removal, and routine follow-up care. Additional reductions are independent procedures not included in the original treatment and are covered separately.

Fracture care includes the insertion and removal of necessary wires, pins, etc. If the wire, pins, etc., are the types that are not normally removed but the removal is medically necessary, Medicaid also covers such removal. Documentation of the need must be included on the claim.

Coverage also includes subsequent recasting required during the course of fracture treatment (i.e., following initial cast application). Medicaid covers cast removal as a separate service only when performed by a physician who was not involved in the fracture care and who is not reapplying another cast.

4.12 Immunizations (Vaccines and Toxoids)

Vaccines and toxoids (immunizations) are covered when given according to Advisory Committee on Immunization Practices (ACIP) recommendations. An immunization administered for travel to a foreign country is not a Medicaid-covered benefit. For Medicaid children under the age of 19 years old, the Vaccine for Children (VFC) Program provides covered vaccines at no cost to the provider. Tetanus (Td), Hepatitis B, Polio (IPV), and Measles, Mumps and Rubella (MMR) are covered for beneficiaries 19 years of age or older. Any LHD in the state can be contacted for specifics about the VFC program, what vaccines are available, and instructions on enrolling and obtaining vaccines. Medicaid does not cover vaccine costs for any product that is available free for Medicaid enrollees.

An administration fee is covered separately for vaccines and toxoids given to Medicaid beneficiaries whether the vaccine is free or not, and without regard to other services provided on the same day. The administration fee is set for each immunization.

For vaccines and toxoids available free under the VFC program, Federal statutes limit the amount a provider can charge for the administration of the vaccine. Providers cannot charge more for services provided to Medicaid beneficiaries than for services provided to their general patient population. For example, if the charge for administering a vaccine to a private pay patient is $5.00, then the charge for vaccine administration to the Medicaid patient cannot exceed $5.00.

MDCH encourages providers to immunize all Medicaid beneficiaries according to the accepted immunization schedule. For Medicaid beneficiaries enrolled in a MHP, the health plan must ensure that the Medicaid beneficiaries receive complete and timely immunizations. When a provider contracts with a health plan to provide primary care (which includes immunizations), then the provider must immunize the beneficiaries assigned to him by the plan. MHPs must not refer beneficiaries to a LHD for immunizations.

If a beneficiary is in a nursing facility, the facility is responsible for appropriately immunizing the residents. Coverage of the immunizations is included in the payment made to the facility.

4.13 Injectable Drugs and Biologicals

4.13.A. Coverage of the Injectable

Medicaid covers injectable drugs and biologicals administered by a physician in the office or clinic setting and the beneficiary's home. The drug must be Federal Drug Administration (FDA) approved and reasonable and necessary according to accepted standards of medical practice for the diagnosis or treatment of the illness or injury of the beneficiary.

An injectable drug is covered if the drug is:

- Specific and effective treatment for the condition for which it is being given.
- Given for the treatment of a particular documented diagnosis, illness, or condition (e.g., vitamin injections which are not specific replacement therapy for a documented deficiency or disease and are given simply for the general good and welfare of the patient).
- Administered by the recommended or accepted administration method for the condition being treated.
- Administered according to the recommended dosing schedule and amount for the condition being treated.

For any injections given by the physician in the office, clinic setting, or the beneficiary's home, the injectable drug is considered a physician service rather than a pharmacy benefit. The physician must not send the beneficiary to a pharmacy to obtain an injectable drug or to have the pharmacy bill directly to MDCH for injectable drugs under the pharmacy benefit if the physician is administering the drug in the office, clinic, or beneficiary's home. If a pharmacy sells injectable drug products to a physician, the pharmacy must obtain payment directly from the purchasing physician.

When administering a dose drawn from a multidose vial, only the amount administered to the beneficiary is covered. If a drug is only available in a single use vial and any drug not administered must be discarded, the amount of the drug contained in the vial is covered.

4.13.B. Administration of the Injectable

Medicaid covers the injectable drug and the administration of the drug. If another covered service is provided at the same time, the administration of the drug is considered a part of that service and is not covered separately.

Payment for administration of injectables provided through a PIHP/CMHSP clinic or affiliated physician practice is included in the capitation rate to the PIHP/CMHSP and is not separately reimbursable to the physician.

Injections in the office/clinic/beneficiary's home may be administered by appropriate non-physician staff who are employed by the physician or are employed by the same clinic/group as the physician. Administration of the injectable drug by non-physician staff must be under the physician's personal supervision or under the delegation and supervision of the physician, as required by the Public Health Code. Providers should refer to the Coordination of Benefits Chapter of this manual for additional requirements that apply when a beneficiary has Medicare or commercial insurance coverage.

4.13.C. Injectables Administered Through PIHP/CMHSP for MHP Enrollees

Specific injectable drugs administered through a PIHP/CMHSP clinic to Medicaid Health Plan (MHP) enrollees are reimbursable by the MDCH on a fee-for-service basis when meeting the following criteria:

- The beneficiary has an open case with the PIHP/CMHSP, and
- The beneficiary receives the injections on a scheduled or routine basis as part of the PIHP/CMHSP treatment/supports regimen, and
- The PIHP/CMHSP physician has determined that the beneficiary may not comply with the medication regimen if the injections were not administered through the PIHP/CMHSP clinic and that this noncompliance could adversely affect the beneficiary, and
- The PIHP/CMHSP clinic notifies the beneficiary's MHP or primary care physician that this service is being rendered, and
- The injectable drug is listed on the MH/SA (PIHP/CMHSP/Children's Waiver) Injectable Drugs Billable to MDCH database.

A list of the specific drugs covered under this policy is maintained on the MDCH website. (Refer to the Directory Appendix for website information.) The list may be modified as new drugs are approved for Medicaid coverage. No notice of changes to the list will be issued directly to providers.

The specific injectable drugs are only covered by MDCH through fee-for-service **if** provided by a physician as part of his affiliation with a PIHP/CMHSP, and must be billed using the Medicaid Provider ID number(s) associated with the PIHP/CMHSP. Payments made to physicians for injectable drugs administered to beneficiaries enrolled in a MHP that are billed under a physician's Medicaid ID number **not** associated with a PIHP/CMHSP physician group are subject to recovery.

Physicians not affiliated with a PIHP/CMHSP physician group practice must not bill MDCH for injectables provided to MHP enrollees.

All covered injectable drugs (including those addressed in this subsection) administered to Medicaid fee-for-service beneficiaries through the PIHP/CMHSP clinics continue to be covered by MDCH under the PIHP/CMHSP physician's Medicaid ID number(s) associated with the PIHP/CMHSP physician group(s).

4.14 LABORATORY

Medicaid covers medically necessary laboratory tests needed to diagnose or treat a specific condition, illness, or injury. Medicaid also covers screenings such as Pap smears, PSA, TB, etc. A physician, podiatrist, dentist, or CNM must order laboratory services according to their scope of practice.

The ordering physician or CNM must document required laboratory testing in the beneficiary's medical chart regardless of where the tests are performed. The ordering physician is held responsible if he orders excessive or unnecessary laboratory tests regardless of who actually renders the services. He may be subject to any corrective action related to these services, including recovery of funds.

Ordering or rendering of "profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition is considered random screening and is not covered. Multiple laboratory tests carried out as a part of the initial evaluation of the beneficiary, when the results of the history and physical examination do not suggest the need for the tests, are considered screening and are not covered.

4.14.A. MEDICAL NECESSITY

The documentation of medical necessity must include a description of the beneficiary's symptomatology and other findings that have led the physician to order the test(s). An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity.

4.14.B. REFERRED SERVICES

If a physician refers a beneficiary to an outside laboratory (independent lab, hospital lab, clinic lab, or physician office lab) for testing, the physician must indicate his Medicaid ID Number on the referral.

A physician cannot refer a beneficiary to an outside laboratory where he or an immediate family member has a financial interest. Noncompliance may result in corrective action by MDCH or other agencies.

Physician laboratory services are covered when performed by the physician or by his employees under his direct supervision. Coverage for laboratory services includes the collection of the specimen(s), the analysis, and the report(s). MDCH performs pre- and/or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. Questionable ordering patterns may result in a pre-payment review of each laboratory procedure billed or other corrective measures as a result of that provider's orders.

A beneficiary cannot be charged for any covered laboratory procedure, including those that are determined to be not medically necessary, or for those laboratory procedures which exceed the laboratory daily reimbursement limit.

MDCH limits laboratory payments when rendered by the same provider, for the same beneficiary, on a single date of service. Coverage is limited to only those laboratory procedures which do not exceed the daily reimbursement limits specified in the following table.

Provider Description	Daily Limit
Practitioner, Nurse Midwife	$50.00
Podiatrist	$50.00
Family Planning Clinic	$50.00
Medical Clinic	$50.00
Independent Laboratory	$125.00
Outpatient Hospital	$75.00

4.14.C. Laboratory Tests Exempt from Daily Limit

The following selected laboratory services identified by CPT/HCPCS procedure codes are exempt from the daily dollar limit.

- Limited Pathology Consultation
- Comprehensive Pathology Consultation
- Bone Marrow Procedures
- Cytopathology
- Cytogenetics
- Electron Microscopy

If coverage limits are exceeded, the billing health care provider must request an exception to the daily limit by submitting documentation of medical necessity for each laboratory procedure. All services provided on that date of service are manually reviewed for medical necessity and payment is determined accordingly.

When it is anticipated that Medicaid payments for testing ordered from an outside laboratory will exceed the coverage limit, the ordering practitioner must forward medical necessity documentation to the servicing laboratory for submission with the laboratory billing.

4.14.D. Children's Special Health Care Services Coverage

The coverages defined in this section and the daily reimbursement limits do not apply to beneficiaries with only Children's Special Health Care Services (CSHCS) eligibility. The coverage limits do apply to beneficiaries with dual Medicaid and CSHCS eligibility if the laboratory procedures are not related to the crippling diagnosis.

Blood Handling	MDCH reimburses for blood handling only under the following circumstances: ▪ A beneficiary may be referred to a laboratory, clinic, or outpatient hospital for the sole purpose of drawing, packaging, and mailing a blood sample to MDCH for blood lead analysis. In this instance, the laboratory, clinic, or outpatient hospital may bill for blood handling. The MDCH provides lead-free vacutainers for the analysis. Requests for vacutainers and the samples for analysis should be sent to MDCH Blood Lead Laboratory. (Refer to the Directory Appendix for contact information.) ▪ A beneficiary occasionally requires blood tests that are not performed in conjunction with other reimbursable services. Whenever possible, the beneficiary should be sent to the laboratory that will be performing the test(s). If this is not practical (i.e., the laboratory is not a local facility) and the sole purpose of a visit is to draw, package, and mail the sample to a laboratory, the blood handling may be covered. An office visit or other service code is not covered on the same date of service (DOS) as the blood handling service.
Hematology Studies	A practitioner's order for a complete blood count (CBC) with white blood cell (WBC) differential includes the RBC and WBC count, Hgb, Hct, MCH, MCHC, MCV, RBC morphology, platelet estimate, and WBC differential only. Additional hematology testing must have specific practitioner orders. The ordering practitioner is responsible for documenting medical necessity and recording the order in the beneficiary's medical record.
Microbiology Studies	Gram, fluorescent/acid fast stain procedures are included in the coverage for microbiology procedures when performed on the same DOS for the same beneficiary.

Pap Smear	Coverage for obtaining the cervical smear is included as a part of the pelvic examination. A pathologist must perform interpretation of the smear. The pathology report must include the printed or typewritten name of the pathologist and his handwritten signature. More than one Papanicolaou test within a 12-month period is covered only when determined medically necessary by the attending practitioner.
Pathology Consultations	Pathology consultations performed by a hematologist/pathologist for the review of abnormal laboratory test results are covered by Medicaid if: ▪ The abnormality relates to the beneficiary's medical condition and corresponding medical care (i.e., a peripheral blood smear review must be necessary for the specific beneficiary's care). ▪ The referring physician orders the review and records the order in the beneficiary's medical record. (Standing consultation orders from a physician to a laboratory are not covered by Medicaid.) ▪ A detailed report is sent to the referring physician. The report prepared from the study performed by the hematologist/pathologist must include: ▪ Identification of the laboratory where the review was performed. ▪ Name of the referring physician. ▪ Beneficiary's name. ▪ Date of review. ▪ Identification of material examined. ▪ Comments and descriptions of normal and abnormal findings. ▪ Descriptions detailed enough to support a clinical impression or diagnosis. ▪ Clinical impression or diagnosis presented in relation to the suspected disease, disease process, or state of altered physiology. ▪ Recommendations for investigation or therapy, if any. ▪ The typewritten or printed hematologist/pathologist's name and his handwritten signature. This information must be retained in the beneficiary's medical records.
Pregnancy Related Lab Services	For routine pregnancy testing, Medicaid covers the serum or urine HCG qualitative method. The obstetric profile is covered when ordered by the attending practitioner as an all-inclusive panel of tests for required prenatal laboratory services. The individual tests of the OB Profile are: ▪ ABO typing ▪ CBC with WBC differential ▪ Hepatitis B surface antigen

	▪ RBC antibody detection ▪ Rh (D) typing ▪ Rubella antibody ▪ Syphilis testing HIV testing and Urinalysis are covered separately when determined to be medically necessary and are ordered by the practitioner.
Practitioner Laboratory Procedures	Clinics and office-based laboratories must be registered as required by the Clinical Laboratory Improvement Act (CLIA). Medicaid only covers the procedures contained in the CLIA Certificate of Waiver Testing list for Certificate of Waiver practitioners. Coverage includes only the procedures contained in the CLIA Certificate of Registration Testing list for Certificate of Registration practitioners. Medicaid covers the procedures identified in the CLIA Physician Performed Microscopy list for appropriately certified physicians. Laboratory tests covered for CNMs and podiatrists who have the appropriate CLIA certification are identified in the appropriate database on the MDCH website.

4.15 Mycotic Nails, Debridement

Medicaid covers debridement of mycotic nails once in a 60-day period when provided during or following any appropriate course of medical treatment for the causative fungal infection. Documentation in the beneficiary's medical record must support clinical evidence of the mycosis, identification of the toenail(s) affected, and evidence that the mycosis is likely to result in significant medical complications if appropriate antifungal treatment is not rendered.

The debridement of mycotic nails is covered for beneficiaries in the nursing facility only on the written order of the attending physician (MD or DO). The order must be patient-specific and not for routine care only.

4.16 Nerve Blocks

Nerve blocks are covered as a surgical procedure when performed for diagnostic or therapeutic purposes. As a surgical procedure, a complete description of the services rendered must be documented in the beneficiary's medical record. When used as anesthesia for another procedure, the anesthesia guidelines apply. Nerve blocks are not separately covered when used as a local anesthetic for another surgical procedure.

A nerve block is the injecting of a local anesthetic or neurolytic agent around a nerve to produce a block of that specific nerve. It is not injecting a painful area under the skin or a trigger point, or an injection into the general muscle mass of subcutaneous tissue that does not follow the anatomy of a specific nerve, to produce temporary relief of pain in that area.

Nerve blocks are payable in the hospital or office setting as appropriate. No more than three nerve blocks to the same area are covered within a six-month period without documentation of medical necessity. Documentation must include the diagnosis or condition, the management/treatment plan, specific nerve(s) affected, indications, and expected benefits. A medical visit is not covered separately on the same day unless documentation is supplied to justify the separate services.

4.17 Oxygen

Medicaid covers oxygen and the equipment necessary for the administration of oxygen therapy.

A pharmacy or a medical supplier may provide gaseous cylinder oxygen. Portable cylinder oxygen is allowable if the cylinder can be refilled and if the flow rate is adjustable.

Only a medical supplier may provide concentrators, liquid oxygen, and oxygen tents, and PA is required.

All oxygen and equipment requires a physician's prescription and a CMN. The initial prescription is valid for six months. The first follow-up prescription is valid for six months, and each subsequent prescription is valid for one year.

The written prescription for oxygen must include all of the following:

- The date the oxygen was prescribed;
- The beneficiary's diagnosis(es);
- The flow rate (liters per minute);
- The number of hours to be used per day;
- Duration of need;
- Delivery system to be used; and
- PO2 level or oxygen saturation.

(Refer to the Medical Supplier Chapter of this manual for additional information and specific PA requirements.)

4.18 Substitute and Locum Tenens Physicians

Medicaid covers substitute physicians or locum tenens physicians and allows payment to be made to the beneficiary's attending physician for these services. Federal statutes and CMS requirements determine parameters for these arrangements.

Medicaid coverage under the beneficiary's attending physician for the services of a substitute physician can only occur under the following substitute physician billing arrangements:

- An informal reciprocal arrangement for a period not to exceed 14 days; or
- A locum tenens or temporary arrangement for 90 continuous days in the case of a per diem or other fee-for-time compensation.

Coverage for services provided by a substitute physician under either a reciprocal billing or a locum tenens arrangement must follow Medicaid policy for the service(s) rendered. Documentation in the beneficiary's medical record must identify the physician actually providing the service.

4.19 Supplies in the Office Setting

Medicaid separately covers a limited number of supplies used in the office setting. RVU-based payment to practitioners includes payment for the office overhead expense associated with the service. In most cases, the overhead includes the supplies used or provided by the practitioner in connection with the service. Providers must not require beneficiaries to buy a supply item in advance from a pharmacy or other supplier that is necessary to use in providing the service. If a beneficiary needs supplies to use in the home, providers should write a prescription that the beneficiary can take to a pharmacy or medical supplier to be filled. Medicaid does not cover take-home supplies for the office setting. Any surgical dressings applied by a physician in the office or other nonfacility setting are not covered separately.

In keeping with the RVU-based fee schedule, casting and splinting supplies are covered separately in the office setting when used with the fracture and dislocation or casting, splinting or strapping procedure codes listed in the musculoskeletal surgery section of the CPT coding manual. An allowance for these supplies is not included in these treatment codes. Cast/splint supplies are not covered without the appropriate fracture/dislocation codes.

The following supplies are covered separately when provided in the office setting:

- Implantable external access device.
- Levonorgestrel implant (is payable in addition to the insertion procedure on the same day).
- Progestasert IUD or copper IUD (is payable in addition to the insertion of the device on the same day).
- Levulan PDT.

(Refer to the MDCH Practitioner Medical Clinic Database on the MDCH website for specific supplies which are covered separately.)

4.20 Vision Services

Refer to the Vision chapter of this manual for specific coverage information.

4.21 Orthoptic Services

Strabismus surgeries are covered for beneficiaries of any age and do not require PA. Providers are reminded that these surgeries must be medically necessary and not performed solely for cosmetic purposes.

Refer to the Vision chapter of this manual for other specific orthoptic coverages.

4.22 Weight Reduction

Medicaid covers treatment of obesity when done for the purpose of controlling life-endangering complications, such as hypertension and diabetes. If conservative measures to control weight and manage the complications have failed, other weight reduction efforts may be approved. The physician must obtain PA for this service. Medicaid does not cover treatment specifically for obesity or weight reduction and maintenance alone.

The request for PA must include the medical history, past and current treatment and results, complications encountered, all weight control methods that have been tried and have failed, and expected benefits or prognosis for the method being requested. If surgical intervention is desired, a psychiatric evaluation of the beneficiary's willingness/ability to alter his lifestyle following surgical intervention must be included.

If the request is approved, the physician receives an authorization letter for the service. A copy of the letter must be supplied to any other provider, such as a hospital, that is involved in providing care to the beneficiary.

4.23 Tuberculosis Testing

Medicaid covers TB testing according to the guidelines of the AAP, which is based on risk. A risk assessment is completed at each visit. Coverage for the TB test includes any return visit to read the results of the TB test.

For assistance in determining high risk, providers may contact the MDCH, Communicable Disease and Immunization Division, or the AAP. (Refer to the Directory Appendix for contact information.)

SECTION 5 - GENERAL PRACTICE - SPECIAL CONSIDERATIONS

5.1 APHERESIS, THERAPEUTIC

Therapeutic apheresis is covered for the following indications:

- Plasma exchange for acquired myasthenia gravis.
- Leukapheresis in the treatment of leukemia.
- Plasmapheresis in the treatment of primary macroglobulinemia (Waldenstrom).
- Treatment of hyperglobulinemias, including (but not limited to) multiple myelomas, cryoglobulinemia and hyperviscosity syndromes.
- Plasmapheresis or plasma exchange as a treatment of last resort for thrombotic thrombocytopenic purpura (TTP).
- Plasmapheresis or plasma exchange as a treatment of last resort for life-threatening rheumatoid vasculitis.
- Plasma perfusion of charcoal filters for treatment of pruritis of cholestatic liver disease.
- Plasma exchange in the treatment of life-threatening forms of Goodpasture's Syndrome.
- Plasma exchange in the treatment of life-threatening forms of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage.
- Treatment of chronic relapsing polyneuropathy for patients with severe or life-threatening symptoms, or failed to respond to conventional therapy.
- Apheresis in the treatment of life-threatening scleroderma and polymyositis, when the patient is unresponsive to conventional therapy.
- Apheresis for the treatment of Guillain-Barre Syndrome, and
- Apheresis as a treatment of last resort for life-threatening Systemic Lupus Erythematosous (SLE) when conventional therapy has failed to prevent clinical deterioration.

Coverage is limited to the following settings:

- In a hospital setting (either inpatient or outpatient). Nonphysician services furnished to hospital patients are covered as hospital services. When covered services are provided to hospital patients by an outside provider/supplier, the hospital is responsible for paying the provider/supplier for the services.
- In a nonhospital setting, such as a physician directed clinic, when all of the following conditions are met:
  - A physician is present to perform medical services and to respond to medical emergencies at all times during patient care hours.
  - Each patient is under the care of a physician.

- All nonphysician services are furnished under the personal supervision of a physician.

When the physician provides direct supervision of the procedure or personally performs any services, professional services are covered as therapeutic apheresis (plasma and/or cell exchange).

5.2 Chemotherapy Administration

Medicaid covers the services of a physician who administers antineoplastic chemotherapy to beneficiaries with a cancer diagnosis in the office setting and in the beneficiary's home. The chemotherapy drugs administered by the physician are covered separately.

Administration of other drugs for diagnoses other than cancer is covered under therapeutic, diagnostic, or prophylactic injection/infusion services.

Chemotherapy administration by push and by infusion techniques is covered on the same day; however, only one push administration is covered on a single day.

Physicians must personally administer the drug or be present when a qualified employee of the physician administers the drug. If chemotherapy is administered without face-to-face contact between the physician and the beneficiary, the services are covered if furnished in the physician's office by a qualified employee under the physician's supervision and the medical record reflects the physician's active participation in and management of the course of treatment.

In the hospital setting, chemotherapy administration is only covered when the physician personally administers the drug.

Refilling and maintenance of an implantable pump or reservoir is covered. Chemotherapy administration by IV push, infusion, or intra-arterial technique is not covered in addition to refilling the implantable pump or reservoir. Flushing of a vascular port prior to chemotherapy is included in the administration and is not covered separately. If a special visit is made to the physician's office only for port flushing, the service is covered under the appropriate E/M code.

Hydration therapy intravenous (IV) infusion is covered as a part of the chemotherapy IV infusion service when administered simultaneously. Hydration therapy is covered separately when administered sequentially or as separate procedures. The distinct procedural service modifier should be reported with the hydration therapy code when performed sequentially.

Supplies necessary to administer chemotherapy in the office setting are included in the overhead expense portion of the administration services and are not covered separately. (Refer to the MDCH Practitioner Medical Clinic Database on the MDCH website for a listing of covered chemotherapy drugs.)

5.3 Hemodialysis and Peritoneal Dialysis

Medicaid covers physician services required to manage care of beneficiaries with end-stage renal disease (ESRD) who are receiving ongoing dialysis in an outpatient facility or at home.

Most physician services are covered through a monthly capitation payment (MCP) to the managing physician. The MCP covers ESRD related physician services in all settings necessary to manage the beneficiary's dialysis care, except declotting of shunts, dialysis training, and nonrenal-related medical services.

Self-dialysis training services provided by the physician are covered.

5.4 Home Health Care

Medicaid covers home health care subject to the requirements in this section.

Home Health services include intermittent nursing care, home health aide services, and physical therapy provided in the beneficiary's home by a Medicaid enrolled Home Health Agency (HHA). The service must be reasonable and necessary for the treatment of a specific illness, injury, or disability, and must be consistent with the nature and severity of the beneficiary's condition, particular medical need and accepted standards of medical practice. Limited services to ensure stability of beneficiaries with an established disability or frail condition, or to prevent an illness, injury or disability for women and newborns during the postpartum period are covered.

Home health is intended for beneficiaries whose conditions require intermittent rather than continuous medical/nursing care. In special instances, intensive nursing care in the home may be approved if MDCH determines that home care is appropriate and is a cost-effective alternative to institutional care.

5.4.A. Physician Order for Care

The beneficiary's physician must order covered home health services as part of a written plan of care (POC), and must review the POC every 60 days for continuing need. A HHA should not provide home care prior to the date of the physician's order for the care. The agency must maintain a patient plan of treatment form which must be signed and dated by the physician, or a narrative summary of the POC which must have the physician's signed and dated order attached. The HHA is responsible for obtaining necessary authorization from MDCH for special or extended care which may be provided.

Home health services are not to replace the services of a physician and are not covered solely for the lack of transportation or as a convenience to the beneficiary. Home health services may be appropriate when leaving the home is medically contraindicated or special transportation or effort is required.

5.4.B. Medical Supplies and Equipment

Medical supplies, durable medical equipment, orthotic and prosthetic appliances, shoe supplies, and oxygen are covered for beneficiaries receiving services from an enrolled HHA. The physician (MD, DO, DPM) must prescribe these items. (Refer to the Home Health and the Medical Supplier Chapters of this manual for specific information concerning which equipment/supplies are covered for the medical supplier and which are covered for the HHA.)

5.4.C. Personal Care

If beneficiaries are not in need of nursing care or physical therapy, but have a need for nonspecialized, unskilled personal care or chore services, such services are available through the DHS Home Help Program. The local county DHS office should be contacted for information.

5.5 Hospice Services

Medicaid covers hospice services which include palliative and supportive services to meet physical, psychological, social, and spiritual needs of terminally ill beneficiaries and their families in the home, adult foster care facility, home for the aged, nursing facility, or an inpatient hospice setting.

To enroll in hospice, the beneficiary must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the referring physician and the hospice medical director must certify the life expectancy. (Refer to the Hospice Chapter of this manual for specific requirements related to the provision of hospice services.)

If the physician is not familiar with Medicaid-enrolled hospices in his area, hospice names, addresses, and telephone numbers may be obtained from MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

5.6 Implantable Infusion Pumps

Medicaid covers the refill and reprogramming of implantable infusion pumps by physicians in the physician's office. The refill kit and the electronic analysis of the pump are covered as a part of the refill and reprogramming procedure. Injectable drugs used during this procedure are covered separately in the physician's office.

5.7 Pediatric Multichannel Recordings

Multichannel recording is covered for a child under age 21 when provided in the inpatient or outpatient hospital setting by qualified personnel and interpreted by a physician. Multichannel recordings are not covered in the beneficiary's home.

A pediatric multichannel recording is a continuous and simultaneous recording of at least four channels that may include ECG, thoracic impedance, airflow measurements, oxygen saturation, esophageal pH, or strain gauge measurements. Other additional recording parameters may be included. A multichannel recording does not have to include an electroencephalogram (EEG). When an EEG is performed in addition to the four or more channels, it is covered separately. Payment for the multichannel recording is the same regardless of the number of channels or the length of time required. Use of a video camera is not separately covered.

Two multichannel recordings may be covered in one year for the same beneficiary. If more than two are medically justified for CSHCS beneficiaries, the physician must obtain PA from CSHCS. A copy of the PA approval letter must be attached to the claim form to be reimbursed. Physicians are responsible for providing a copy of the PA approval letter to the hospital.

A multichannel recording is covered as a professional service to the physician and as a technical service to the hospital. The professional service includes the interpretation with written report, and the scanning and scoring.

SECTION 6 - EVALUATION AND MANAGEMENT SERVICES

Medicaid covers medically necessary evaluation and management (E/M) services provided by a physician or other practitioner authorized by the State. Providers should refer to the CPT explanations, coding conventions, and definitions for E/M services.

Most E/M services are covered once per day for the same beneficiary. In these cases, only one office or outpatient visit is covered on a single day for the same beneficiary unless the visits were for unrelated reasons and at different times of the day (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).

Coverage of an E/M service includes related activities such as coordination of care, telephone calls, writing prescriptions, completing insurance forms, review and explanation of diagnostic test reports to the beneficiary.

Do not report the modifier for unusual procedural services with E/M services in order to request individual consideration. This does not follow CPT coding guidelines and causes longer delays in processing the claims for payment.

6.1 PREVENTIVE MEDICINE SERVICES

One preventive medicine E/M service is covered for all beneficiaries annually. For beneficiaries under the age of 21 years, EPSDT screening services are covered according to the AAP periodicity schedule and CMS requirements. (Refer to the Early and Periodic Screening, Diagnosis, and Treatment Section of this chapter for specific information.)

A preventive medicine E/M visit and another E/M visit on the same date are covered separately if, during the preventive visit, a problem or abnormality is detected which requires additional work which meets the key component requirements of a problem oriented E/M visit. When this occurs, the office/outpatient E/M procedure code is covered using the modifier for a separately identifiable service, and the preventive E/M visit is covered without using a modifier. (Refer to CPT guidelines for additional information.)

6.2 E/M VISITS IN RELATION TO GLOBAL SURGERY PACKAGE

An E/M service that results in the decision for surgery is covered separately when provided by the surgeon on the day before or the day of a procedure with a 90-day global period and the decision for surgery modifier is reported. This same E/M service provided the day before or the day of a procedure with a 0-day or 10-day global period is not covered separately.

An E/M service is not covered separately on the same day as a procedure with any global surgery period unless the beneficiary's condition requires a significant, separately identifiable E/M service that is above and beyond the pre- and post-operative care associated with the procedure or service performed.

If the surgeon performs E/M services during the post-operative global surgery period for a reason unrelated to the surgical procedure, report the appropriate modifier with the E/M service. All care provided during the inpatient stay in which the surgery is performed is compensated through the global surgery package and is not covered separately.

6.3 Consultations

Medicaid covers consultations rendered by a physician whose opinion or advice is requested by another appropriate practitioner (e.g., physician, CNM, dentist) for the further evaluation and management of the patient. A consultation includes preparation of a report of findings that is provided to the referring provider for the referring provider's use in the treatment of the beneficiary. A consultant may initiate diagnostic and/or therapeutic services. If the referring provider transfers complete responsibility for treatment either orally or in writing to the consultant at the time of the request for consultation, the receiving physician's services are covered as normal E/M services rather than as a consultation.

If the referring provider transfers responsibility for the beneficiary's care to the consultant after the consultation is completed, the consultant's service is covered as a consultation. After the consulting physician assumes responsibility for the beneficiary's care, subsequent visits are covered as established patient office visits or subsequent hospital care, depending on the setting.

A consultation is covered if one provider in a group practice requests a consultation from a physician of a different specialty in the same group practice as long as all of the requirements for use of the CPT/HCPCS consultation codes are met. A request for a consultation from the attending provider and the need for consultation must be documented in the beneficiary's medical record. In an inpatient setting, the request may be documented as part of a plan written in the requesting physician's progress notes, an order in the hospital record, or a specific written request for the consultation.

Medicaid covers second opinions for surgery. The second opinion is covered as a consultation as long as all requirements for a consultation are met.

Ancillary services provided to a beneficiary in a nursing facility must be ordered by the attending physician and are not covered as consultations unless a specific request for opinion and advice is documented. Requests for services by another physician are covered as the actual service provided (e.g., nursing facility visit or eye examination).

6.4 Initial Visits

Medicaid covers one new patient visit for a physician or a group practice for the same beneficiary, regardless of the type of new patient visit billed (e.g., office visit, clinic visit, long term care visit, home visit).

6.5 Observation Care

Medicaid covers physician services for beneficiaries admitted and discharged from observation status in the hospital setting for a stay less than 24 hours. Coverage is based on CPT coding conventions to report observation stays occurring on a single date and observation stays which start on one date and end on the subsequent date. It is expected that the beneficiary would be discharged from the hospital at the end of observation care. The medical record must include the following documentation:

- The length of time of the observation stay.
- The physician was present and personally performed the services.
- The physician wrote the observation admission and/or discharge notes.

For outpatient surgical procedures, the global surgery rules apply. The surgeon is responsible for all post-operative care in the hospital and observation care is not covered separately.

Observation care for psychiatric reasons must be authorized by the PIHP/CMHSP. The PIHP/CMHSP is responsible for coverage of authorized psychiatric observation care services.

6.6 Nursing Facility Services

Visits necessary to perform Medicare and Medicaid required assessments are covered under the appropriate E/M services involving comprehensive resident assessments.

Visits required to monitor and evaluate residents at the frequencies detailed in the coverage portion of the Nursing Facility chapter of this manual are also covered under the appropriate E/M service for subsequent nursing facility care.

Additional visits for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, are only covered when documentation of the medical necessity for the visit is included on, or attached to, the claim. Documentation must include diagnoses describing the acute illness or injury; or remarks documenting the necessity for the additional visit recorded on the claim; or documentation such as notes from the visit supporting the above criteria attached to the claim. Additional visits which repeatedly reflect the same chronic diagnoses and additional visits for the purpose of routine monitoring are not covered.

Refer to the Coverages portion of the Nursing Facility chapter of this manual for timeframes and additional details for required nursing facility visits.

SECTION 7 - EMERGENCY SERVICES

Medicaid covers all medically necessary emergency services. Federal statutes prohibit PA for coverage of emergency services. Emergency services include covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and the services are necessary to evaluate or stabilize an emergency medical condition. All professional services must be identified as either an emergency or not an emergency.

7.1 SCREENING EXAM AND STABILIZATION IN THE EMERGENCY DEPARTMENT

MDCH and its contracted health plans must follow the applicable requirements and definitions of the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Medicaid covers the medical screening examination, any ancillary service(s) when performed in a hospital emergency department (ED) for the sole purpose of determining if an emergency medical condition exists, and any necessary stabilizing treatment.

For both Medicaid FFS and MHP beneficiaries, the screening examination and any physician-ordered procedures (e.g., x-rays, lab, etc.) necessary to determine the beneficiary's condition are covered without PA. For Medicaid FFS beneficiaries, the screening examination and related diagnostic procedures are covered by MDCH. For Medicaid MHP beneficiaries, these services are covered by the beneficiary's MHP.

Professional services for the medical screening and stabilization in the ED are covered separately from the facility fees.

7.2 TREATMENT OF EMERGENCY MEDICAL CONDITION IN THE EMERGENCY DEPARTMENT

PA is not required for the treatment of emergency medical conditions.

An emergency medical condition is defined by the Balanced Budget Act of 1997 and its regulations.

An emergency medical condition may exist whether the beneficiary is discharged from the ED or admitted to the inpatient hospital. This includes admissions where death occurs before a bed is occupied.

If an emergency medical condition exists, the medical findings must be fully documented in the beneficiary's medical record.

7.3 NONEMERGENCY MEDICAL CONDITIONS IN THE EMERGENCY DEPARTMENT

If the medical findings from the screening indicate the beneficiary's condition does not meet the definition of an emergency medical condition, but requires additional, follow-up treatment, the following rules apply:

- FFS Medicaid beneficiaries without private health insurance should be referred to their primary care provider to obtain treatment. However, treatment may be rendered in the ED and does not require PA.
- FFS Medicaid beneficiaries with private health insurance must follow the rules of the private health insurance. Private insurers frequently require that the primary care provider perform the follow-up care.

- MHP enrollees must be referred to their primary care provider for treatment, or the MHP can be contacted to request authorization to provide the treatment. If the MHP fails to respond within one hour to the request to provide additional services beyond those required for stabilization, the request for authorization is deemed approved.

7.4 Psychiatric Emergency Services in the Emergency Department

Screening and stabilization of a psychiatric emergency does not require PA. These services are covered in the same manner as other emergency services provided in the ED detailed above. If it is determined that the beneficiary requires post-stabilization psychiatric services, the PIHP/CMHSP must be contacted for PA. The need for PA from the PIHP/CMHSP includes, but is not limited to, inpatient psychiatric admission, psychiatric partial hospitalization, and specialty mental health services.

A psychiatric emergency is defined as a situation in which an individual must be treated to protect him from inflicting injury to self or others as the result of a serious mental illness, emotional disturbance, or developmental disability, or could reasonably be expected to intentionally or unintentionally injure himself or others in the near future. The emergency may result from an inability to provide food, clothing, or shelter for him or others, inability to attend to activities of daily living, or when judgment is so impaired the individual is unable to understand the need for treatment.

7.5 Urgent Care Settings

Physician services rendered in urgent care centers or similar settings that are not part of a licensed hospital are covered. Coverage is based on the appropriate office or other outpatient services E/M procedure codes. Coverage for any additional professional services rendered in these settings follows CPT guidelines.

SECTION 8 - MATERNITY CARE AND DELIVERY SERVICES

Medicaid covers maternity care and delivery services. The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care. These services are included in the global obstetric package. The global obstetric package is covered when one physician or physician group practice provides the obstetric care to a beneficiary. The global obstetric package is covered as long as the provider or group has provided seven or more antepartum visits, the delivery, and the postpartum care. If less than seven antepartum visits are provided, report the global package with the modifier for reduced services and indicate the number of antepartum visits on the claim.

8.1 ANTEPARTUM CARE

Includes the initial and any subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Typically, if a beneficiary enrolls in the first trimester and delivers at term, she has about 13 antepartum visits. This varies depending on the actual start of antepartum care and the delivery date. If the total number of antepartum visits exceeds 13 due to a high-risk condition, the additional visits are covered when using the appropriate E/M codes with the diagnosis for the high-risk condition.

8.2 DELIVERY

Includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, delivery, and all post-delivery in-hospital care. All hospital visits within 24 hours of delivery are generally considered part of the global package. If the beneficiary is admitted more than 24 hours before delivery and stays more than 24 hours, then hospital care rendered prior to the day of delivery is covered separately as an E/M code. Medical problems complicating labor and delivery management that require additional resources are also covered separately.

8.3 POSTPARTUM

Includes all the visits following a delivery, both in the hospital and in the office. Services provided by physicians within the same group practice are considered as provided by the primary physician responsible for the beneficiary's overall obstetrical care.

8.4 OBSTETRICAL PACKAGE VS. COMPONENTS

If the same physician or group practice does not provide all of the obstetric care, Medicaid covers the portion of the care provided by each provider. Postpartum care is covered separately if provided by a different physician or group than the one providing the delivery services.

Services that are not included in the global package include:

- Maternal or fetal echography or fetal echography procedures.
- Fetal biophysical profile.
- Chorionic villus sampling, any method.
- Fetal contraction stress test.

- Fetal nonstress test.
- Hospital and observation care visits for premature labor (prior to 36 weeks gestation).

8.5 High-Risk Pregnancy

High-risk pregnancies are those with complicating conditions that are life-threatening to either the mother or fetus and, therefore, require more services than those provided in a routine pregnancy. When high-risk pregnancies require more visits than described for routine obstetrical care and more laboratory data than normally required, the additional services are covered in addition to the global obstetric package. If beneficiary visits are required due to conditions unrelated to the pregnancy, they are also covered in addition to the global obstetric package. Medicaid follows CPT guidelines for reporting high-risk pregnancy services.

8.6 Multiple Gestation

In the case of multiple gestation, Medicaid covers the services provided. Payment follows the multiple procedure rules. Providers must use a diagnosis code representing multiple gestation.

8.7 OB Enhanced Payments

MDCH provides an enhanced payment for each Medicaid delivery performed. This additional reimbursement is added to the fee reimbursed under FFS for the global maternity and delivery procedure codes. The maternity case rate paid to MHPs is also enhanced.

8.8 Maternity Outpatient Medical Services Program

Under the Maternity Outpatient Medical Services (MOMS) program, pregnant women can enroll and receive pregnancy related care early in the pregnancy.

Targeted Population	Women who are pregnant or recently pregnant (within 60 days following the month the pregnancy ended), who apply for medical coverage for their pregnancy at a LHD, Federally Qualified Health Center (FQHC), or DHS, and meet one or more of the following criteria: ▪ Women with incomes at or below 185 percent of the federal poverty level. ▪ Women who are covered by the Medicaid Emergency Services Only (ESO) program. Frequently, individuals determined eligible for MOMS may subsequently become eligible for Medicaid. MOMS eligibility is terminated on the effective date of full Medicaid coverage. Medicaid covers all services available under the MOMS program. (This does not include Medicaid ESO.)
Period of Coverage	Once the woman is enrolled into MOMS, outpatient pregnancy-related services and the provider's professional fee for labor and delivery are covered from the date of conception through 60 days after the pregnancy ends, regardless of the reason (live birth, miscarriage, or stillborn).

Covered Services	Coverage includes inpatient hospital services related to an inpatient delivery. No other inpatient hospital services are covered. Coverage includes the following outpatient pregnancy-related services during the prenatal and postpartum period: ▪ Prenatal care ▪ Pharmaceuticals and prescription vitamins ▪ Laboratory services ▪ Labor and delivery, both professional fees and inpatient hospitalization ▪ Postpartum care through 60 days after the pregnancy ends ▪ Radiology and ultrasound ▪ Maternal Infant Health Program (MIHP) until delivery ▪ Childbirth education ▪ Outpatient hospital care ▪ Other pregnancy-related services with PA
Private Insurance	Private insurance coverage, if any exists for pregnancy related care, must be billed first. MOMS is the secondary payer of services if private insurance coverage exists. (Reimbursement for services is specified in the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual.) This would include following the rules of any private commercial managed care contract. Services to the infant are not covered at any time under this program. The infant's family/primary caregiver is encouraged to apply promptly for Medicaid coverage for the infant. Policies and procedures are parallel to Medicaid FFS beneficiaries.
Guarantee of Payment Letter	MDCH has developed a process whereby providers are assured payment for services provided to pregnant women. If it is determined that the woman appears to qualify for MOMS or Medicaid, a Guarantee of Payment Letter for Pregnancy Related Services (DCH-1164) will be issued to the pregnant woman to enable her to obtain care immediately and not have to wait for her identification card.

8.9 MATERNAL INFANT HEALTH PROGRAM

Maternal Infant Health Program (MIHP) provides preventive health services that are delivered by an agency, which must be certified by MDCH. MIHP services include:

- Psychosocial and nutritional assessment.
- Plan of care development.
- Professional intervention services of a multidisciplinary team consisting of a qualified:
  - Social worker;
  - Nutritionist;

- Nurse; and
- Infant mental health specialist (if available).

- Arranging transportation as needed for health, substance abuse treatment, support services, and/or pregnancy-related appointments.
- Referral to community services (e.g., mental health, substance abuse).
- Coordination with medical care providers.
- Childbirth classes or parenting education classes.

Services consist of social work, nutrition, nursing services (including health education), counseling/social casework, and beneficiary advocacy services.

Infant mental health specialists should be involved with infant cases, if available in the geographic area. If not available, the provider must consider carefully how to provide this service.

8.9.A. Maternal Services

MIHP referrals for pregnant women are encouraged given the presence of any of the following conditions which are likely to adversely affect the pregnancy:

- Homeless or dangerous living/home situation.
- Negative or ambivalent feelings about the pregnancy.
- Mother under age 18 and has no family support.
- Need for assistance to care for herself and the infant.
- Mother with cognitive, emotional or mental impairment.
- Nutrition problem.
- Abuse of alcohol or drugs, or smoking.
- Need for transportation to keep medical appointments.
- Need for childbirth education classes.

Only those pregnant women that meet the above risk criteria should be enrolled in MIHP. Medicaid eligibility by itself is not a qualifying condition for enrollment in MIHP.

8.9.B. Infant Services

MIHP referrals for infants are encouraged if the presence of any one of the following conditions exists with the mother or infant:

- Abuse of alcohol or drugs (especially use of cocaine), or smoking.
- Mother is under 18 years of age and has no family support.
- Family history of child abuse/neglect.
- Failure to thrive.

- Low birth weight (less than 2500 grams).
- Mother with cognitive, emotional or mental impairment.
- Homeless or dangerous living/home situation.
- Any other condition that may place the infant at risk for death, illness or significant impairment when indicated by a physician.

(Refer to the Maternal Infant Health Program Chapter of this manual for additional information.)

SECTION 9 - PHARMACY

Refer to the Pharmacy Chapter of this manual for additional information.

SECTION 10 - RADIOLOGY, RADIATION THERAPY AND NUCLEAR MEDICINE

10.1 RADIOLOGY SERVICES

Medically necessary radiological services are covered when ordered by a physician to diagnose or treat a specific condition based on the beneficiary's signs, symptoms, and past history as documented in the medical record. Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging (MRI) services, diagnostic ultrasound, and other imaging procedures. Medical need for all services must be documented in the medical record and are subject to post-payment review.

10.1.A. GLOBAL / COMPONENT SERVICES

Medicaid covers global physician services in nonhospital settings or the professional component only in any setting. The technical component is only covered when provided and billed by a hospital.

When a physician reports a global procedure, the physician is responsible for the overall performance and quality of the test. The physician must either personally perform the test or it must be performed under the physician's supervision and direction. The physician must personally interpret the results and complete the written report. While some radiology procedures and diagnostic tests may not require the presence of the supervising physician on the premises, other procedures dictate that the physician be present and may even need to be directly involved in the performance of the procedure.

Interpretation of radiology services are covered for any physician trained in the interpretation of the study. The provider who interprets the study must be the one who evaluates the study and prepares and signs the written report for the medical record. Review of results and explanation to the beneficiary are part of the attending physician's E/M service and are not considered as interpretation of the study.

10.1.B. MULTIPLE SERVICES ON SAME DAY

Medicaid covers bilateral x-rays when medically necessary. Bilateral services are studies done on the same body area, once on the right side and once on the left side. Comparison films obtained for routine purposes are not covered. Providers should use a bilateral code when available. The MDCH Practitioner Medical Clinic Database indicates all diagnostic procedures that are covered as bilateral services. Medicaid also covers multiple studies of both areas if reported with the appropriate modifier. Examples would include bilateral wrist studies done before and after fracture care on both wrists the same day for the same patient or doing films to assess a patient's response to medical care, such as multiple chest films to monitor the cardiopulmonary status of a critically ill patient.

Contiguous Areas	Studies of contiguous areas, such as the wrist and hand, lumbosacral spine and pelvis, ankle and foot, are covered on the same day when medically necessary to visualize each space. The medical record must support the need for individual studies. If cervical, lumbosacral and thoracic views are performed, an entire spine study should be reported.
Screening Mammography	Screening mammography is covered according to the American Cancer Society guidelines. Women age 40 and older should have annual breast cancer screening consisting of a clinical breast examination and a mammogram.
Transrectal or Prostate Ultrasound	Transrectal or prostate ultrasound is covered when the patient is considered at high risk for prostate cancer. It is also covered for pathologic indications that include evaluation of prostatic nodule(s) or abnormalities of the seminal vesicles, staging of prostatic cancer, and monitoring of response to therapy for prostatic cancer.
CT, MRI, PET Scans	For CT, MRI and PET scans to be covered, all conditions of Certificate of Need (CON) must be met. These services are subject to standards for provision of the service that include specific staff and designation of who is qualified to interpret the results. Flat films and CT or MRI studies of the same area are covered on the same day when medically indicated. The provider is responsible for using the most appropriate diagnostic test(s) according to current standards of practice. A CT and a myelogram may be covered on the same day; however, an MRI and a myelogram are not covered separately if done on the same day. Coverage of a CT of the spine is limited to one level per day and coverage of an MRI is limited to two levels of the spine on the same day. Providers should be directing the study at the area of the suspected problem. CT and MRI scans may be done with or without contrast media or both. When a scan is done without contrast followed by another with contrast, only the full service is covered. The global RVUs for CT and MRI contrast scans include allowance for high osmolar contrast media, and the RVUs for global MRIs include allowance for paramagnetic contrast media. In certain instances, the use of low osmolar contrast media (LOCM) is separately covered. In the case of intra-arterial and intravenous radiological procedures, LOCM is covered separately for nonhospital patients with one or more of the following: ▪ A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting; ▪ A history of asthma or allergy; ▪ Significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension; ▪ Generalized severe debilitation; or ▪ Sickle cell disease. If the patient does not meet any of these criteria, the contrast media is considered bundled into the global service and is not covered separately.

	When high dose contrast technique is used with MRI, the global service is covered for the procedure designated without contrast, then with contrast. The third MRI (again with contrast) is not covered separately. The contrast material used in the second MRI procedure is not covered separately; however, the contrast material for the third MRI procedure is covered separately.
Obstetrical Ultrasound	Obstetrical ultrasound studies are covered in addition to the global obstetrical package. More than two studies are covered only for high-risk conditions such as bleeding, placental abnormalities, fetal post-maturity, etc. The need for the additional studies, including the change in clinical symptoms, must be documented. Pelvic ultrasounds are not covered to diagnose pregnancy or vaginal infections. The use of ultrasound studies for routine fetal age determination in or preparatory for pregnancy termination procedures is considered part of the termination procedure and is not covered separately.

10.2 Radiation Therapy

Medicaid covers medically necessary radiation therapy services provided to beneficiaries. CPT/HCPCS guidelines for radiation therapy services are followed.

Following the Medicare guidelines, many services are bundled into the treatment management codes and are not covered separately when the diagnosis is related to the weekly treatment diagnosis and the services are provided by the radiation oncologists or in conjunction with the therapy. The following services are included in the weekly treatment management service:

- Anesthesia
- Care of infected skin
- Checking treatment charts
- Continuing-care patient evaluation and examination
- Final medical examination
- Nutritional counseling
- Pain management
- Medical prescription
- Review and revision of the treatment plan
- Routine medical management of related problems
- Special care of ostomy
- Verification of dosage
- Written reports, progress notes
- Follow-up examination and care 90 days after the last treatment

Medicaid separately covers services furnished by a radiation physicist only when provided to a nonhospital beneficiary in a freestanding facility.

Professional services provided to hospital patients are covered only when personally performed by a physician.

Global physician services are only covered if provided in a freestanding, nonhospital setting.

10.3 Nuclear Medicine

Medicaid covers medically necessary nuclear medicine procedures. Providers are responsible for complying with Nuclear Regulatory Commission (NRC) requirements. Only professional services rendered to hospital patients are covered for the practitioner.

Medicaid covers global services when provided in a freestanding, nonhospital setting. Radionuclides used in the procedures are covered separately.

When specific nuclear medicine diagnostic procedures are performed, multiple procedure coverage rules apply. Generation and interpretation of automated data is covered as a part of the primary procedure.

SECTION 11 - HOSPITAL INPATIENT PHYSICIAN SERVICES

Medicaid covers physician services to hospital inpatients that are medically necessary and follow the requirements in this section. Medicaid does not cover physician services related to inappropriate or unnecessary inpatient admissions. This includes elective admissions and readmissions, all transfers that are not authorized through the Pre-Admission and Certification Evaluation Review (PACER) system, and admissions or readmissions which have been inappropriately identified as emergent. This also includes selected ambulatory surgeries inappropriately performed on an inpatient basis or any other inpatient admission determined to have not been medically necessary.

If Medicaid does not cover the services of the physician or hospital, the physician or hospital must not bill the beneficiary, a member of the beneficiary's family, or other beneficiary representative.

11.1 ADMISSION

All inpatient admissions must be medically necessary and appropriate, and all services must relate to a specific diagnosed condition. Elective admissions, readmissions, and transfers for surgical and medical inpatient hospital services must be authorized through the Admissions and Certification Review Contractor (ACRC). The physician should refer to the PACER subsection of this section for specific requirements.

Medicaid does not cover inpatient hospital admissions for the sole purpose of:

- Cosmetic surgery (unless prior authorized)
- Custodial or protective care of abused children
- Diagnostic procedures that can be performed on an outpatient basis
- Laboratory work, electrocardiograms, electroencephalograms, diagnostic x-rays
- Observation
- Occupational therapy
- Patient education
- Physical therapy
- Routine dental care
- Routine physical examinations not related to a specific illness, symptom, complaint, or injury
- Speech pathology
- Weight reduction, weight control (unless prior authorized)

Any accommodation or ancillary services provided during nonallowable admissions or parts of stays are not covered. Physicians may not bill the beneficiary for any surgical/medical charges since the admission was unnecessary.

11.2 Pre-Admission and Certification Evaluation Review

Elective admissions, all readmissions within 15 days of discharge, and all transfers for surgical or medical inpatient hospital services to and from any hospital enrolled in the Medicaid program require authorization through the ACRC. This includes transfers between a medical/surgical unit and an enrolled distinct part rehabilitation unit of the same hospital. All cases are screened using the Medicaid approved Severity of Illness/Intensity of Services (SI/IS) criteria sets and the clinical judgment of the review coordinator. An ACRC physician makes all adverse decisions.

If an admission, readmission, transfer, or continued stay is not approved, Medicaid does not cover the hospital or physician services rendered.

The ACRC completes the admission, readmission, or transfer review through the Pre-admission and Certification Evaluation Review (PACER) system and assigns a PACER number.

The attending/admitting physician or representative is responsible for obtaining the PACER number before admitting, readmitting, or transferring the beneficiary with exceptions as noted below. (Refer to the Directory Appendix for PACER authorization contact information.)

Physicians are asked to provide the procedure code when a surgical admission/readmission is requested. If the ACRC does not authorize the admission/readmission/transfer, the physician can request reconsideration. This request must be made within three working days of the denial.

Authorization for the hospital admission does not remove the need for PA for specific services. Any PA required for the service must be obtained before the ACRC authorization is requested.

The following do not require a PACER number:

- Emergent admissions. (Hospital services billed as emergent are reviewed on a post-payment sample basis.)
- Transfers to distinct-part psychiatric units or freestanding psychiatric hospitals. (Authorization must be requested through the local PIHP/CMHSP.)
- Obstetrical beneficiaries admitted for any delivery.
- Newborns admitted following delivery except for all transfers. Transfers include any of the following situations:
  - Transfer from one inpatient hospital to another.
  - Transfer from one unit of an inpatient hospital to another unit of the same hospital (i.e., distinct part rehabilitation unit) which has a separate Medicaid ID number.

  Newborns who are transferred following delivery require a PACER number. The ACRC must authorize the initial and subsequent transfers of the newborn.
- Admissions of beneficiaries that are eligible for CSHCS only.
- Admissions of beneficiaries that are dually eligible for CSHCS and Medicaid, and the admission is related to the CSHCS qualifying diagnosis.
- Medicaid beneficiaries enrolled in a MHP.

- When a beneficiary is admitted to a hospital that is not enrolled with the Michigan Medicaid Program.
- When a beneficiary becomes Medicaid eligible after the admission, readmission, transfer, or certification review period.

Physicians are responsible for providing the PACER number to the admitting hospital. If an urgent or emergent readmission to the same hospital as the original admission occurs, the PACER number for the readmission must be made by the next working day following the readmission.

(Refer to the Hospital Chapter of this manual for additional information concerning the ACRC and PACER processes.)

11.3 Ventilation Management

Ventilation management provided in the inpatient hospital setting is covered separately unless an E/M service is provided on the same day.

11.4 Critical Care

Medicaid covers critical care consistent with the CPT/HCPCS definitions and guidelines. Each day that critical care is provided, the medical record must support the level of service provided. The actual time spent with the patient delivering critical care services must be documented in the medical record.

11.5 Respiratory Care

Medicaid covers respiratory care as a separate service in the inpatient hospital setting for the anesthesiologist/physician who initiates respiratory care by setting up the respirator, placing the beneficiary on the respirator, and providing daily supervision of the beneficiary for the respiratory care alone.

11.6 Standby Services

Medicaid does not cover the services of a standby surgeon, anesthesiologist or surgical team. Only direct beneficiary care is covered. Physician standby services are covered as a part of the hospital services.

SECTION 12 - SURGERY - GENERAL

Medicaid covers medically necessary surgical procedures.

12.1 GLOBAL SURGERY

Coverage for the global surgery package includes related services that are furnished by the physician who performs the surgery or by members of the same group with the same specialty. Medicaid policy is based on CMS guidelines for Medicare services for the global surgery package.

Global periods are identified on the MDCH Practitioner Medical Clinic Database. The payment rules for global surgery apply to global periods of 000 (only services on the day of the procedure are included), 010 (10-day global period), 090 (90-day global period), and YYY (global period determined on case-by-case basis). Codes with 000 and 010 global periods include endoscopies and minor procedures. Codes with a 090 global period include major surgeries. Codes with an YYY are individually priced and MDCH determines the global period.

12.1.A. SERVICES INCLUDED IN THE GLOBAL SURGERY PACKAGE

- Pre-operative visits beginning with the day before the surgery for major surgeries and the day of the surgery for minor surgeries.
- Intra-operative services that are a usual and necessary part of a surgical procedure.
- Complications following surgery. This includes all additional medical or surgical services required of the surgeon during the post-operative period due to complications that do not require return to the operating room. The surgeon's visits to a patient in an intensive care or critical care unit are also included.
- Follow-up visits within the post-operative period related to recovery from the surgery.
- Post-surgical pain management by the surgeon.
- Supplies for certain services furnished in a physician's office.
- Miscellaneous services and items such as dressing changes, local incisional care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes.

12.1.B. SERVICES NOT INCLUDED IN THE GLOBAL SURGERY PACKAGE

- The surgeon's initial consultation or evaluation of the problem to determine the need for surgery.
- The office or hospital visit to decide upon surgery if it occurs on the day before or the day of a major surgery.
- Other physicians' services, except when the surgeon and the other physician(s) agree on the transfer of care (The transfer of care agreement may be in the form of a letter or an annotation in the discharge summary, hospital records, or ambulatory surgical center records).

- Visits unrelated to the diagnosis for which the surgical procedure was performed.
- Treatment of the underlying condition or an added course of treatment that is not part of the normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiology procedures.
- Clearly distinct surgical procedures that are not repeat procedures, or treatment for complications during the post-operative period. A new post-operative period begins with the subsequent procedure.
- Staged procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples include procedures to diagnose and treat epilepsy in succession within 90 days of each other.
- Laser eye surgeries (and all other services whose CPT/HCPCS description includes one or more sessions) performed in a series over a period of weeks or months are not considered staged procedures. All sessions during the post-operative period of the first session are covered as a part of the global package.
- Chemotherapy and/or radiation therapy following cancer surgery.
- Treatment for post-operative complications that requires a return to the operating room. For this purpose, an operating room is a place of service specially equipped and staffed for the sole purpose of performing surgical procedures, including a cardiac catheterization suite, a laser suite, and an endoscopy suite. Not included is a patient's room, a minor treatment room, a recovery room, or intensive care unit unless the patient's condition is so critical there is insufficient time for transportation to an operating room.
- A second, more extensive procedure when a less extensive procedure fails.
- A therapeutic service that is required during the post-operative period of a diagnostic service. Example: A D&C followed by a therapeutic hysterectomy performed during the D&Cs global period.
- Immunosuppressive therapy for organ transplants.
- Critical care services unrelated to the surgery when a seriously injured or burned patient is critically ill and requires constant attendance of the physician.
- Visits that are a significant, separately identifiable service on the same day as a minor surgery or endoscopy. For example, a visit for a full evaluation of a lump in the breast on the same day as a removal of a lesion on the back.
- When a beneficiary is returned to the operating room for treatment of complications, only the intra-operative portion of the service is covered.

12.2 Partial Global Package

Services of physicians furnishing less than the full global surgery package are covered. Modifiers are used to identify the portion of the global surgery package that is covered separately when performed by different physicians under certain circumstances. Only procedures with 10- or 90-day global periods are eligible for partial global surgery package coverage.

Surgeons should use the modifier for surgical care only when another physician provides all or part of the outpatient post-operative care. MDCH assumes that the surgeon is responsible for pre-operative, intra-operative and inpatient hospital post-operative care at a minimum. The modifier for post-operative management only is used when a second physician provides all or part of the post-operative care after hospital discharge in the global package. Surgeons must transfer care to the second physician, and both must keep a copy of the written transfer agreement in the beneficiary's medical record.

12.3 Bilateral Surgery

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The descriptions for some procedure codes include the terms "bilateral" or "unilateral or bilateral." The RVUs for these codes reflect the work involved if done bilaterally as the description states. Other procedure code descriptions do not include bilateral but may be performed bilaterally. The bilateral procedure modifier is used with these procedure codes.

The MDCH Practitioner Medical Clinic Database includes an indicator for those procedures that the bilateral procedure modifier can be used with. Reimbursement for a bilateral procedure reported appropriately with this modifier is based on the lower of the amount billed or 150 percent of the fee screen for the procedure.

12.4 Multiple Surgical Procedures

Multiple surgeries are separate procedures performed by a physician on the same beneficiary during the same operative session or on the same day for which separate coverage may be allowed. Co-surgeons, surgical teams, or assistants at surgery may participate in performing multiple surgeries on the same beneficiary on the same day.

When the same physician performs multiple surgical procedures during one operative session, all services are covered separately. MDCH follows CMS multiple surgery guidelines for coverage of the procedures. If an integral procedure (one that is part of a larger surgery and is necessary to perform the larger surgery) is performed, it is covered as a part of the larger procedure. If two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases), the procedures are covered separately.

Multiple surgery reimbursement policy applies to procedures performed during the same operative session or on the same day by the same physician or physicians of the same specialty in the same group practice. Medicaid reimburses up to 100 percent of the fee screen for the most complex surgical procedure and up to 50 percent of the fee screens for the second through the fifth surgical procedures. If more than five multiple procedures are performed, an operative report must be provided with the claim.

12.5 Multiple Endoscopy Procedures

Multiple endoscopy procedures are reimbursed based on the full fee for the highest paid service, plus the difference between the next highest and the base endoscopy. When related endoscopies are performed on the same day as other endoscopies or other surgical procedures, the standard multiple surgery rules apply. The multiple surgery rules consider the coverage for the related endoscopies as one service, and any other unrelated endoscopy or procedure as another service.

12.6 Multiple Surgeons

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same beneficiary during the same operative session. This may be required due to the complex nature of the procedures or the beneficiary's condition. The MDCH Practitioner Medical Clinic Database (located on the MDCH website) includes multiple surgeon indicators on allowable procedures.

12.7 Co-Surgeons

Two surgeons who work together as primary surgeons performing distinct parts of a total service are considered co-surgeons. The medical record must contain sufficient documentation supporting the medical necessity for co-surgeons. Report the modifier indicating two surgeons for the services furnished by each co-surgeon. The primary procedure is reimbursed at the full screen times 62.5 percent. Second and subsequent services are paid at 50 percent of the full-allowed amount times 62.5 percent.

12.8 Team Surgeons

Three or more surgeons who work together as primary surgeons to perform a specific procedure are considered team surgeons. Sufficient documentation must be submitted with the claim to establish that a team was medically necessary. If two or more surgeons are of the same specialty, the reason each was needed must be documented also. Report the surgical team modifier when billing for services rendered by each team surgeon. Each surgeon's dictated operative report must be included with the claims. Reimbursement is based on individual consideration.

12.9 Assistant at Surgery / Assistant Surgeon

Medicaid covers assistant at surgery services for designated surgical procedures. Assistant at surgery services must be considered reasonable and necessary for the surgery performed. An assistant at surgery actively assists the primary surgeon during the surgical procedure. Coverage for assistant at surgery services is not allowed when co-surgeons or team surgeons are utilized.

Medicaid does not cover assistant surgeon services in a teaching hospital setting unless a qualified resident is not available. The medical record must document the circumstances causing the unavailability of a qualified resident. The surgical procedure is reported with appropriate modifier identifying use of an assistant surgeon.

Medicaid covers assistant at surgery services performed by a second physician, a physician's assistant, or a nurse practitioner (NP). Physician's assistant and NP services as assistant at surgery must be under the delegation and supervision of the physician employing the physician's assistant or NP, or a physician employed by the same group practice that employs the physician's assistant or NP. If the physician's assistant and/or NP are employees of the hospital, their services are covered as a part of the hospital charges.

12.10 Surgeons Performing Distinctly Different Unrelated Procedures

If two or more physicians each perform distinctly different, unrelated surgeries on the beneficiary on the same day, the payment adjustment rules for multiple surgeries or co-surgeons do not apply. In such cases, the multiple procedures modifier should not be used unless one of the surgeons individually performs multiple surgeries.

12.11 Destruction of Lesions

Medicaid covers destruction of lesions by methods such as electrocautery, cryocautery, laser, and surgery.

Coverage of the surgical destruction of lesions that involve more extensive procedures is limited to the hospital setting. Less extensive procedures are covered in the office setting. (Refer to the MDCH Practitioner Medical Clinic Database to determine which procedures require a hospital setting for coverage and which procedures are covered in the office setting.) If a repeat procedure to the same lesion is necessary, it is covered as an office visit.

Chemocautery or chemical destruction of any lesion, such as the use of a nitrate stick or podophyllin, is covered as a part of the office visit.

12.12 Vision Procedures and Care

Ophthalmologists may transfer post-operative care associated with cataract removal or insertion of intraocular lens prosthesis to an optometrist. In this case, the ophthalmologist who performs eye surgery but does not provide the post-surgical care must report the surgical care only modifier with the surgery procedure code. This includes the pre-operative care, the surgery, and any in-hospital post-operative care. Post-operative care after hospital discharge is covered separately for the provider that the care was transferred to using the surgery code with the post-operative management only modifier.

Surgical procedure descriptions that include the phrase "one or more sessions" include all sessions. These procedures include the 90-day global period during which the procedure(s) can be completed in one or more session(s). These procedures include trabeculoplasty by laser surgery, iridotomy/iridectomy by laser or photocoagulation, repair of retinal detachment, destruction of retinal or choroid lesions. The code description in CPT identifies when one or more sessions are included. Separate coverage for a second or subsequent session of the same procedure during the global period of the initial service is limited to cases where the modifier reported with the procedure code indicates that services were performed on different eyes.

SECTION 13 - SURGERY - SPECIAL CONSIDERATIONS

13.1 ABORTIONS

Medicaid only covers an abortion performed by a physician and related hospital charges (e.g., room, supplies) when it has been determined medically necessary to save the life of the mother or the pregnancy is the result of rape or incest. Medicaid funding is not available for any elective therapeutic abortion or service related to the performance of such abortion unless one of these criteria has been met.

Physicians must certify on a completed Certification for Induced Abortion form (MSA-4240) that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest.

The physician who completes the MSA-4240 must also ensure completion of the Recipient Verification of Coverage form (MSA-1550) and is responsible for providing copies of the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) that would submit claims for services related to the abortion.

A copy of the MSA-4240 completed by the physician and an MSA-1550 must accompany all claims except those for ectopic pregnancies or spontaneous, incomplete or threatened abortions.

The medical record must include a complete beneficiary history, including the medical conditions that made the abortion necessary to save the life of the mother. When the pregnancy is the result of rape or incest, the medical record must include the circumstances of the case and that the pregnancy was the result of rape or incest.

(Refer to the Forms Appendix for copies of the MSA-4240 and MSA-1550.) The forms are also available on the MDCH website. (Refer to the Directory Appendix for contact information.)

13.2 COSMETIC SURGERY

Medicaid only covers cosmetic surgery if PA has been obtained. The physician may request PA if any of the following exist:

- The condition interferes with employment.
- It causes significant disability or psychological trauma (as documented by psychiatric evaluation).
- It is a component of a program of reconstructive surgery for congenital deformity or trauma.
- It contributes to a major health problem.

The physician must identify the specific reasons any of the above criteria are met in the PA request.

Physicians should refer to the General Information for Providers Chapter for specific information for obtaining authorization.

13.3 HYSTERECTOMY

Hysterectomies are covered only if the beneficiary has been informed orally, prior to surgery, that a hysterectomy will render her permanently incapable of reproducing. The beneficiary or her representative must sign a written acknowledgment of receipt of that information. The Acknowledgment of Receipt of Hysterectomy Information (MSA-2218) serves as the written acknowledgment.

All items on the MSA-2218 must be completed and the form must be signed by the beneficiary (or representative) and the physician (MD or DO).

Federal regulations prohibit Medicaid coverage for hysterectomies performed solely for the purpose of sterilization. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications, which alone do not indicate a hysterectomy.

13.3.A. EXCEPTIONS

The MSA-2218 is not required in the following situations:

- The beneficiary was already sterile before the hysterectomy.
- The beneficiary requires a hysterectomy because of a life-threatening emergency situation. It was not possible for the physician to inform the beneficiary in advance that the surgery would make her permanently incapable of reproducing.
- The hysterectomy (as covered according to Medicaid policy) was performed during a period of retroactive eligibility.

13.3.B. ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Providers may use the following option or continue to attach a copy of the MSA-2218 to the claim without going through this pre-approval process. The MSA-2218 form is available on the MDCH website.

To encourage paperless billing and reduce administrative burden, MDCH allows for submission of the MSA-2218 via fax. Federal regulations require that this form be submitted to Medicaid before reimbursement can be made for any hysterectomy procedure. This process can eliminate submitting paper attachments for hysterectomy claims and pre-confirms the acceptability of the completed acknowledgement form, as well as reduces costly claim rejections.

13.3.C. PROCEDURE FOR ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION APPROVAL

- The provider who obtains the required Acknowledgement completes a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed acknowledgement form to the Medicaid Payments Division, Hysterectomy Acknowledgement Form Approval. (Refer to the Directory Appendix for contact information.) Do not fax invoices.

- The form is reviewed within five working days, and a notice of errors or acceptance is returned to the provider. When notified that the acknowledgement form has been accepted and is on file, inform the other providers via a copy of the response. All invoices related to the service may be submitted without attachments.
- If there is no response within five working days:
  - Confirm that the fax is working.
  - Be sure that the cover sheet included the necessary information for Medicaid staff to respond to the provider.
  - Resend the information if necessary.

13.4 ORGAN TRANSPLANTS

Medicaid covers organ transplants and related services if all requirements for these services are met. PA is required for all beneficiary, donor, and potential donor services related to all organ transplants except cornea and kidney transplants. If transplantation of additional organ(s) is to occur during the same operative session as a cornea or kidney transplant, PA is required.

Prior to surgery, the beneficiary must be evaluated at an accepted transplant center approved by the Office of Medical Affairs (OMA) to determine if he is a good transplant candidate. The attending physician must obtain the PA for this evaluation. If the beneficiary is accepted as a transplant candidate, the PA for the evaluation also covers the transplant and related services.

Authorization Instructions	If Medicare eligibility is denied, the denial notice must be attached to the PA request. If the Medicare application is still pending, this should be indicated on the PA request. Once a final determination is made, MDCH must be notified. The donor must exhaust all possible insurance sources before Medicaid is billed for the services. A copy of the letter of authorization for the evaluation for transplant that was sent to the attending physician from the OMA must be submitted with the claim.
Transportation and Lodging	Transportation and lodging expenses associated with the evaluation and the transplant are covered for the beneficiary and one accompanying individual (e.g., spouse, parent, guardian). The beneficiary's local DHS office should be contacted to make travel arrangements if the beneficiary has only Medicaid coverage or they are dually eligible for CSHCS and Medicaid. If the beneficiary only has CSHCS coverage, he must contact the CSHCS office in the LHD of the county where he resides to make travel arrangements. The mode of transportation should be that deemed medically necessary for the beneficiary by the attending physician.
Donor Searches	Charges for donor searches which do not result in an organ acquisition and transplant are covered as an outpatient service by the hospital and not covered for the physician.

13.5 STERILIZATION

Medicaid covers sterilization procedures when specific requirements are met. Medicaid defines a sterilization procedure as any medical procedure, treatment, or operation for the purpose of rendering an individual (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under Medicaid's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). The physician is responsible for obtaining the signed Informed Consent to Sterilization form (MSA-1959).

Sterilizations are only covered if all of the following are met:

- The beneficiary is at least 21 years of age at time of informed consent.
- The beneficiary is not legally declared to be mentally incompetent.
- The beneficiary is not institutionalized in a corrective, penal, or mental rehabilitation facility.
- Informed consent is obtained.
- Informed consent is not obtained while the beneficiary is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.
- Informed consent must be obtained not less than 30 days nor more than 180 days prior to sterilization.

The only exception is in the case of premature delivery or emergency abdominal surgery. If the premature delivery or emergency abdominal surgery occurred before the 30-day waiting period is over, at least 72 hours must have passed between the time of obtaining informed consent and the sterilization procedure.

- In cases of premature delivery, informed consent must have been given at least 30 days before the expected delivery date. The consent form must indicate the expected date of delivery.
- In cases of abdominal surgery, the emergency nature of the surgery must be clearly identified (e.g., diagnosis, physician's statement, or hospital summary). The nature of the emergency must be included on the consent form.

13.5.A. INFORMED CONSENT PROCESS

The following procedures must be included in the process of informed consent:

- The beneficiary must be advised that the sterilization will not be performed for at least 30 days after the informed consent to sterilization is signed, except in cases of emergency abdominal surgery or premature delivery.
- The person who obtains informed consent must offer to answer any questions the beneficiary may have concerning the procedure.
- Suitable arrangements must be made to ensure that information is effectively communicated to the deaf, blind, or otherwise handicapped.

- An interpreter must be provided if the beneficiary does not understand the language used on the informed consent form or the language used by the person obtaining informed consent.
- The beneficiary is permitted to have a witness of his choice present when informed consent is obtained.
- At the time of the informed consent, a copy of the consent form must be given to the beneficiary.

All of the following sterilization information and advice must be presented orally to the beneficiary both at the time the beneficiary signs the informed consent form and again by the physician performing the sterilization shortly before the procedure (e.g., during the pre-operative examination):

- Advice that the beneficiary is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the beneficiary might be otherwise entitled.
- A description of available alternative methods of family planning and birth control.
- Advice that the sterilization procedure is considered to be irreversible.
- A thorough explanation of the specific sterilization procedure to be performed.
- A full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
- A full description of the benefits or advantages that may be expected as a result of the sterilization.

The beneficiary, the person who obtained the consent, and the interpreter (if required) must sign the informed consent form not less than 30 days nor more than 180 days prior to the sterilization. The physician performing the sterilization must also sign and date the informed consent form after the sterilization has been performed.

No additional reimbursement is allowed for the examination or the sterilization explanation.

If the procedure occurs in a place other than that in which the consent form is signed (e.g., forms were signed in the physician's office, but the procedure will be rendered in the hospital), the person obtaining consent must send a copy of the completed form to the place of surgery. The second provider (e.g., hospital) is responsible for acquiring the physician's statement (if not previously documented) and for photocopying the signed form and supplying copies to any other Medicaid provider who is billing as a participant in the sterilization.

A copy of the completed MSA-1959 is required for coverage of charges related to a sterilization procedure. This form may be faxed or attached to the claim form.

13.5.B. Consent Form for Sterilization

Providers may use the following option or continue to attach a copy of the MSA-1959 to the claim without going through this pre-approval process. The MSA-1959 form is available on the MDCH website.

To encourage paperless billing and reduce administrative burden, MDCH allows for submission of MSA-1959 forms via fax. Federal regulations require that this form be submitted to MDCH before reimbursement can be made for any sterilization procedure. This process can eliminate submitting paper attachments for sterilization claims, and pre-confirms the acceptability of the completed consent form.

13.5.C. Procedure for Consent Form for Sterilization Approval

- The provider who obtains the required Consent and completed MSA-1959 completes a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed consent form to the Medicaid Payments Division, Sterilization Consent Form Approval. (Refer to the Directory Appendix for contact information.) Do not fax invoices.
- The form is reviewed within five working days, and a notice of errors or acceptance is returned to the provider. When notified that the consent form has been accepted and is on file, inform the other providers via a copy of the response. All invoices related to the service may be submitted without attachments.
- Providers may then submit claims (either electronic or hard copy) to Medicaid. The remarks section or appropriate electronic segment must include the statement "Consent on File."
- When sterilization claims are received with this information in the remarks section, consent form edit requirements are forced if the submitted invoice matches the consent form on file.
- If there is no response within five working days:
  - Confirm that the fax is working.
  - Be sure that the cover sheet included the necessary information for Medicaid staff to respond to the provider.
  - Resend the information if necessary.

13.5.D. Reversal of Sterilization

Services to reverse a previous sterilization are not covered by Medicaid.

SECTION 14 - DURABLE MEDICAL EQUIPMENT/ORTHOTICS/PROSTHETICS

Refer to the Medical Supplier Chapter of this manual for additional information.

SECTION 15 - PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES

15.1 PSYCHIATRIC SERVICES

Medicaid covers psychiatric services for diagnostic or active treatment purposes. Psychiatric services are covered by the local PIHP/CMHSP for services included under the capitation payments to the PIHPs/CMHSPs, and a limited outpatient benefit is covered for beneficiaries enrolled in MHPs. Services to beneficiaries not included in the capitation payments to the PIHPs/CMHSPs and not enrolled in Medicaid Health Plans are covered through FFS Medicaid. FFS limits outpatient visit coverage to a maximum of ten psychiatric visits in 12 months. Under FFS, only those psychiatric services personally rendered by a physician (MD or DO) are covered. Those services performed by other staff (e.g., psychologists, social workers, NPs, physician's assistants) are not covered. (Refer to the MDCH Practitioner Medical Clinic Database for specific services that are covered.)

Services provided to beneficiaries enrolled in MHPs must be authorized by the individual MHP. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.)

(Refer to the Mental Health/Substance Abuse Chapter of this manual for services covered by the PIHPs/CMHSPs and authorization requirements.)

Psychological Testing	Medicaid covers psychological testing that is reasonable and necessary for diagnosing the beneficiary's mental or developmental status and strengths and needs. If a beneficiary requires psychological testing more than once per year, documentation of medical necessity must be maintained in the medical record. Psychological testing must be ordered by a physician (MD or DO) and must be performed by a psychologist who is fully licensed, limited-licensed, or temporary limited-licensed. This order must be kept in the beneficiary's clinical record. Supervision of limited-licensed and temporary limited-licensed psychologists must comply with the requirements of Michigan Public Act 368 of 1978, as amended. Psychological testing under FFS is only covered under the physician's provider ID number. The physician's provider ID number reported for coverage must be the ordering physician, the physician employing the psychologist, or a physician employed by the group which also employs the psychologist. The physician ordering psychological testing must examine the beneficiary. The physician employing the psychologist or employed by the same group that employs the psychologist does not need to examine the beneficiary in order to bill for the psychological testing unless that physician orders the psychological testing.
Inpatient Psychiatric Admissions	Inpatient stays in a psychiatric unit of a general hospital are covered for beneficiaries of any age. Inpatient treatment, including related psychiatric visits, in a freestanding psychiatric hospital, both private and state owned, is limited to eligible beneficiaries under age 21, and age 65 and older. If the beneficiary was an inpatient immediately prior to attaining age 21, he would be eligible to continue as an inpatient until age 22. If the beneficiary is discharged at some time following his 21st birthday, coverage terminates on the discharge date. All psychiatric admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Mental Health/Substance Abuse Chapter of this manual for specific coverages and authorization requirements.)

Psychiatric Partial Hospitalization	Psychiatric coverage includes partial hospitalization on a day-care or night-care plan for all beneficiaries, regardless of age. To be eligible for partial hospitalization, the beneficiary must be receiving active psychiatric treatment provided under the direction of a psychiatrist. All partial hospitalization admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Mental Health/Substance Abuse Chapter of this manual for specific coverages and authorization requirements.)

15.2 SUBSTANCE ABUSE SERVICES

Medicaid covers acute care detoxification in the inpatient hospital for FFS beneficiaries and through the MHPs for beneficiaries enrolled in Medicaid Health Plans.

Acute Care Detoxification	Admission to the acute care setting for a diagnosis of substance abuse must meet at least one of the following criteria as reflected in the physician's orders and patient care plans: ▪ Vital signs, extreme and unstable. Uncontrolled hypertension, extreme and unstable. ▪ Delirium tremens, (e.g., confusion, hallucinations, seizures) or a documented history of delirium tremens requiring treatment. ▪ Convulsions or multiple convulsions within the last 72 hours. ▪ Unconsciousness. ▪ Occurrence of substance abuse with pregnancy and monitoring the fetus is vital to the continued health of the fetus. ▪ Insulin dependent diabetes complicated by diabetic ketoacidosis. ▪ Suspected diagnosis of closed head injury based on trauma injury. ▪ Congestive heart disease or ischemic heart disease, or significant arrhythmia as examples of active symptomatic heart disease. ▪ Suicidal ideation and gestures necessitating suicidal precautions as part of treatment. ▪ Blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse. ▪ Blood alcohol level 400 mg/dl with diagnosis of alcohol dependence. ▪ Active presentation of psychotic symptoms reflecting an urgent condition.
Other Substance Abuse Services	Medicaid covers other substance abuse services provided to beneficiaries. These services are covered under capitation payments to the PIHPs/CMHSPs. (Refer to the Mental Health/Substance Abuse Chapter of this manual for coverage details and authorization requirements.)

SECTION 16 - PRIVATE DUTY NURSING

Refer to the Private Duty Nursing Chapter of this manual for additional information.

SECTION 17 - OCCUPATIONAL THERAPY

Medicaid covers medically necessary occupational therapy (OT) services that meet the requirements of this section. Evaluations must be ordered and a physician must prescribe therapy.

17.1 PRESCRIPTION REQUIREMENTS

For Medicaid or CSHCS coverage of OT, a physician's prescription must include:

- Name of the beneficiary;
- Therapy prescribed; and
- Diagnosis(es) or medical condition(s).

If therapy is not initiated within 30 days after the prescription date, a new prescription is required.

17.2 COVERAGE CONDITIONS

Services are covered as OT when provided by:

- An occupational therapist currently registered in Michigan (OTR).
- A certified occupational therapy assistant (COTA) under the supervision of an OTR (i.e., the COTA's services must follow the evaluation and treatment plan developed by the OTR and the OTR must supervise and monitor the COTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the appropriately registered supervising OTR.
- A student completing his clinical affiliation under the direct supervision of an OTR. All documentation must be reviewed and signed by the appropriately registered supervising OTR.

For CSHCS beneficiaries	OT must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the physician who is overseeing the care of the beneficiary. Functional progress must be demonstrated and documented.
For beneficiaries 21 years of age and older	OT is covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations, or participation restrictions.
For beneficiaries under age 21	OT must be medically necessary, reasonable, and required to: ▪ Return the beneficiary to the functional level prior to illness or disability; ▪ Return the beneficiary to a functional level that is appropriate to a stable medical status; and ▪ Prevent a reduction in medical or functional status had the therapy not been provided.

Therapy must require the skills, knowledge, and education of an OT. Interventions that could be expected to be provided by another practitioner (e.g., teacher, registered nurse, licensed physical therapist), family member, or caregiver are not covered as occupational therapy.

OT services may be covered for one or more of the following reasons:

- Therapeutic use of occupations;
- Adaptation of environments and processes to enhance functional performance in occupations;
- Graded tasks (performance components) in activities as prerequisites to engagement in occupations;
- Design, fabrication, application, or training in the use of assisted technology or orthotic devices; or
- Skilled services that are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers.

Occupational evaluations and therapy are covered when provided by a Medicaid-enrolled home health agency (HHA) in the home setting when:

- There is a need for adaptation of procedures, equipment, appliance, or prosthesis in the home setting identified by the OT;
- Services will prevent undue exposure to infection and stress for the beneficiary, as identified by the physician or treating nurse;
- The OTR, physician, or treating nurse documents problems with access to an outpatient facility, or coordination or continuity of services;
- Therapy must be initiated within 30 days of the prescription date. A new prescription is required if therapy is not initiated within 30 days of the original prescription; or
- OT may be provided up to a maximum of 24 times within the first 60 consecutive calendar days in the home setting without prior approval.

Some areas of therapy (e.g., dysphagia, assistive technology, hand therapy) may appropriately be addressed by more than one discipline (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. Duplication of service (i.e., where two disciplines are working on similar areas/goals) is not covered. It is the OTR's responsibility to communicate with other therapists and coordinate services. Documentation should include a report of this coordination.

School-aged beneficiaries may be eligible to receive OT through multiple sources. Educational OT is provided by the school system and is not covered by Medicaid. Educational OT includes coordination for handwriting, increasing attention span, identifying colors and numbers.

Evaluations	Evaluations are covered for the same medical diagnosis twice per year with a physician's order. If an evaluation is needed more frequently, prior approval is required. The occupational therapy evaluation must be completed by an OTR and must include: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis (e.g., medical diagnosis of cerebral palsy with contractures being treated). ▪ OT provided previously, including facility/site, dates, duration, and summary of change. ▪ Current therapy being provided to the beneficiary in this or other settings. ▪ Medical history as it relates to the current course of therapy. ▪ The beneficiary's current functional status (functional baseline). ▪ The standardized and other evaluation tools used to establish the baseline and to document progress. ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function. ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension).
Treatment Plan	The treatment plan consists of: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's life goals. ▪ Long-term goals that identify specific functional maximum reasonable achievement which serve as indicators for discharge from therapy. ▪ Anticipated frequency and duration of treatment required to meet short-term and long-term goals. ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational). ▪ Signature of physician verifying acceptance of the treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring physician.
Initiation of Services	Therapy may be initiated upon completion of the assessment and development of a treatment plan that is reasonable and medically necessary as documented in the beneficiary's record. For the initial 60-day treatment period, up to 24 OT services may be provided in the home setting. For the outpatient hospital setting, up to 36 OT services may be provided in the initial 90-day treatment period.

Requirements for Continued Active Therapy	To request PA to continue therapy beyond the initial 60 or 90 days, the OTR must complete an Occupational/Physical Therapy - Speech Pathology Prior Approval - Request/Authorization (MSA-115). The OTR may request up to 90 consecutive calendar days of continued active therapy in the outpatient hospital setting or up to 60 consecutive calendar days in the home setting. Requests to continue active therapy must be accompanied by: ▪ A treatment summary of the previous period of OT, including measurable progress on each short-term and long-term goal. This should include the treating OT's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. ▪ A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy. ▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ A copy of the prescription must be provided with each request. The prescription must be hand-signed by the referring physician and dated within 30 days prior to initiation of the continued service. ▪ A discharge plan. Requests for PA may be mailed or faxed to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.) After processing, MDCH returns a copy of the PA. This copy should be retained in the beneficiary's medical record.
Maintenance/Monitoring Services	In some cases, the beneficiary does not require active treatment, but the skills of an OTR are required for training or monitoring of maintenance programs that are being carried out by family and/or caregivers or continued follow-up for the fit and function of orthotic or prosthetic devices. PA is not required for these types of services for up to four times per 60-day period in the home or 90-day period in the outpatient hospital settings. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required. PA requests for continued maintenance/monitoring may ask approval for up to 90 consecutive calendar days in the outpatient setting and up to 60 consecutive calendar days in the home setting. The OT must complete an MSA-115 which must include:

	▪ A service summary, including a description of the skilled services being provided. This should include the treating OT's analysis of the rate of progress and justification for any change in the treatment plan. Documentation must relate to the period immediately prior to that time period for which prior approval is being requested. ▪ A comprehensive description or copy of the maintenance/activity plan. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ The anticipated frequency and duration of continued maintenance/monitoring. ▪ A discharge plan. Requests for PA may be mailed or faxed to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.) The copy of the MSA-115 returned to the provider should be retained in the beneficiary's medical record.

17.3 DISCHARGE SUMMARY

When the beneficiary is discharged from therapy services, a discharge summary must be on file with the OTR for identifying completion of services and status at discharge. The discharge summary includes:

- Dates of service (i.e., initial and discharge dates).
- Description of services provided.
- Functional status related to treatment areas/goals at discharge.
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status.
- Description or copy of follow-up or maintenance program put into place, if appropriate.
- Identification of orthotic/prosthetic and adaptive equipment provided (e.g., hand splint) and its current utilization, if appropriate.
- Recommendations/referral to other services, if appropriate.

SECTION 18 - PHYSICAL THERAPY

Medicaid covers medically necessary physical therapy (PT) services that meet the requirements of this section. A physician must order the evaluations and prescribe the therapy.

18.1 PRESCRIPTION REQUIREMENTS

For Medicaid or CSHCS coverage, a physician's prescription must include:

- Name of the beneficiary;
- Therapy prescribed; and
- Diagnosis(es) or medical condition(s).

If the therapy is not initiated within 30 days after the prescription date, a new prescription is required.

PT is covered in the following settings:

- Physician's office (provided by or under the direct supervision of the physician);
- Home (provided by a HHA); and
- Outpatient hospital.

18.2 COVERAGE CONDITIONS

Services are covered as PT when provided by:

- A Michigan-licensed physical therapist (LPT).
- A certified physical therapy aide (CPTA) under the supervision of an LPT. The LPT supervises and monitors the CPTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the appropriately licensed supervising LPT.
- A physician or under the physician's direct supervision, when provided in the physician's office.

For CSHCS beneficiaries	PT must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the physician who is overseeing the care of the beneficiary. Functional progress must be demonstrated and documented.
For beneficiaries 21 years of age and older	PT is covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations, or participation restrictions.
For beneficiaries under age 21	PT must be medically necessary, reasonable, and necessary to: ▪ Return the beneficiary to the functional level prior to illness or disability; or ▪ Return the beneficiary to a functional level that is appropriate to a stable medical status within a reasonable amount of time.

PT requires the skills, knowledge, and education of an LPT. Interventions that could be expected to be provided by another practitioner (e.g., teacher, registered nurse, registered occupational therapist), family member, or caregiver are not covered as PT.

Therapy services are covered for one or more of the following reasons:

- Therapy can be expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills.
- The service is diagnostic.
- Therapy is for a condition that is temporary in nature and creates decreased mobility.
- Skilled services are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers. Routine provision of the maintenance/prevention program is not reimbursable as therapy.

PT evaluations and therapy are covered when provided by a Medicaid-enrolled HHA in the home setting when:

- Services will prevent undue exposure to infection and stress for the beneficiary, as identified by the physician or treating nurse.
- Documented problems of access to an outpatient facility, coordination of services, or continuity of services, as identified by an LPT, physician, or treating nurse.
- PT does not require concurrent skilled nursing care but must be provided through a Medicaid-enrolled HHA.

If therapy is not initiated within 30 days after the prescription date, a new prescription is required.

PT may be provided up to a maximum of 24 times within the first 60 consecutive calendar days in the home setting without prior approval.

Some areas of therapy (e.g., dysphagia, assistive technology, hand therapy) may appropriately be addressed by more than one discipline (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. Duplication of service (i.e., where two disciplines are working on similar areas/goals) is not covered. It is the LPT's responsibility to communicate with other therapists and coordinate services. Documentation should include a report of this coordination.

School-aged beneficiaries may be eligible to receive PT through multiple sources. Educational physical therapy is provided by the school system and is not covered by Medicaid. Examples of educational PT include strengthening to play school sports, etc.

Evaluations	Evaluations are covered for the same medical diagnosis twice per year with a physician's order. If an evaluation is needed more frequently, PA is required. The PT evaluation must be completed by an LPT. It must include: ▪ The treatment diagnosis and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with gait being treated).

	▪ PT provided previously, including facility/site, dates, duration, and summary of change. ▪ Current therapy being provided to the beneficiary in this or other settings. ▪ Medical history as it relates to the current course of therapy. ▪ The beneficiary's current functional status (i.e., functional baseline). ▪ The standardized and other evaluation tools used to establish the baseline and to document progress. ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function. ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension).
Treatment Plan	The PT treatment plan consists of: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function and/or mobility. ▪ Long-term goals that identify specific functional maximum reasonable achievement which serve as indicators for discharge from therapy. ▪ Anticipated frequency and duration of treatment required to meet short-term and long-term goals. ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational). ▪ Signature of physician verifying acceptance of the treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring physician.
Initiation of Services	Therapy may be initiated upon completion of an evaluation and development of a treatment plan that is reasonable and medically necessary as documented in the beneficiary's medical record. PT may be provided up to a maximum of 24 times in the initial 60-day period in the home setting, or up to 36 times in the initial 90-day period in the outpatient hospital setting, or up to 20 times during a 75-day time period in the physician's office.
Requirements for Continued Active Therapy	To request approval to continue therapy beyond the initial 60 or 90 days, the LPT must complete an Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization (MSA-115). The LPT may request up to 90 consecutive calendar days of continued active therapy in the outpatient hospital setting or up to 60 consecutive calendar days in the home setting. PA is not required for continuation of physical therapy provided in the physician's office. Requests for PA may be mailed or faxed to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

	After processing, MDCH returns a copy of the PA. This copy should be retained in the beneficiary's medical record. Requests to continue active therapy must be accompanied by: ▪ A treatment summary of the previous period of PT, including measurable progress on each short-term and long-term goal. This should include the treating LPT's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. ▪ A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy. ▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ A copy of the prescription, hand-signed by the referring physician and dated within 30 days prior to initiation of continued service (must be provided for each request). ▪ A discharge plan.
Maintenance/ Monitoring Services	In some cases, the beneficiary does not require active treatment, but the skills of an LPT are required for training or monitoring of maintenance programs that are being carried out by family and/or caregivers. PA is not required for these types of services for up to four times per 60-day period in the home setting or 90 days in the outpatient hospital setting. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required. Requests for PA may be mailed or faxed to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.) PA requests for continued maintenance/monitoring may ask approval for up to 90 consecutive calendar days in the outpatient setting and up to 60 consecutive calendar days in the home setting. The LPT must complete an MSA-115, which must include: ▪ A service summary, including a description of the skilled services currently being provided. This should include the treating LPT's analysis of the rate of progress and justification for any change in the treatment plan. ▪ A comprehensive description or copy of the maintenance/activity plan. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ A discharge plan. The copy of the MSA-115 returned to the provider should be retained in the beneficiary's medical record

18.3 Discharge Summary

When the beneficiary is discharged from PT, a discharge summary must be on file with the LPT for identifying the completion of services and the status at discharge. The discharge summary includes:

- Dates of service (i.e., initial and discharge dates).
- Description of services provided.
- Functional status related to treatment areas/goals at discharge.
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status.
- Description or copy of follow-up or maintenance program put into place, if appropriate.
- Identification of adaptive equipment provided (e.g., walker) and its current utilization, if appropriate.
- Recommendations/referral to other services, if appropriate.

SECTION 19 - SPEECH AND LANGUAGE THERAPY

Medicaid covers medically necessary speech and language therapy services that meet the requirements of this section. A physician must order the evaluations and prescribe the therapy.

19.1 PRESCRIPTION REQUIREMENTS

For Medicaid or CSHCS coverage, a prescription for therapy must include:

- Name of the beneficiary;
- Therapy prescribed; and
- Diagnosis(es) or medical condition(s).

If therapy is not initiated within 30 days of the prescription date, a new prescription is required.

Speech therapy may be provided in the following settings:

- Hearing and speech center;
- Home (only for CSHCS beneficiaries) when provided by a HHA (see exceptions below); and
- Outpatient hospital.

19.2 COVERAGE CONDITIONS

Services are covered as speech-language therapy when provided by:

- A speech-language pathologist (SLP) possessing a current Certificate of Clinical Competence (CCC) or Letter of Equivalency.
- An appropriately supervised SLP candidate (i.e., in his clinical fellowship year [CFY] or having completed all requirements but has not obtained a CCC or Letter of Equivalency). All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.
- A student completing his clinical affiliation under the direct supervision of an SLP having a current CCC or Letter of Equivalency. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

Exceptions: Speech evaluations and therapy are covered in the home setting for CSHCS beneficiaries when:

- There is a need for adaptation of procedures or equipment in the home setting as identified by an SLP.
- Services will prevent undue exposure to infection and stress for a child at risk, as identified by the physician or treating nurse.
- Documented problems of access to an outpatient hospital, coordination of services, or continuity of service is identified by an SLP, OTR, LPT, physician, or treating nurse.

- PA is obtained (this includes therapy for the initial 60 consecutive calendar days, continued active treatment, and maintenance/monitoring services).
- Speech-language evaluations and therapy services do not require concurrent skilled nursing care; however, treatment always requires PA and must be provided through a Medicaid-enrolled HHA.
- Therapy may be requested for up to 60 consecutive calendar days in the home setting.

For CSHCS beneficiaries who are not enrolled in Medicaid: Speech therapy must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the physician who is overseeing the care of the beneficiary.

For Medicaid beneficiaries who are not enrolled with CSHCS and who are under 21 years of age: Speech therapy must be obtained from a Medicaid enrolled hearing and speech center.

For Medicaid beneficiaries 21 years of age and older: Speech therapy may be provided by an outpatient hospital or a hearing and speech center.

For all beneficiaries: Speech therapy must relate to a medical diagnosis. Coverage is limited to services for:

- Articulation
- Language
- Rhythm
- Swallowing
- Training in the use of an augmentative communication device
- Training in the use of an oral-pharyngeal prosthesis
- Voice

For Medicaid beneficiaries who are receiving specialty mental health services through a PIHP/CMHSP, palliative therapy may be provided through the PIHP/CMHSP.

Therapy must be reasonable, medically necessary, and expected to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy would be when the treatment is required due to a recent change in the beneficiary's medical or functional status affecting speech and the beneficiary would experience a reduction in medical or functional status were the therapy not provided.

Speech therapy services must require the skills, knowledge, and education of a certified speech-language pathologist to assess the beneficiary for deficits, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], registered occupational therapist [OTR]), family member, or caregiver are not covered as speech therapy.)

Some areas of service (e.g., dysphagia, assistive technology) may appropriately be addressed by more than one discipline (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. Duplication of service (i.e., where two disciplines are working on similar areas/goals) is not covered. It is the treating therapist's responsibility to communicate with other practitioners and coordinate services. Documentation should include a report of this coordination.

School-aged beneficiaries may be eligible to receive speech-language therapy through multiple sources. Educational speech is provided by the school system, and is not covered by Medicaid or CSHCS. Examples of educational speech include enhancing vocabulary, improving sentence structure, improving reading, increasing attention span, identifying colors and numbers.

Evaluations	Are covered for the same diagnosis twice per year with a physician's prescription. If an evaluation is needed more frequently, PA is required. The speech-language evaluation must be completed by an SLP and must include: ▪ The disorder and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with dysphagia as the speech disorder being treated). ▪ Speech therapy provided previously, including facility/site, dates, duration, and summary of measurable change. ▪ Current rehabilitation services being provided to the beneficiary in this or other settings. ▪ Medical history as it relates to the current course of therapy. ▪ The beneficiary's current functional communication status (functional baseline). ▪ The standardized and other evaluation tools used to establish the baseline and to document progress. ▪ Assessment of the beneficiary's functional communication skill level, which must be measurable. ▪ Medical, physical, intellectual deficits that could interfere with the beneficiary's improvement in therapy. Evaluations may include, but are not limited to: ▪ Articulation - standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication, and a medical diagnosis. ▪ Language - standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es). ▪ Rhythm - standardized tests that measure receptive and expressive language, mental age, oral motor skills, measurable assessment of dysfluency, current means of communication, and a medical diagnosis.

	▪ Swallowing - copy of the videofluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment, and a standardized cognitive assessment. ▪ Voice - copy of the physician's medical assessment of the beneficiary's voice mechanism and the medical diagnosis.
Treatment Plan	The speech-language therapy treatment plan consists of: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's communication needs. ▪ Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from speech-language therapy services. ▪ Anticipated frequency and duration of treatment required to meet short-term and long-term goals. ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational). ▪ Signature of physician verifying acceptance of stated treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring physician.
Initiation of Services	Therapy may be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without prior approval. For this initial period, speech therapy may be provided up to a maximum of 36 times during the 90 consecutive calendar days in the hearing and speech center or outpatient hospital. Speech therapy may be provided up to a maximum of 24 times during the 60 consecutive calendar days in the home.
Requirements for Continued Active Therapy for All Settings	To request approval to continue therapy beyond the initial 60 or 90 days (as applicable), the SLP must complete a PA request (the applicable form depending upon the setting). ▪ Special Services Prior Approval - Request/Authorization (MSA-1653-B) must be used for the hearing and speech center setting. ▪ Occupational/Physical Therapy - Speech Pathology Prior Approval - Request/Authorization (MSA-115) must be used for the outpatient hospital setting and services requested through a HHA for CSHCS. The SLP may request up to 90 consecutive calendar days of continued active therapy in the hearing and speech center or outpatient hospital settings or up to 60 consecutive calendar days for the CSHCS beneficiary receiving therapy in the home setting.

	Requests for PA may be mailed or faxed to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.) After processing, MDCH returns a copy of the PA. This copy should be retained in the beneficiary's medical record. Requests to continue active treatment must be accompanied by: ▪ A treatment summary of the previous period of service, including measurable progress on each short-term and long-term goal. This should include the treating SLP's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes. ▪ A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy. ▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ The anticipated frequency and duration of maintenance/monitoring. ▪ A discharge plan. ▪ A copy of the prescription, hand-signed by the referring physician and dated within 30 days prior to initiation of continued service (must be provided for each request).
Maintenance / Monitoring Services	In some cases, the beneficiary does not require active treatment, but the skills of an SLP are required for training or monitoring of maintenance programs that are being carried out by family and/or caregivers. In the outpatient hospital or hearing and speech center, these types of service may be provided without prior approval for up to four times per 90-day period. For the home setting, these types of services require prior approval for a 60-day period. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required. Requests for PA may be mailed or faxed to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.) After processing, MDCH returns a copy of the prior approval. This copy should be retained in the beneficiary's medical record. Continued maintenance/monitoring requires prior approval in all settings. The SLP must complete the prior approval request which must include: ▪ A service summary, including a description of the current skilled services being provided. This should include the treating SLP's analysis of the rate of progress and justification for any change in treatment plan. It can cover up to three months. ▪ A comprehensive description or copy of the maintenance/activity plan.

	▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ The anticipated frequency and duration of continued maintenance/monitoring. ▪ A discharge plan.

19.3 DISCHARGE SUMMARY

When the beneficiary is discharged from therapy services, it is requested that a discharge summary be on file with the SLP as a mechanism for identifying completion of services and status at discharge. The discharge summary should include:

- Dates of service (i.e., initial and discharge dates).
- Description of services provided.
- Functional status related to treatment areas/goals at discharge.
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status.
- Description or copy of follow-up or maintenance program put into place, if appropriate.
- Identification of adaptive equipment provided and its current utilization, if appropriate.
- Recommendations/referral to other services, if appropriate.

SECTION 20 - CERTIFIED REGISTERED NURSE ANESTHETIST

Medicaid covers anesthesia services provided by a Medicaid enrolled Certified Registered Nurse Anesthetist (CRNA). CRNA services are covered for the CRNA or for the entity with which the CRNA has an employment or contract relationship that provides for payment to be made to the entity. CRNAs must comply with Michigan scope of practice licensing laws and regulations.

If a rural hospital elects reasonable cost reimbursement for CRNA services under Medicare, the CRNA costs are included in the facility payments to the hospital and are not covered separately by Medicaid.

For specific coverage parameters, refer to the Anesthesia Services Section of this chapter.

To enroll as a Medicaid provider, a CRNA must be currently licensed in Michigan as a nurse and certified by the State as a CRNA. Provider enrollment forms are available from the Medicaid Payments Division, Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

SECTION 21 - PHYSICIAN'S ASSISTANT

Medicaid covers services provided by a physician's assistant provided under the delegation and supervision of a physician licensed under part 170 or part 175 of Michigan Public Act 368 of 1978, as amended. The supervising physician must comply with the physician delegation and supervision requirements for utilizing physician's assistants specified in Public Act 368 of 1978, as amended, and any related rules promulgated by the State of Michigan or its Departments.

The physician's assistant may provide direct patient care under the delegation and supervision of a physician at the medical care site where the physician regularly sees patients. Records must demonstrate that the physician's assistant provided the services and that the licensed physician is regularly available and provides medical care to beneficiaries at the site on a routine basis. When the supervising physician is not physically present on the premises, he must be continuously available to the physician's assistant through direct communication such as telephone, radio, or telecommunication. This does not preclude licensed persons under the physician's delegation and supervision from making calls or going on rounds to private homes, public institutions, hospitals, or other health care facilities, as long as the care is a supplement to, and does not replace, the physician's personal services.

(Refer to the Surgery – General Section of this chapter for information on a physician's assistant functioning as an assistant at surgery.)

Medicaid only covers services performed by a physician's assistant under the delegating/supervising physician's provider identification number. The supervising physician is responsible for the services performed by the physician's assistant.

SECTION 22 – PODIATRIST

Medicaid covers the medically necessary services of a podiatrist. (Refer to the MDCH Practitioner Medical Clinic Database on the MDCH website for specific covered services.)

Podiatrists should refer to the appropriate sections of this chapter for specific information related to the coverage of specific services.

22.1 CO-PAYMENT

A $2.00 co-payment is required for each separately covered visit for beneficiaries age 21 and older who are not residents in a nursing facility or are not receiving services covered by Medicare. If more than one separately covered service is rendered on the same day, such as an office visit and laboratory services, only one co-payment is required. If a procedure such as a surgery with a global period is rendered, only one co-payment is required.

22.2 CONSULTATIONS

Medicaid covers limited and intermediate level consultations if requested by a physician.

SECTION 23 - PHYSICAL THERAPIST

Medicaid only covers Medicare coinsurance and deductible amounts for services provided by enrolled physical therapists. A physician must order physical therapy services.

To qualify for coverage, services must be provided in the physical therapist's office. Services provided in the physician's office are covered under the physician, and services provided in a nursing facility setting are covered under the long term care provider. A licensed physical therapist (LPT) or a physical therapy assistant under the direct supervision of the physical therapist must provide services.

SECTION 24 - CERTIFIED NURSE MIDWIFE

Medicaid covers services provided by enrolled certified nurse midwives (CNMs). (Specific procedures covered for CNMs are listed in the Certified Nurse Midwife Database available on the MDCH website.)

CNM coverage includes the management of low risk and uncomplicated pregnancies and services to essentially normal women and newborns. Medically complicated pregnancies and services to beneficiaries with high-risk conditions MUST be referred to a physician. Services provided to high-risk women and women with medical complications are only covered under the delegation and supervision of a physician.

24.1 ENROLLMENT

The CNM must enroll with Medicaid by submitting a Medical Assistance Provider Enrollment & Trading Partner Agreement (DCH-1625) and a copy of their license. A CNM must be able to demonstrate a safe mechanism for physician consultation, collaboration, and referral within an alliance agreement that includes mutually approved protocols.

24.2 FAMILY PLANNING

Medicaid covers family planning services provided by CNMs. (Refer to the Family Planning portion of the General Practice Section of this chapter for specific coverage information.) A CNM can only prescribe oral contraceptives under the delegation of a physician.

24.3 GYNECOLOGIC CARE

Medicaid covers gynecologic care provided by CNMs. CNMs may receive direct reimbursement for these services when completed within the CNM scope of practice guidelines.

24.4 LABORATORY TESTS

Laboratory testing ordered by the CNM is covered and must be documented in the beneficiary's medical record by the ordering CNM regardless of where the tests are performed.

The following laboratory tests can be ordered by a CNM:

- Acetone and diacetic acid (ketone bodies), both qualitative and semi-quantitative
- Albumin, qualitative, semi-quantitative, and quantitative
- Antibody titer Rh system
- Blood typing, ABO, Rh(D), RBC antibody screening
- Blood count, RBC, WBC, hemoglobin, hematocrit, indices (MCV, MCH, MCHC)
- Culture, presumptive screening, for Neisseria, Gonorrhea, Candida, Hemophilus, or beta hemolytic Streptococci group A, etc.
- Culture, urine, definitive, with or without colony count
- Cytopathology, vaginal and/or cervical smears

- Glucose, qualitative, quantitative, timed specimen, tolerance
- Hemoglobin, electrophoretic separation, qualitative
- Hepatitis B test
- HIV detection
- Pregnancy test
- Quantitative sediment analysis and quantitative protein, 12- or 24-hour urine specimen
- Reticulocyte count, manual
- Routine prenatal laboratory services (OB profile)
- Rubella test, titer
- Syphilis test (VDRL, RPR, etc.), qualitative
- Sickle cell slide test
- TB skin test, tine
- Susceptibility (sensitivity) for aerobes
- Treponema antibodies, fluorescent, absorbed
- Complete urinalysis
- Wet mount, smear, tissue, direct microscopic examination

The following laboratory tests are covered when performed by the CNM:

- Complete urinalysis
- Direct microscopic examination of a smear, wet mount, and/or tissue for fungi
- Hematocrit
- Hemoglobin
- Pregnancy testing

These tests are not covered for the CNM if rendered by an outside laboratory.

24.5 Maternity Care

Medicaid covers antepartum care, delivery, and postpartum care rendered by a CNM when provided in compliance with the specific coverage policies of this chapter.

Antepartum Care	Coverage for antepartum care includes all usual antepartum services provided prior to delivery and referral to MIHP given the presence of psychosocial or nutritional factors that could adversely affect the pregnancy.

	If the provider initiated prenatal care within the first six months of pregnancy through the month of delivery, the appropriate antepartum care CPT code is covered. If the beneficiary is seen by several CNMs within a group or multiple CNMs supervised by the same physician or physician group, the antepartum care package is covered. (Refer to the Maternity Care and Delivery Services Section of this chapter for details on coverage of antepartum care and when individual E/M services are covered.) Enhanced coverage is available for CNM prenatal care services to women under 17 years of age or to women 35 years of age or older with their first pregnancy if these women are not medically at risk. (Refer to the Maternity Care and Delivery Services Section of this chapter for specific coverage information.) Enhanced coverage is also available for women with psychosocial or nutritional problems when confirmed by an enrolled MSS provider. CNMs may perform and bill Medicaid for non-stress tests when this service is determined medically necessary and is part of routine care provided for uncomplicated pregnancies. CNMs may receive direct reimbursement for this service when completed within the CNM scope of practice guidelines.
Delivery	Deliveries performed by a CNM are covered in a licensed setting only. Home deliveries and services associated with these deliveries are not covered. Coverage of the delivery includes monitoring, vaginal delivery, and resuscitation of the newborn infant when necessary.
Post-partum Care	Medicaid covers post-partum office visits following the delivery. Routine post-partum hospital care for the mother is covered as a part of the delivery. Routine care of the newborn in the hospital is covered for the provider who examines and provides the total hospital care of the newborn regardless of whether he performed the delivery. (Refer to the Services to Newborns sub-section in this chapter for additional coverage information.)

24.6 Office Visits

Visits not directly related to the antepartum care or follow up to a delivery, such as family planning visits, are covered under the appropriate office visit procedure code. (Refer to the Certified Nurse Midwife Database on the MDCH website for a listing of office visit codes covered for CNMs.) (Refer to the Evaluation and Management (E/M) Services Section of this chapter for specific coverage information related to office visits.)

24.7 Pharmacy

Pharmaceuticals can only be ordered by a CNM under the delegation of a physician. The pharmaceutical must be provided by an enrolled pharmacy or, if appropriate, by an enrolled Family Planning Clinic (FPC).

SECTION 25 - NURSE PRACTITIONER

Medicaid covers the services of a nurse practitioner (NP) when provided pursuant to a current collaborative practice agreement with a physician. Evidence of consultation, as needed, between the NP and the physician is documented. Medicaid covers NP services only if the services would be covered if furnished by a physician, the services are not otherwise excluded from coverage, and the NP is legally authorized to perform the services under state law.

The services are subject to the limitations that apply to physician services. Certain services, such as long term care facility visits, consultations, and initial hospital care, may be restricted to physicians by program policy or federal and state statutes and are not covered for NPs. Professional services are only covered when the NP has personally performed the services.

Determination of the medical necessity and appropriateness of services is the responsibility of the NP/physician based on the terms of the agreement.

Services provided by NPs while a hospital employee are included in the hospital's charges and are not covered separately for the individual NP. Services that are covered for other enrolled providers, such as a home health agency, a long term care facility, a Family Planning Clinic (FPC), etc., are not separately covered for the NP. Services provided jointly by a NP and the supervising physician are covered for only one practitioner. Some services are only covered by Medicaid under the physician's ID number. (Refer to the appropriate section of this chapter for more information regarding specific services.)

NPs are not required to enroll in Medicaid. They may provide services to Medicaid beneficiaries under the employing physician's ID number.

Once enrolled, the NP may submit bills to MDCH directly if the beneficiary is in FFS Medicaid. For beneficiaries enrolled in a MHP, the NP must negotiate provider terms and payment arrangements with each individual MHP.

25.1 ENROLLMENT OF NURSE PRACTITIONER

In order for the NP to enroll, he must comply with all of the following:

- Meet state qualifications for nurse practitioners.
- Have an ambulatory based practice.
- Provide services according to the terms of a written collaborative practice agreement in place with a physician.
- Complete the appropriate enrollment forms and a Nurse Practitioner/Physician Agreement (DCH-1575).
- Attest to the type of nurse practice engaged in, such as pediatric, family, geriatric, adult, etc.
- If engaged in family or pediatric nurse practice, continue to provide proof of certification as a family nurse practitioner or a pediatric nurse practitioner by the appropriate accepted national credentialing body. (Refer to Michigan Rule 338.10404 [3].)

25.2 Collaborative Practice Agreement

This is a formal document under which the NP and the physician deliver covered medical services. It is mutually developed or approved as satisfactory to both professionals involved and describes the kinds of services to be provided and any criteria for referral and consultation. This agreement must be available to MDCH upon request. Services must be delivered within each practitioner's scope of practice as allowed by federal regulations and state law. Services provided by the NP under the physician's delegation and supervision are also included.

The collaborative practice agreement must be reviewed at least annually and updated as necessary. The NP must notify MDCH if the agreement is dissolved so the NP's enrollment with Medicaid can be terminated. Medicaid only covers NP services provided within the provisions of the agreement.

PRACTITIONER REIMBURSEMENT APPENDIX

SECTION 1 – REIMBURSEMENT METHODOLOGY

1.1 PRACTITIONER FEE SCREENS

Practitioner payment rates are established by the MDCH as a fee screen for each procedure. The Medicare prevailing fees, the Resource Based Relative Value Scale (RBRVS) and other relative value information, other state Medicaid fee screens, and providers' charges may be utilized as guidelines or references in determining the maximum fee screens for individual procedures. Fee screens are generally updated April 1 of each year. Subsequent quarterly adjustments are made as necessary. Fee screens and coverage parameters are published on the MDCH website. (Refer to the Directory Appendix for website information.)

1.2 EMERGENCY DEPARTMENT SERVICES

Physician services provided in the ED are covered as individual services. Critical care services are covered according to the CPT/HCPCS definitions and coding conventions for critical care. If critical care is required for a beneficiary in the ED, then only the critical care codes are covered. ED E/M or visit codes are not covered on the same day as critical care for the same provider.

When a beneficiary is seen in the ED, the appropriate level of ED E/M service is covered unless another E/M service is more appropriate (e.g., observation care, initial inpatient hospital care, or critical care). The ED E/M service which includes the medical screening exam is covered without regard to whether the medical screening results in the medical condition being deemed an emergency or not. The results of the medical screening examination, along with any medically necessary appropriate diagnostic services, determine if further treatment must be provided. If the attending physician determines that an emergency medical condition does exist, all subsequent medically appropriate services to stabilize the patient must be provided and are covered in addition to the ED E/M service. CPT/HCPCS coding conventions and Medicaid guidelines must be followed.

The medical record must support the need for the type and extent of diagnostic services performed based on the presenting symptoms of the beneficiary. The ED physician's review of x-rays and EKGs performed on the beneficiary are covered as a part of the E/M service. Professional component services are covered only for the physician who prepares a complete, written report of the findings for the medical record. If a specialist in the field prepares this, then the ED physician's review of the findings does not meet the conditions for separate coverage of the service.

The ED E/M services provided by the attending physician, regardless of the level of the service, are covered using a two-tiered rate based on whether the beneficiary was released or admitted. If the beneficiary was released from the ED, a single rate is used as the fee screen. If the beneficiary was admitted to the hospital or transferred to another hospital from the ED, a higher single rate is used as the fee screen.

Additional services will continue to be covered separately. Annually, when these physician rates are re-based using the current RVUs (relative value units), historic utilization, and funds appropriated by the Legislature, the ED E/M fee screens are adjusted accordingly.

Counties that administer their own Adult Benefits Waiver (indigent care) program may have different coverage policies for physician ED services. Physicians rendering care to these beneficiaries must contact the entity administering the ABW County Health Plan for information on their coverage policies and rates.

1.3 INJECTABLES

Fee screens for the cost of the drug are established using Medicare applicable payment limits.

SECTION 2 – ENHANCED PRACTITIONER PAYMENTS

The MDCH makes payment adjustments for practitioner services payable under Medicaid Fee-For-Service (FFS) through the following four public entities:

- University of Michigan Health System
- Wayne State University
- Hurley Hospital
- Michigan State University

Adjustments are applied to the reimbursement for practitioner services for dates of service on or after March 1, 2004. Payment adjustments **do not apply** to services for which reimbursement is the responsibility of Medicaid Managed Care Organizations (MMCOs). This includes Medicaid Health Plans (MHPs) and Prepaid Inpatient Health Plans (PIHPs).

Adjustments apply to both public and private practitioners and practitioner groups that are either employees of one or more of the above public entities, or are under contract with one or more of the above public entities and include the following:

- University medical and dental faculty, employed practitioners, and private practice groups with contractual arrangements with one or more of the above universities and provide services to Medicaid beneficiaries in a variety of settings.
- Hurley Hospital employed or contracted physicians, dentists, and other practitioners who provide services to Medicaid beneficiaries in a variety of settings.

Services eligible for the payment adjustments are billed under the federal employer number of the public entity or under the employer identification number of the practitioner/practitioner group.

Inpatient and outpatient services provided by the following practitioners, when **not** included in facility payments to the public entity, are included:

- Physicians (MD and DO)
- Ophthalmologists
- Oral Surgeons
- Dentists
- Podiatrists
- Physician Assistants
- Nurse Practitioners
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Optometrists

The payment adjustment amount for services provided to Medicaid beneficiaries who do not have other insurance coverage will be the lesser of:

- The difference between the practitioner Medicaid fee-for-service fee screen and the allowed amount established by Medicare; OR,
- The difference between the practitioner Medicaid fee-for-service fee screen and the practitioner's customary charge.

The payment adjustment amount for services provided to Medicaid beneficiaries who have Medicare and/or commercial insurance coverage will be the lesser of:

- The difference between the total of the Medicaid, Medicare, and commercial insurance payments and the allowed amount established by Medicare; OR,
- The difference between the total of the Medicaid, Medicare, and commercial insurance payments and the practitioner's customary charge.

In cases where Medicare does not have an established allowed amount for a particular service/procedure, the MDCH will estimate the Medicare allowed amount based on the following:

- If CMS has established relative value units (RVUs) for the procedure code, the estimated rate is the RVU value times the Medicare conversion factor.
- If no RVUs or partial RVUs are established by CMS for the procedure code, the estimated rate is the Medicare rate established for the service(s) under the procedure code that Medicare uses for payment purposes in cases where there is a direct crosswalk between the procedure codes.
- If no RVUs or partial RVUs are established by CMS and the procedure code(s) used by Medicare for payment does not directly crosswalk to the procedure code(s) used by commercial payers, the estimated rate is the Medicaid fee-for-service fee screen times the ratio of the Medicare conversion factor over the Medicaid conversion factor. This ratio would be adjusted when Medicare or Medicaid changes their respective conversion factors.

Practitioners/public entities will continue to bill MDCH following the requirements detailed in the Billing & Reimbursement Chapters of this manual.

The public entities must certify to MDCH that they will provide the non-federal share of the payment adjustments established by this policy. These public entities must also certify to MDCH that the financial arrangements used to offset the non-federal share of these Medicaid payment adjustments do not violate Title XIX of the Social Security Act, §1903 Payment to States, Subsection (W) Prohibition on Use of Voluntary Contributions, and Limitation on Use of Provider-Specific Taxes to Obtain Federal Financial Participation Under Medicaid.

The non-federal share of the Medicaid payment adjustments is supplied by the public entity through an intergovernmental transfer (IGT) to the MDCH.

The initial covered period includes dates of service from March 1, 2004 through March 31, 2004, inclusive. Subsequent covered periods include dates of service for each calendar quarter beginning with April 1, 2004 through June 30, 2004 and continuing for the duration of this policy.

Each of the identified public entities will supply the MDCH with a listing of the federal identification numbers for their providers who are affected by this policy for each covered period.

Upon receipt of the provider information from the public entity, the MDCH will generate a report which will include the federal identification numbers and utilization data for the providers affected by this policy for each covered period. This report will be provided to the public entity.

The public entity must review the report and acknowledge the completeness and accuracy of the report. After receipt of this confirmation, the MDCH will make the payment adjustment.

The payment adjustments will be made to the federal identification number used to bill Medicaid under the FFS program.

The payment adjustments will be processed quarterly for each covered period to facilitate different fiscal year end dates for affected groups. Each payment adjustment process will include a reconciliation that takes into account all valid claim replacements affecting claims that were previously processed.

PRIVATE DUTY NURSING

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION [CHANGE MADE 4/1/06]

This chapter applies to Independent & Agency Private Duty Nurses (Provider Types 10, 15).

Private duty nursing (PDN) is a Medicaid benefit when provided in accordance with the policies and procedures outlined in this manual. Providers must adhere to all applicable coverage limitations, policies and procedures set forth.

PDN is covered for beneficiaries under age 21 who meet the medical criteria in this section. If the beneficiary is enrolled in or receiving case management services from one of the following programs, that program (except CSHCS) **(per bulletin MSA 06-06 effective 3/1/06)** authorizes the PDN services.

- Children's Special Health Care Services (CSHCS) – services are authorized by the Prior Authorization Review Division. **(per bulletin MSA 06-06 effective 3/1/06)**
- Home and Community-Based Services Waiver for the Elderly and Disabled (known as the MI Choice Waiver)
- Children's Waiver (Community Mental Health Service Program [CMHSP])
- Habilitation Supports Waiver (CMHSP)

For a Medicaid beneficiary who is not receiving services from one of the above programs, the Prior Authorization Division reviews **(modified per bulletin MSA 06-06 effective 3/1/06)** the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met.

Beneficiaries who are receiving PDN services through one Medicaid program cannot seek supplemental PDN hours from another Medicaid Program (i.e., CSHCS, MI Choice Waiver, Children's Waiver, Habilitation Supports Waiver).

For beneficiaries 21 and older, PDN is a waiver service that may be covered for qualifying individuals enrolled in the MI Choice Waiver or Habilitation Supports Waiver. When PDN is provided as a waiver service, the waiver agent must be billed for the services.

1.1 ENROLLMENT REQUIREMENTS

Medicaid Enrolled Nurse (RN/LPN)	To enroll as a Medicaid provider, the nurse must meet the following criteria: ▪ Be a Registered Nurse (RN) licensed to practice in Michigan; or a Licensed Practical Nurse (LPN) licensed to practice in Michigan, working under the supervision of an RN. Supervision of a Medicaid-enrolled LPN must be by an RN who has at least one year of experience in any of the following areas: community health nursing, pediatric nursing, maternal and child health nursing, or a similar nursing practice. Medicaid requires an on-site (beneficiary's home) supervisory visit by the RN of the LPN at least once every two months. The Medicaid-enrolled LPN must maintain documentation that verifies who the supervising RN is, a copy of the RN's license and documentation that supports that the RN supervisory visits were rendered. Documentation of the supervisory visit as signed by the RN must be included in the medical record. The medical record must be complete enough to allow another professional to reconstruct what transpired during the supervisory visit.
	▪ Cooperate with MDCH in quality monitoring activities, beneficiary complaint resolution, and post-payment audit reviews. Medicaid-enrolled nurses must document complaints made by a beneficiary or the beneficiary's family regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the beneficiary's property, and must document both the existence of the complaint and the resolution of the complaint.
Private Duty Nursing Agency	To enroll as a Medicaid provider, the PDN agency must meet the following criteria: ▪ Be accredited by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) or the Community Health Accreditation Program (CHAP) as a PDN agency, or be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as a Home and Community-Based Rehabilitation Program. In the event a PDN agency does not meet the above criteria, the agency may enroll if it was authorized by Medicaid between August 1, 2001 and February 1, 2002 to provide hourly home care to a Medicaid beneficiary (e.g., letter from CSHCS Program or Children's Waiver Program). Medicaid enrollment based on these approval letters for the hourly home care will end after five years after the date of Medicaid enrollment, at which point the agency will be required to meet the above requirement. In the event these requirements for accreditation are not met, the provider will be disenrolled from Medicaid. PDN agencies are not permitted to avoid the above accreditation requirements by individually enrolling RNs or LPNs in the Medicaid Program.

	▪ Cooperate with MDCH in quality monitoring activities, beneficiary complaint resolution, and post-payment audit reviews. Providers must document complaints made by a beneficiary or the beneficiary's family regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the beneficiary's property, and must document both the existence of the complaint and the resolution of the complaint. If a PDN agency delivers services from more than one location (office) each location (office) must enroll with Medicaid as a private duty nursing agency; and must bill for PDN services using the provider ID number specific to each location (office).

1.2 Provision of Private Duty Nursing

PDN must be ordered by a physician and provided by a Medicaid enrolled private duty agency, a Medicaid enrolled registered nurse (RN), a Medicaid enrolled licensed practical nurse (LPN) who is working under the supervision of an RN (per Michigan Public Health Code). It is the responsibility of the LPN to secure the RN supervision.

Supervision of a Medicaid enrolled LPN must be by an RN who has at least one year of experience in any of the following areas:

- Community health nursing,
- Pediatric nursing,
- Maternal and child health nursing, or
- A similar nursing practice.

MDCH requires an onsite supervisory visit by the supervising RN at least once every two months. The Medicaid enrolled LPN must maintain documentation that identifies the supervising RN.

If a beneficiary's services are performed exclusively by LPNs, the supervisory RN is responsible for completing the beneficiary's physical assessment and is required to participate in the development of the beneficiary's plan of care. The above assessments and supervisory visits are not covered by Medicaid, including when provided by a home health agency.

PDN is not covered when rendered in a hospital or nursing facility, including nursing facility for mental illness (NF/MI), an intermediate care facility for mentally retarded (ICF/MR), or licensed adult foster care facility (AFC).

PDN is not covered when provided by an RN or LPN who is the beneficiary's spouse, legally responsible relative, stepparent, adoptive parent, legal guardian, or foster parent.

1.3 Prior Authorization [Change Made 4/1/06]

PDN services must be authorized by one of the above-mentioned entities **(changed 4/1/06)** before services are provided. (Refer to the Directory Appendix for contact information.) **(added per bulletin MSA 06-06 effective 3/1/06)** Prior authorization of a particular PDN provider to render services considers the following factors:

- Available third party resources.
- Beneficiary/family choice.
- Beneficiary's medical needs and age.
- The knowledge and appropriate nursing skills needed for the specific case.
- The understanding of the concept and delivery of home care and linkages to relevant services and health care organizations in the area served.

The Prior Authorization for Private Duty Nursing (PDN) form (MSA-0732) must be submitted when requesting PDN services for persons with CSHCS or Medicaid coverage. A copy of the form is provided in the Forms Appendix and is also available on the MDCH website. (Refer to the Directory Appendix for website information.) This form is **not** to be used for beneficiaries enrolled in, or receiving case management services from, the Children's Waiver, Habilitation Supports Waiver, or MI Choice Waiver.

If services are authorized, the provider receives an approval letter containing a PA number. The provider must maintain the letter in the beneficiary's medical record. When billing, the prior approval number must be entered on the claim. The prior approval letter should not be sent with the claim.

The PA number is for private duty nursing only. Any CMHSP prior authorized respite services must be billed to the authorizing CMHSP.

1.4 Other Insurance

It is the responsibility of the family, private duty nursing agency, RN or LPN to assess, investigate and exhaust all commercial insurance for the beneficiary prior to billing Medicaid. A private duty nursing agency, RN, or LPN should not accept any Medicaid PDN case until it has been determined what, if any, commercial insurance a beneficiary may have.

For any Medicaid case accepted in which the beneficiary has other insurance, the provider must first follow the rules of the other insurance. Such rules may include obtaining a physician's order, obtaining prior authorization, and being a participating provider with the other insurance carrier. Failure to follow the rules of the other insurance may result in nonpayment from Medicaid.

If a beneficiary's commercial insurance does not cover PDN, the PDN agency, RN or LPN must inform MDCH of this prior to billing to expedite processing of the claim. A copy of the letter of explanation or explanation of benefits (EOB) must be faxed to MDCH Third-Party Liability. (Refer to the Directory Appendix for contact information.) Once it has been established that the commercial insurance does not cover PDN, a letter of explanation or EOB is valid as long as the insurance coverage remains unchanged. On an annual basis, the policyholder and provider should confirm with the commercial insurance that PDN coverage has not changed.

(Refer to the Coordination of Benefits Chapter of this manual for additional information.)

1.5 General Eligibility Requirements

The beneficiary is eligible for PDN coverage when all of the following requirements are met:

- The beneficiary is eligible for Medicaid in the home/community setting (i.e., in the noninstitutional setting).

- The beneficiary is under the age of 21 and meets the medical criteria for PDN.
- PDN is appropriate, considering the beneficiary's health and medical care needs.
- PDN can be provided safely in the home setting.
- The beneficiary, his family (or guardian), the beneficiary's physician, the Medicaid case manager, and RN (i.e., from the PDN agency or the Medicaid enrolled RN, or the supervising RN for the Medicaid enrolled LPN) have collaborated and developed an integrated plan of care (POC) that identifies and addresses the beneficiary's need for PDN. The PDN must be under the direction of the beneficiary's physician; the physician must prescribe/order the services. The POC must be signed and dated by the beneficiary's physician, RN (as described above), and by the beneficiary or beneficiary's parent/guardian. The POC must be updated at least annually and must also be updated as needed based on the beneficiary's medical needs.

1.6 Benefit Limitations

The purpose of the PDN benefit is to assist the beneficiary with medical care, enabling the beneficiary to remain in their home. The benefit is not intended to supplant the care giving responsibility of parents, guardians, or other responsible parties (e.g., foster parents). There must be a primary caregiver (i.e., parent, guardian, significant other adult) who resides with a beneficiary under the age of 18 and the caregiver must provide a monthly average of a minimum of eight hours of care during a typical 24-hour period. The calculation of the number of hours authorized per month includes eight hours of care that will be provided by the caregiver during a 24-hour period, which are then averaged across the hours authorized for the month. The caregiver has the flexibility to use the monthly-authorized hours as needed during the month.

The time a beneficiary is under the supervision of another entity or individual (e.g., in school, in day/child care, in work program) cannot be used to meet the eight hours of obligated care as discussed above, nor can the eight hours of care requirement for beneficiaries under age 18 be met by other public funded programs (e.g., MDCH Home Help Program), or other resources for hourly care (e.g., private health insurance, trusts, bequests, private pay).

1.7 Service Log

If PDN is prior approved and care is initiated, a detailed log indicating the shift hours for each date of service for each procedure must be maintained. The provider must maintain this log in the beneficiary's medical record.

Example: Facsimile of Log for Private Duty Nursing Agency

October 2004

Name	Date	Shift	Quantity (Hours)
RN	10/06/04	8:00 AM – 12:00 PM	4
RN	10/09/04	8:00 AM – 12:00 PM	4

RN	10/15/04	8:00 AM – 12:00 PM	4
RN	10/22/04	8:00 AM – 12:00 PM	4

1.8 Clinical Record

In addition to the Service Log, the provider must maintain clinical records as detailed in the General Information for Providers Chapter of this manual. The clinical record must be sufficiently documented to allow another professional to reconstruct what transpired during each hour of nursing service billed to Medicaid.

1.9 Holidays

MDCH allows additional reimbursement for holidays. Currently recognized holidays are: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving and Christmas Day.

A holiday begins at 12:00 a.m. and ends at 12:00 midnight of that holiday day.

1.10 Mileage

Staff mileage to the beneficiary's home is covered as a part of the PDN service and may not be billed separately.

1.11 Caring for More than One Patient at a Time

For ratios of more than two patients per nurse, providers must contact the patient's case manager at the Children's Special Health Care Services (CSHCS), Home and Community-Based Services Waiver for the Elderly and Disabled (MI Choice), Children's Waiver (CMHSP), Habilitation Supports Waiver (CMHSP). These ratios are considered exceptional cases and require prior approval.

1.12 Billing for Private Duty Nursing

For billing instructions, nurses should refer to the Billing & Reimbursement for Professionals Chapter of this manual and agencies should refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.

As explained in the Billing & Reimbursement chapters, most private duty nursing services are billed through the MI AuthentiCare system. MI AuthentiCare is an Interactive Voice Response (IVR) system that allows a PDN provider to check-in by calling a toll-free telephone number when arriving at a beneficiary's home, and check-out when care is completed. MI AuthentiCare generates a claim to Medicaid based on the information obtained from these calls. More information regarding MI AuthentiCare is available on the MDCH website. (Refer to the Directory Appendix for website information.)

SECTION 2- CARE REQUIREMENTS

2.1 PLAN OF CARE

A written plan of care (POC) guides all services provided to the beneficiary by the PDN provider. The care plan and the process for developing it reflect the beneficiary's and family's basic rights of self-determination and autonomy.

- Family members and the beneficiary (as appropriate to his maturity) participate in developing the POC. They are provided with accurate information and support appropriate to informed decision-making; and they must give informed consent for planned services.
- Beneficiary/family strengths, including cultural and ethnic identity, are respected and utilized in the delivery of care. Services delivered in the home accommodate beneficiary/family life activities.
- The plan includes goals directed toward increasing beneficiary/family capability, effectiveness, and control.
- The plan includes compensatory services to support the growth and developmental potential of each beneficiary, given his disability or illness.
- Appointments are coordinated and services are scheduled with the goals of minimizing inconvenience to the beneficiary/family, and of facilitating the family's participation in the beneficiary's care.
- If the services are provided by LPNs, the POC must identify the frequency of the supervisory RN visits.

The written POC must be retained in the beneficiary's medical record.

2.2 MEDICAL CRITERIA

To qualify for PDN, the beneficiary must meet the medical criteria of **either** I and III below **or** II and III below:

Medical Criteria I	The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means: ▪ Mechanical ventilation four or more hours per day or assisted respiration (Bi-PAP or CPAP); or ▪ Oral or tracheostomy suctioning 8 or more times in a 24-hour period; or ▪ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or ▪ Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or ▪ Continuous oxygen administration, in combination with a pulse oximeter and a documented need for observations and adjustments in the rate of oxygen administration.

Medical Criteria II	Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments or interventions as described in III below, due to a substantiated progressively debilitating physical disorder. ▪ "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months; ▪ "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder; ▪ "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. ▪ "Progressively debilitating physical disorder" means an illness, diagnosis, or syndrome that results in increasing loss of function due to a physical disease process, and that has progressed to the point that continuous skilled nursing care (as defined in III below) is required; and ▪ "Substantiated" means documented in the clinical/medical record, including the nursing notes. For beneficiaries described in II, the requirement for frequent episodes of medical instability is applicable only to the initial determination of medical necessity for PDN. Determination of continuing eligibility for PDN for beneficiaries defined in II is based on the original need for skilled nursing assessments, judgments, or interventions as described in III below.
Medical Criteria III	The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services. ▪ "Continuous" means at least once every three hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode. ▪ Equipment needs alone do not create the need for skilled nursing services. ▪ "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to, performing assessments to determine the basis for acting or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; injections; indwelling central venous catheter care; managing mechanical ventilation; oxygen administration and evaluation; and tracheostomy care.

2.3 Determining Intensity of Care and Maximum Amount of PDN

As part of determining the maximum amount of PDN a beneficiary is eligible for, his Intensity of Care category must be determined. This is a clinical judgment based on the following factors:

- The beneficiary's medical condition;
- The type and frequency of needed nursing assessments, judgments and interventions; and
- The impact of delayed nursing interventions.

Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary, but do not determine the number of hours of nursing for which the beneficiary is eligible.

High Category	Medium Category	Low Category
Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

Medicaid uses the "Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis" to establish the amount of PDN that is approved. The Decision Guide is used to determine the appropriate range of nursing hours that can be authorized under the Medicaid PDN benefit and defines the "benefit limitation" for individual beneficiaries. The Decision Guide is used by the authorizing entity after it has determined the beneficiary meets both general eligibility requirements and medical criteria as stated above. The amount of PDN (i.e., the number of hours) that can be authorized for a beneficiary is based on several factors, including the beneficiary's care needs which establish medical necessity for PDN, the beneficiary's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts, bequests, private pay). To illustrate, the number of hours covered by private health insurance is subtracted from the hours approved under Medicaid PDN. These factors are incorporated into the Decision Guide. The higher number in the range is considered the maximum number of hours that can be authorized. Except in emergency circumstances, Medicaid does not approve more than the maximum hours indicated on the guide.

Only those factors that influence the maximum number of hours that can be authorized are included on this decision matrix. Other factors (e.g., additional dependent children, additional children with special needs, and required nighttime interventions) that impact the caregiver's availability to provide care should be identified during an assessment of service needs. These factors have implications for service planning, and should be considered when determining the actual number of hours (within the range) to authorize.

Decision Guide For Establishing Maximum Amount of Private Duty Nursing To Be Authorized on a Daily Basis

FAMILY SITUATION / RESOURCE CONSIDERATIONS		INTENSITY OF CARE Average Number of Hours Per Day		
		LOW	MEDIUM	HIGH
Factor I – Availability of Care Givers Living in the Home	2 or more caregivers; both work or are in school F/T or P/T	4-8	6-12	10-16
	2 or more caregivers; 1 works or is in school F/T or P/T	4-6	4-10	10-14
	2 or more caregivers; neither works or is in school at least P/T	1-4	4-8	6-12
	1 caregiver; works or is in school F/T or P/T	4-8	6-12	10-16
	1 caregiver; does not work or is not a student	1-4	6-10	8-14
Factor II – Health Status of Care Giver(s)	Significant Health issues	Add 2 hours if Factor I <= 8	Add 2 hours if Factor I <= 12	Add 2 hours if Factor I <= 14
	Some health issues	Add 1 hour if Factor I <= 7	Add 1 hour if Factor I <= 9	Add 1 hour if Factor I <= 13
Factor III – School *	Beneficiary attends school 25 or more hours per week, on average	Maximum of 6 hours per day	Maximum of 8 hours per day	Maximum of 12 hours per day

***** Factor III limits the maximum number of hours which can be authorized for a beneficiary:

- Of any age in a center-based school program for more than 25 hours per week; or
- Age six and older for whom there is no medical justification for a homebound school program.

In both cases, the lesser of the maximum "allowable" for Factors I and II, or the maximum specified for Factor III applies.

When using the Decision Guide, the following definitions apply:

- "Caregiver": legally responsible person (e.g., birth parents, adoptive parents, spouses); paid foster parents; guardian or other adults who are not legally responsible or paid to provide care, but who choose to participate in providing care.
- "Full-time (F/T)": working at least 30 hours per week for wages/salary, or attending school at least 30 hours per week.

- "Part-time (P/T)": working at least 15 hours per week for wages/salary, or attending school at least 15 hours per week.
- "Significant" health issues: one or more primary caregiver(s) has a health or emotional condition that prevents the caregiver from providing care to the beneficiary (e.g., beneficiary weighs 70 pounds and has no mobility and the primary caregiver just had back surgery and is in a full-body cast).
- "Some" health issues: one or more primary caregiver(s) has a health or emotional condition, as documented by the caregiver's treating physician, that interferes with, but does not prevent, provision of care (e.g., caregiver has lupus, alcoholism, depression, back pain when lifting, lifting restrictions, etc.).
- "School" attendance: The average number of hours of school attendance per week is used to determine the maximum number of hours that can be authorized for the individual of school age. The average number of hours is determined by adding the number of hours in school, plus transportation time. During planned breaks of at least 5 consecutive school days (e.g., spring break, summer vacation), additional hours can be authorized within the parameters of Factors I and II.

  The Local School District (LSD) or Intermediate School District (ISD) is responsible for providing such "health and related services" as necessary for the student to participate in his education program. Unless medically contraindicated, individuals of school age should attend school. Factor III applies when determining the maximum number of hours to be authorized for an individual of school age. The Medicaid PDN benefit cannot be used to replace the LSD's or ISD's responsibility for services (either during transportation to/from school or during participation in the school program).

2.4 Exception Process

Because each beneficiary and his family are unique and because special circumstances arise, it is important to maintain an exception process to ensure the beneficiary's safety and quality of care. PDN services that exceed the beneficiary's benefit limitation as established by the Decision Guide must be prior authorized by the appropriate Medicaid case management program. Limited authority to exceed the published PDN benefit limitations may be granted on a time-limited basis as detailed below.

The beneficiary or his primary care giver must initiate the request for an exception. The applicable Medicaid case management program's representative is responsible for facilitating the request and documenting the necessity for an exception. Factors underlying the need for additional PDN must be identified in the beneficiary's POC, which must include strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception;
- Current lack of natural supports required for the provision of the needed level of support; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care; and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition.

Exceptions are time-limited and must reflect the increased identified needs of the beneficiary. Consideration for an exception are limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

A temporary alteration in the beneficiary's care needs following a hospitalization, resulting in one or both of the following:	**The temporary inability of the primary caregiver(s) to provide the required care, as the result of one of the following:** ("Inability" is defined as the caregiver is either unable to provide care, or is prevented from providing care.)
▪ A temporary increase in the intensity of required assessments, judgments, and interventions. ▪ A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs. The total number of additional PDN hours cannot exceed two hours per day, for a maximum of six months.	▪ An acute illness or injury of the primary caregiver(s). The total number of additional PDN hours cannot exceed two hours per day for the duration of the caregiver's inability, not to exceed six months. In the event there is only one caregiver living in the home and that caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. ▪ The death of the primary caregiver(s) or an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days. ▪ The home environment has been determined to be unstable, as evidenced by DHS protective or preventive services involvement. The written POC and community-based care coordination activities must include strategies directed toward stabilizing service supports and/or the family situation. The maximum number of hours varies by the beneficiary's Intensity of Care category: High = maximum of 18 hours per day; Medium = maximum of 14 hours per day; Low = maximum of 10 hours per day. The length of time for this exception is three months or the time needed to stabilize service supports and/or family situation, whichever is less. A one-time extension of up to three months may be made if there is documented progress toward achieving the stabilized home environment.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

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SECTION 1 – GENERAL INFORMATION

The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model of community-based care that enables elderly individuals, who are certified by their state as needing nursing facility care, to live as independently as possible.

PACE provides an alternative to traditional nursing facility care by offering pre-paid, capitated, comprehensive health care services designed to meet the following objectives:

- Enhance the quality of life and autonomy for frail, older adults;
- Maximize the dignity of, and respect for, older adults;
- Enable frail, older adults to live in the community as long as medically and socially feasible; and
- Preserve and support the older adult's family unit.

The PACE capitated benefit was authorized by the Balanced Budget Act of 1997 and features a comprehensive service delivery system with integrated Medicare and Medicaid financing.

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses beneficiary needs, develops a plan of care, and monitors delivery of all services (including acute care services as well as nursing facility services, when necessary) within an integrated system for a seamless provision of total care. Typically, PACE organizations provide social and medical services in an adult day health center supplemented by in-home and other services as needed.

The financing model combines payments from Medicare and Medicaid, allowing PACE organizations to provide all needed services rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. PACE organizations assume full financial risk for beneficiary care without limits on amount, duration, or scope of services.

Physicians currently treating Medicaid patients who are in need of nursing facility care may consider PACE as an option. Hospital discharge planners may also identify suitable candidates for referral to PACE as an alternative to a nursing facility. (Refer to the Directory Appendix for PACE contact information.)

SECTION 2 - SERVICES

The PACE organization becomes the sole source of services for Medicare and Medicaid beneficiaries who choose to enroll in a PACE organization.

The PACE organization is able to coordinate the entire array of services to older adults with chronic care needs while allowing elders to maintain independence in the community for as long as possible. The PACE service package must include all Medicare and Medicaid covered services, in addition to other services determined necessary by the interdisciplinary team for the individual beneficiary. Services must include, but are not limited to:

- Adult day care that offers nursing, physical, occupational and recreational therapies, meals, nutritional counseling, social work and personal care
- All primary medical care provided by a PACE physician familiar with the history, needs and preferences of each beneficiary, all specialty medical care, and all mental health care
- Interdisciplinary assessment and treatment planning
- Home health care, personal care, homemaker and chore services
- Restorative therapies
- Diagnostic services, including laboratory, x-rays, and other necessary tests and procedures
- Transportation for medical needs
- All necessary prescription drugs and any authorized over-the-counter medications included in the plan of care
- Social services
- All ancillary health services, such as audiology, dentistry, optometry, podiatry, speech therapy, prosthetics, durable medical equipment, and medical supplies
- Respite care
- Emergency room services, acute inpatient hospital and nursing facility care when necessary

SECTION 3 – ELIGIBILITY AND ENROLLMENT

3.1 ELIGIBILITY REQUIREMENTS

To be eligible for PACE enrollment, applicants must meet the following requirements:

- Be age 55 years or older
- Meet applicable Medicaid financial eligibility requirements. (Eligibility determinations will be made by the Michigan Department of Human Services for all counties except Wayne. Determinations for Wayne County will be made by MDCH.)
- Reside in the PACE organization's service area
- Be capable of safely residing in the community without jeopardizing health or safety while receiving services offered by the PACE organization.
- Receive a comprehensive assessment of participant needs by an interdisciplinary team.
- Be appropriate for placement in PACE based on completion of the Michigan Medicaid Nursing Facility Level of Care Determination
- Be provided timely and accurate information to support Informed Choice for all appropriate Medicaid options for Long Term Care
- Not concurrently enrolled in the MI Choice program
- Not concurrently enrolled in an HMO

3.2 COMPLETION OF THE MEDICAID NURSING FACILITY LOC DETERMINATION

The PACE organization must verify applicant appropriateness for services by completing an electronic web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination. Instructions and required forms related to the completion of the Medicaid Nursing Facility Level of Care Determination are available on the MDCH website. (Refer to the Directory Appendix for website information.)

Services will only be reimbursed when the determination demonstrates functional/medical eligibility through the web-based tool or the Nursing Facility Level of Care Exception Process. Providers must submit the Nursing Facility Level of Care Determination information via the web no later than 14 calendar days following start of service.

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed by a health professional (physician, registered nurse, licensed practical nurse, clinical social worker (BSW or MSW), or physician assistant) representing the proposed provider. Nonclinical staff may perform the evaluation when clinical oversight by a professional is performed. The PACE organization will be held responsible for enrolling only those participants who meet the criteria outlined in this section.

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the electronic web-based form in the following situations:

- all new enrollments of Medicaid-eligible beneficiaries
- re-enrollment of Medicaid-eligible beneficiaries

For participants enrolled in PACE on November 1, 2004, the Michigan Medicaid Nursing Facility Level of Care Determination must be applied for no earlier than the next anniversary date of their enrollment into the program. All participants enrolled prior to November 1, 2004 must be evaluated no later than October 31, 2005.

Continuing participants who are assessed at their next anniversary date, and who qualify under Door 7 only, must be offered the opportunity and assistance to transition to other community programs, but cannot be required to do so. In applying the criteria for Door 7, it is assumed that current services provided to participants are necessary to maintain function.

PACE organizations will not be reimbursed for participants who do not demonstrate eligibility through the electronic web-based tool. In addition, providers must submit participant information via the web no later than 14 calendar days following the start of service.

The PACE organization must provide an adverse action notice to participants who are found to be not eligible and who have been enrolled in the program for less than 12 months, and must refer the participant to appropriate service programs. When the PACE organization anticipates that the participant may become eligible again within the next six months, the PACE participant may continue to qualify for the program, when approved by MDCH.

The electronic web-based tool must be completed only once for each admission or readmission to the program.

3.3 Informed Choice

When a beneficiary is determined eligible for Nursing Facility LOC through completion of the Nursing Facility Level of Care Determination, he must be provided timely and accurate information to support informed choice for all appropriate Medicaid options for LTC.

Process Guidelines available on the MDCH website define the required process. (Refer to the Directory Appendix for website information.)

3.4 Nursing Facility LOC Determination Exception Process

An exception process is available for those applicants who have demonstrated a significant level of long term care need but do not meet the Michigan Medicaid Nursing Facility Level of Care Criteria. The Nursing Facility Level of Care Exception Process is initiated when the prospective provider telephones the MDCH designee and requests review after the applicant has been determined ineligible using the electronic web-based tool. The NF LOC Exception criteria and information on how to request an exception review is available on the MDCH website. (Refer to the Directory Appendix for website information.)

3.5 Telephone Intake Guidelines

The Telephone Intake Guidelines are questions that identify potential PACE participants for further assessment. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the PACE organization. The guidelines are available on the MDCH website. (Refer to the Directory Appendix for website information.)

3.6 Annual Recertification

MDCH must annually certify that PACE financial eligibility requirements continue to be met by the participant. In addition, PACE organizations must ensure that participants meet the Michigan Medicaid Nursing Facility Level of Care criteria on an ongoing basis, as demonstrated in the medical record. The electronic web-based tool must be completed only once for each admission. Initial comprehensive assessments, reassessments and progress notes must demonstrate that the participant has met the criteria on an ongoing basis.

The PACE federal regulation allows for continuing eligibility of those individuals who are determined through the annual recertification process to no longer meet the nursing facility level of care requirement if, in the absence of continued coverage under PACE, the individual would reasonably be expected to again meet the nursing facility level of care in the next six months.

3.7 Retrospective Review and Medicaid Recovery

At random and whenever indicated, MDCH will perform retrospective reviews to validate the Michigan Medicaid Nursing Facility Level of Care Determination. If the participant is found to be ineligible for PACE services, MDCH will recover all Medicaid payments made for PACE services rendered during the period of ineligibility.

3.8 Adverse Action Notice

When the provider determines that the beneficiary does not qualify for services based on the Michigan Medicaid Nursing Facility Level of Care Determination, the organization must immediately issue an adverse action notice to the beneficiary or his authorized representative. The action notice must include all of the language of the sample letters for long term care. Copies of the letters are available on the MDCH website. (Refer to the Directory Appendix for website information.)

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal Policies and Procedures Manual explains the process by which each different case is brought to completion. The manual is available for review on the MDCH website. (Refer to the Directory Appendix for Administrative Tribunal contact and website information.)

3.9 Immediate Review-Adverse Action Notices

MDCH or its designee will review all pre-admission or continued stay adverse action notices upon request by a beneficiary or his representative. When a beneficiary requests an immediate review before noon of the first working day after the date of receipt of the notice:

- The MDCH designee will request that the PACE organization provides pertinent information by close of business the first working day after the date the beneficiary requests an immediate review.
- The MDCH designee will review the records, obtain information from the beneficiary or beneficiary representative, and notify the beneficiary and the provider of the determination by the first full working day after the date of receipt of the beneficiary request and the required medical records.

The beneficiary (or representative) may still request an MDCH appeal of the Michigan Medicaid Nursing Facility Level of Care Determination.

Beneficiaries may contact the MDCH designee to request an immediate review. (Refer to the Directory Appendix for contact information.)

3.10 Freedom of Choice

When an applicant has been qualified to receive services under the Nursing Facility Level of Care criteria, the beneficiary must be informed of his benefit options and elect to receive services in a specific program. This election must take place prior to initiating PACE services.

The applicant (or legal representative) must be informed of the following:

- services available under PACE
- services available in other community settings, such as the MI Choice Program
- services available through Medicaid-reimbursed nursing facilities

If applicants are interested in nursing facility or MI Choice Program care, the PACE organization must provide appropriate referral information using the Access Guidelines to Medicaid Services for Persons with Long Term Care Needs. These guidelines are available on the MDCH website. (Refer to the Directory Appendix for website information.)

Applicants must acknowledge that they have been informed of their program options in writing by signing the Freedom of Choice form that is witnessed by the applicant's representative when appropriate. A copy of the completed form for non-participants must be retained for a period of three years. The completed form must be kept in the medical record if the applicant chooses to receive PACE services.

A copy of the Freedom of Choice form is included with the Michigan Medicaid Nursing Facility Level of Care Determination on the MDCH website. (Refer to the Directory Appendix for website information.)

3.11 Applicant Appeals

3.11.A. Financial Eligibility

A determination that an applicant is not financially eligible for Medicaid is an adverse action. Applicants may appeal such an action to the Michigan Department of Community Health.

3.11.B. Functional / Medical Eligibility

A determination that a beneficiary is not functionally/medically eligible for PACE services is an adverse action. If the beneficiary and/or representative disagrees with this determination, they have the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found at the Administrative Tribunal portion of the MDCH website. Beneficiaries may appeal such an action to MDCH for Wayne County determinations and to the Michigan Department of Human Services (MDHS) for determinations in all other counties. (Refer to the Directory Appendix for website information.)

3.12 Provider Appeals

A retrospective determination that a beneficiary is ineligible for PACE services, based on review of the functional/medical screening, is an adverse action for the PACE organization if MDCH proposes to recover payments made. If the PACE organization disagrees with this determination, it should refer to the Contract Dispute Section of their contract with MDCH.

SECTION 4 - PACE ORGANIZATION EVALUATION CRITERIA

A prospective PACE organization must be a not-for-profit private or public entity that is primarily engaged in providing PACE services, and participate in both Medicare and Medicaid. Michigan licensure as a health care entity is not required; however, unlicensed entities may only serve Medicare and Medicaid beneficiaries. Federal regulations (42 CFR Part 460) describe administrative requirements for PACE. At a minimum, prospective entities must meet the federal requirements for PACE organizations, enroll as a Michigan Medicaid provider, and complete a feasibility study. MDCH will evaluate potential PACE organizations using the following criteria:

- Submission of a feasibility study that:
  - identifies the proposed service area;
  - shows evidence of demand for PACE services in the proposed service area (the potential pool of PACE beneficiaries should be sufficient to have 250 to 300 beneficiaries enrolled within four to five years of start-up);
  - identifies competing PACE organizations, documents the organization's timeline for development and anticipated costs;
  - identifies the anticipated source of referrals for potential beneficiaries; and
  - assesses the supply of alternative long-term care services already in existence in the community.
- Organizational commitment to principles consistent with the PACE model.
- Evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support.
- Evidence that the organization has the depth in leadership and experience required to develop and implement PACE successfully.
- Evidence that the PACE organization will either be cost neutral or save money for long term care services provided by MDCH in the PACE organization's service area (i.e., total Medicaid expenditures for services in the service area will not increase and may decrease)
- Assurance of adequate financial capacity to fund program development and start-up costs, including identification of patient capacity and break-even consideration.
- Evidence of the proposed provider network and assurance that the organization will have staff and professionals experienced in providing care to the target population.
- Evidence that the Executive (Program) Director position will be staffed with a full-time employee.
- Evidence that the key positions of Medical Director, Center Manager, Financial Manager, and Quality Improvement Manager are sufficiently staffed, as determined by MDCH, to meet the needs of the PACE organization.
- Ability to meet federal PACE requirements.

Other evaluation criteria may be considered and will be available to organizations who file a letter of intent with Michigan Department of Community Health (MDCH) to become a PACE organization.

SECTION 5 – BECOMING A PACE ORGANIZATION

Information regarding the process to become a PACE organization is available on the MDCH website. Any entity seeking to become a PACE organization in Michigan may contact MDCH regarding state-specific requirements. (Refer to the Directory Appendix for contact and website information.)

RURAL HEALTH CLINICS

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SECTION 1 – GENERAL INFORMATION

1.1 RURAL HEALTH CLINIC STATUS

This chapter provides policy and reimbursement information specific to Rural Health Clinics (RHCs) and is to be used in combination with other chapters of the Medicaid Provider Manual.

In compliance with the Rural Health Clinic Services Act of 1977 (Public Law 95-210), the Medicaid program reimburses certified and enrolled RHCs for services provided to Medicaid beneficiaries in the State of Michigan. To become certified as a RHC in Michigan, clinics must make application for RHC status through the designated state-certifying agency. (Refer to Directory Appendix for contact information.) Based on information in the application, the certifying agency determines if an applicant clinic meets the staffing and location requirements for certification. If a clinic appears eligible, an on-site visit is conducted. If a clinic meets all the requirements, the certifying agency makes a recommendation for certification to the Centers for Medicare and Medicaid Services (CMS). CMS makes the final determination as to a clinic's eligibility for RHC status and notifies the Michigan Department of Community Health (MDCH) when eligibility is granted.

RHCs may be provider-based or independently operated. Provider-based RHCs may be operated by a hospital, skilled nursing facility (SNF) or home health agency (HHA). An independent RHC is permitted to occupy a permanent structure or be located in a mobile unit. RHCs may be publicly or privately held clinics and they may be operated on a profit or not-for-profit basis.

1.2 GENERAL REIMBURSEMENT INFORMATION

Medicaid-enrolled RHCs are reimbursed with a prospective payment system (PPS) in compliance with Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Specific information related to RHC reimbursement is contained in the Rate Setting Section of this chapter.

SECTION 2 - MEDICAID ENROLLMENT

2.1 PROVIDER ENROLLMENT

MDCH does not issue a group provider ID number to RHCs. Each eligible provider employed by both independent and provider-based RHCs must enroll individually with Medicaid as a provider. Services rendered must be billed using the ID number of the practitioner providing care.

2.1.A. ENROLLMENT REQUIREMENTS

RHCs must enroll each employed or subcontracted RHC physician (MD, DO), dentist, optometrist, podiatrist, chiropractor, certified nurse practitioner (CNP) (who has a collaborative agreement with a physician), and certified nurse midwife (CNM) in order for these providers to bill services on behalf of the RHC. An RHC with several CMS-approved locations must have provider ID numbers for each eligible provider at those locations. This requirement also applies to any off-site location under contract to the RHC.

To enroll, a Medical Assistance Provider Enrollment & Trading Partner Agreement (DCH-1625) must be completed and submitted to the MDCH Provider Enrollment Unit. A copy of the CMS certification approval letter and MDCH Reimbursement Confirmation Letter must accompany the form. (Refer to the General Information for Providers Chapter of this manual for additional information.) The MDCH Hospital and Health Plan Reimbursement Division (HHPRD) must also be notified of any practitioner enrolling to provide services at an RHC location.

2.1.B. TERMINATION OF EMPLOYMENT WITH THE RHC

RHCs must give notice to MDCH (to both the Provider Enrollment Unit and HHPRD) of any physician (MD, DO), dentist, optometrist, podiatrist, chiropractor, CNP (who has a collaborative agreement with a physician), CNM, or subcontractor who terminates employment with the RHC. This notice must be in a letter listing the provider's name, nine-digit Medicaid provider identification (ID) number and termination date.

All inquiries related to provider enrollment should be directed to the MDCH Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

2.2 NONENROLLED PROVIDERS

Professional services provided by RHC clinical social workers, clinical psychologists, and physician's assistants are reimbursed under the RHC PPS. However, these providers are not enrolled in Medicaid and, accordingly, do not have their own Medicaid provider ID numbers. Services performed by these professionals must be billed under the supervising physician's Medicaid ID number. The supervising physician is responsible for the medical necessity and appropriateness of these services.

2.2.A. Clinical Psychologist and Clinical Social Worker Services

Clinical psychologist and clinical social worker services must be billed using the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Health Care Financing Administration Common Procedure Coding System (HCPCS) codes.

2.2.B. Limitations for Clinical Social Worker and Clinical Psychologist Services

All RHCs may bill the clinical social worker and clinical psychologist services but are limited to 20 visits per beneficiary per calendar year. Visits beyond the maximum of 20 visits per beneficiary per calendar year are rejected.

SECTION 3 – INFORMATION SPECIFIC TO PROVIDER BASED RURAL HEALTH CLINICS

When a hospital, nursing facility (NF), or home health agency (HHA) owns and administers a RHC and the RHC is located in the hospital, NF, or HHA, the entity is a provider based RHC (PBRHC). The following instructions apply to PBRHCs:

- Hospitals, NFs or HHAs must not bill for RHC services using the hospital/NF/HHA ID number. PBRHC services must be billed only under the provider ID number of the medical professional supervising or rendering treatment. RHC services, including the overhead costs as an RHC, are reimbursed only under the practitioner's ID number and through use of the PPS methodology for RHCs.
- RHCs that are an integral and subordinate part of a hospital, NF, or HHA must be able to identify and separate the RHC's costs, encounters, and revenue from the non-RHC operations of the governing hospital, NF, or HHA. If the hospital, NF, or HHA is unable to meet this requirement to the satisfaction of MDCH, the RHC is paid as a non-RHC provider (i.e., reimbursement at Medicaid fee screens only).

SECTION 4 – BENEFITS

RHC benefits are:

- Physician (MD, DO), podiatrist, chiropractor, optometrist professional services and services and supplies incidental to physician services including certain drugs and biologicals that cannot be self-administered, immunizations and their administration.
- Physician's assistant, certified family nurse practitioner (CFNP), certified pediatric nurse practitioner (CPNP) and certified nurse midwife (CNM) services and the services and supplies incidental to these services as would otherwise be furnished by, or incidental to physician services.
- Clinical psychologist and clinical social worker services and services and supplies incidental to these services as would otherwise be furnished by, or incidental to physician services.
- Dental services, and services and supplies incidental to dental services.

Primary care services that are covered and reimbursed under the PPS are defined as the above listed services provided in a place of service that is the RHC's office or clinic, patient's home, skilled NF, domiciliary facility or NF.

4.1 SERVICES AND SUPPLIES INCIDENTAL TO AN RHC VISIT

RHC services and supplies incidental to an RHC visit are included in the PPS reimbursement if the service or supply is:

- Of a type commonly furnished in a physician's office.
- Of a type commonly rendered either without charge or included in the professional bill.
- Furnished as an incidental, although integral part of professional services furnished by a physician (MD, DO), dentist, optometrist, podiatrist, chiropractor, CNP (who has a collaborative agreement with a physician), CNM or physician's assistant.
- Furnished under the direct personal supervision of a physician (MD, DO), dentist, optometrist, podiatrist, chiropractor, CNP (who has a collaborative agreement with a physician), CNM or licensed physician's assistant.
- In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

The direct personal supervision requirement is met in the case of a CNP, CNM, or physician's assistant only if such a person is permitted to supervise such services under the written policies governing the RHC.

4.2 SERVICES EXCLUDED FROM RHC REIMBURSEMENT

Payment for any other Medicaid covered services not defined as a primary care service are Medicaid-covered under fee-for-service (FFS) policies. Services not listed as primary care services are excluded from the RHC prospective reimbursement rate.

SECTION 5 - ENCOUNTERS

5.1 DEFINITION

Reimbursement to RHCs under the PPS requires that each office visit that meets the following definition of an encounter be counted for payment purposes.

An encounter is a face-to-face visit between a patient and the provider of health care services who exercises independent judgment in the provision of health care services. For a health service to be defined as an encounter, the provision of the health service must be recorded in the patient's medical record.

Encounters include provision of service by the following professionals:

- Licensed physicians (MD, DO), dentists, optometrists, podiatrists, chiropractors, CNPs (who have a collaborative agreement with a physician), CNMs, physician's assistants or dental hygienists.
- Clinical psychologists or clinical social workers.

The following examples help to define an encounter:

- To meet the encounter criterion for independent judgment, the provider must be acting independently and not be assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history, or drawing a blood sample is not credited with a separate encounter.
- Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, filling/dispensing prescriptions, in and of themselves, do not constitute encounters. However, these procedures may accompany professional services performed by physicians, dentists, or other health providers that do constitute encounters.
- An RHC may be credited for more than one encounter by the same health professional on the same day. For example, a beneficiary suffers illness or injury requiring additional diagnosis or treatment on the same date of service, or a patient sees a physician for flu symptoms early in the day and then later the same day sees the same physician for a broken leg. These visits are classified as two encounters and the patient's medical record must document the circumstances of the two encounters.
- An RHC may be credited for encounters by different health professionals on the same day. For example, if a patient first sees a physician at the RHC and then sees a clinical psychologist, these visits are classified as two encounters.
- An encounter may take place in the RHC or at another approved location.

The encounter criteria are **not** met in the following circumstances:

- Provider participation in a community meeting or group session that is not designed to provide health services.
- When the only service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program.

- Nursing services such as taking vital signs, taking a history, drawing a blood sample, collecting urine specimens, performing laboratory tests, taking x-rays, and/or filling or dispensing prescriptions.
- Calling in prescriptions, filling out insurance forms, etc.
- Allergy injection(s).

5.2 Eligibility Groups Subject to PPS Methodology

The following list identifies Medicaid eligibility groups that are subject to the PPS methodology:

Medicaid	RHC primary care services constitute encounters covered by Medicaid.
Qualified Medicare Beneficiaries	Medicaid is billed coinsurance and deductibles for Qualified Medicare Beneficiaries (QMBs) and the services covered by Medicare are included as encounters.
Healthy Kids	Services for beneficiaries who are eligible for Healthy Kids are identified by Program Code L.
Medicaid Health Plan Enrollees	Medicaid-covered services provided by a RHC to Medicaid-eligible beneficiaries enrolled with a Medicaid Health Plan (MHP) are Medicaid encounters if the following conditions are met: ▪ The RHC and MHP must have a signed contract outlining payment provisions in order for the RHC to provide Medicaid-covered services to the MHP enrollee. ▪ The contract must provide for the MHP to reimburse the RHC at a fair market rate for similarly situated beneficiaries served by a non-RHC provider. The MHP must implement a level of payment equal to, or above, that of other subcontracting arrangements when entering into a subcontract with a RHC. ▪ The RHC must file information with the MDCH HHPRD in a format determined by MDCH showing encounters and payments of Medicaid beneficiaries enrolled with MHP. ▪ RHCs may not bill Medicaid for MHP beneficiaries. ▪ After verification of the fair market rate by the HHPRD, the difference between RHC prospective rate and MHP payments are reconciled by MDCH annually. ▪ The contract between RHCs and MHP services are subject to review and verification by MDCH. A Level of Care Code 07 identifies MHP enrollees.
Healthy Kids Dental	Dental services provided to Medicaid beneficiaries enrolled in the Healthy Kids Dental program are eligible for the prospective rate. RHCs should report Medicaid information on encounters and revenue in the annual reconciliation report. The RHC receives the difference between the prospective rate and the revenue received as part of the annual reconciliation.

Medicare / Medicaid	Medicaid covered primary care services provided to Medicare/Medicaid dual eligibles are considered Medicaid encounters and are reimbursed under the PPS methodology.

5.3 Eligibility Groups Not Subject to PPS Methodology

If an individual does not have Medicaid eligibility (i.e., is eligible for the Adult Benefits Waiver [ABW], CSHCS-Title V or MOMS only), the services and costs are not Medicaid RHC services. ABW, CSHCS or MOMS may be paid FFS rates only.

SECTION 6 - RATE SETTING

The RHC is reimbursed on a per visit basis for RHC services. The per visit payment is equal to 100 percent of the average of the RHC's reasonable costs of providing Medicaid services during fiscal years 1999 and 2000. MDCH defines reasonable costs as the per-visit amount approved and paid by Medicare. For RHCs that have a fiscal year ending other than September 30, the prospective rate is prorated based on the number of months in each period covered by a different prospective rate.

The per visit amount is adjusted each year beginning on October 1, 2001 by 100 percent of the Medicare Economic Index for the prior calendar year (i.e., the adjustment effective October 1, 2001 reflects the index for calendar year 2000).

The per visit amount may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by the RHC. An adjustment to the per-visit amount based upon a change in the scope of services becomes effective as determined by MDCH.

Any rate setting/cost settlement related questions should be directed to the Hospital & Health Plan Reimbursement Division (HHPRD). (Refer to the Directory Appendix for contact information.)

6.1 ESTABLISHING RATES FOR NEW CLINICS

An entity that first qualifies as an RHC after fiscal year 2000 is paid a per visit amount equal to 100 percent of the reasonable costs of furnishing such services during that fiscal year based on the rates established under the PPS for the fiscal year for other RHCs located in the same or adjacent county with a similar caseload. If there is no other RHC similarly situated, the newly established RHC is paid a per visit amount based on an estimate of its reasonable costs of providing such services and is reconciled at the end of its first fiscal year of operation.

6.2 ALTERNATE PAYMENT METHODOLOGY

The State and the RHC may agree to an alternative payment methodology that provides reimbursement at least equal to that which an RHC would receive under the PPS.

6.3 QUARTERLY PAYMENTS

RHCs receive a quarterly payment. This payment is an estimate of the difference between the payment the RHC receives from various sources (FFS, MHP, Medicare and other insurance) and the amount the RHC should receive under the PPS. These quarterly payments are included in the annual reconciliation.

SECTION 7 - BILLING

7.1 BILLING RURAL HEALTH CLINIC SERVICES

RHC services are billed on the HCFA 1500 claim form for paper professional claims or ASC X12N 837 professional electronic format. Refer to the Billing & Reimbursement for Professionals Chapter of this manual for information needed to submit professional claims to MDCH, as well as information about how MDCH processes claims and notifies the RHC of its actions.

MDCH strongly encourages electronic submission of claims.

7.2 PLACE OF SERVICE REQUIREMENTS

RHCs must use place of service (POS) code 72 when billing services provided in the clinic. For services provided outside the RHC, bill with the appropriate POS code noted in the Billing & Reimbursement for Professionals Chapter of this manual.

RHCs may provide Medicaid covered services in settings other than the RHC office, patient's home, nursing facility or domiciliary facility, but these services are not included in the prospective payment system. Services provided outside of the settings noted here are reimbursed at FFS rates.

7.3 BILLING FOR MATERNITY CARE

Global codes for maternity care are used to reimburse a package of services (prenatal visits and delivery) at different places of services (RHC and hospital). In order for the RHC to be reimbursed for prenatal visits under the PPS methodology, the RHC should not bill for global maternity care. The claims for delivery and prenatal care should be billed separately. The claim for delivery should show a hospital place of service and will be paid under the FFS methodology. The claim for prenatal care should be billed with a RHC place of service (72) using the appropriate prenatal codes. These prenatal services will be reimbursed under the PPS methodology.

If the RHC elects to bill for global maternity care, all services will be reimbursed under the FFS rules.

7.4 COORDINATION OF BENEFITS

It is the provider's responsibility to question beneficiaries as to the availability of Medicare and other insurance coverage prior to the provision of a service. Providers must bill third party payers and receive payment to the fullest extent possible before billing Medicaid. Private health care coverage and accident insurance, including coverage held by, or on behalf of, a Medicaid beneficiary is considered primary and must be billed according to the rules of the specific commercial plan. (Refer to the Coordination of Benefits Chapter of this manual for additional information.)

7.5 OTHER INSURANCE AND COVERAGE PAYMENTS

All other insurance payments received for services rendered to a Medicaid beneficiary must be reported on the claim. Even if the other insurance payment for a specific service exceeds the amount Medicaid would have paid, the RHC must bill the FFS procedure code to receive credit for an encounter. Refer to the Billing & Reimbursement for Professionals Chapter of this manual, or the 837 Professional Implementation Guide and MDCH 837 Professional Companion Guide for specific billing guidelines.

7.6 Medicare and Medicaid Crossover Claims

If a Medicaid beneficiary has Medicare and Medicaid, the RHC must follow the billing instructions outlined in the Billing & Reimbursement for Professionals Chapter of this manual or the 837 Professional Implementation Guide and MDCH 837 Professional Companion Guide for specific billing guidelines for Medicare. Even if the Medicare payment exceeds MDCH fee screen, the RHC must bill the FFS procedure code to receive credit for an encounter.

7.7 Co-Payments

Medicaid co-payments for chiropractic, dental, podiatry, and vision services are waived under the RHC benefit as part of the reconciliation. (Services requiring co-payments are listed in the General Information for Providers Chapter of this manual.)

7.8 Dental Claims

RHCs providing dental services must refer to the Dental and Billing & Reimbursement for Dental Providers Chapters of this manual for information regarding program coverages, prior authorization requirements, claims completion and billing instructions.

SECTION 8 - RISK CONTRACTS

RHCs may enter into risk contracts with MHPs for nonprimary care services. However, these contracts are not included in the reconciliation process. All RHC reconciliations are for primary care services only.

8.1 SCOPE OF SERVICE

The prospective payment rate may be adjusted for an increase or decrease in scope of service.

8.1.A. INCREASE IN SCOPE OF SERVICE

An increase in scope of service results from the addition of a new professional staff member (i.e., contracted or employed) who is licensed to perform covered medical services that no current professional staff is licensed to perform.

8.1.B. DECREASE IN SCOPE OF SERVICE

A decrease in scope of service results when no current professional staff member is licensed to perform the medical services currently performed by a departing professional staff member.

8.1.C. CHANGES THAT DO NOT CHANGE THE SCOPE OF SERVICES

An increase or decrease in scope of service does not result from any of the following (although some of these changes may occur in conjunction with a change in scope of service):

- An increase, decrease or change in number of staff working at the clinic.
- An increase, decrease or change in office hours.
- An increase, decrease or change in office space or location.
- The addition of a new site that provides the same set of services.
- An increase, decrease or change in equipment or supplies.
- An increase, decrease or change in the number or type of patients served.

8.2 NOTICE OF INTENT TO CHANGE SCOPE OF SERVICE

If an RHC intends to change its scope of service, MDCH HHPRD must be notified 90 days before any financial commitments (i.e., money paid or committed to be paid, contracts signed, etc.) have been made. Notification should include the following documentation:

- Complete description of the service to be changed (addition or deletion).
- A listing of procedure codes to be billed as a result of this new service.
- A budget for the fiscal year showing an estimate of the total increase or decrease in cost resulting from change.
- An estimate of the change in number of encounters.

- Estimates of the cost change on the current Medicaid encounter rate.
- The proposed customary charges for this service by the RHC.
- The customary charges for this service by other providers in the area served by this RHC.
- The amount to be paid by an MHP for this service for various programs (Medicare/Medicaid).
- The current Medicare encounter rate.
- Medicare fee screen for this service for non-full cost providers.
- Total encounters for last two years by program (Medicaid, Medicare, uninsured, etc.), and type (MHP, fee screen/contracted amount).
- Estimated change in encounters by program for two fiscal periods following the change in scope of service.
- Copies of notices, certifications, applications, approvals and other documentation from the state-licensing agency, CMS, Medicare intermediary, or other organizations documenting the change in scope of service.
- Other information showing cost, encounters or approvals/denials of the change.
- Other information as requested by the HHPRD.

After a review of the information submitted, the HHPRD notifies the RHC of its determination regarding a rate change, including the effective date of any change.

SECTION 9 – RECONCILIATION REPORTING

Medicaid RHC Reconciliation Reports must be completed by each RHC in order to receive reimbursement under the PPS.

The RHC must file the following documents at the end of its fiscal year for full cost reimbursement:

- A copy of its filed Medicare Cost Report and Trial Balance.
- A completed copy of the Medicaid Reconciliation Report.
- Additional documentation as requested.

9.1 REPORT FILING

RHCs must file RHC Reconciliation Reports and supplemental documents to the MDCH HHPRD annually. Due dates are consistent with the Medicare Cost Report filing requirement. If the required reconciliation report and supplemental documents are not submitted within the required time limit the RHC waives its right to the PPS reimbursement for that year.

The reconciliation report is the basis for determining future quarterly payments and the current year's reconciliation. The report must be an original(s) and signed by the authorized individual who normally signs the RHC's federal income tax return or similar reports and should be for the same fiscal period and cover the same sites as the Medicare Cost Report. Improperly completed or incomplete filings are returned to the facility for proper completion and must be resubmitted to MDCH within 30 days of date of receipt.

9.2 ACCOUNTING AND RECORD KEEPING

RHCs must maintain, for a period of not less than six years from the end of the fiscal year of the RHC Reconciliation Report, financial and clinical records for the period covered by the reconciliation report that are accurate and in sufficient detail to substantiate the information reported. If there are unresolved issues at the end of this six-year period, the records must be maintained until these issues are resolved.

MDCH HHPRD retains each required RHC Reconciliation Report and supplemental documents submitted by the RHC for six years after issuance of a final decision. In the event there are unresolved issues at the end of this six-year period, the report is maintained until such issues are resolved.

SECTION 10 – AUDIT, SETTLEMENTS AND APPEALS

An annual reconciliation is performed to assure that the prospective payment rate is paid to the RHC for all eligible encounters. The reconciliation process begins with the receipt of the RHC's Reconciliation Report and supplemental documents and ends with the issuance of the Notice of Amount of Program Reimbursement.

10.1 DESK REVIEWS AND FIELD AUDITS

The desk review may include procedures that:

- Verifies the completeness and mathematical accuracy of all schedules in the report.
- Compares the Reconciliation Report with MDCH paid claim and encounter data.
- Identifies the need for supporting documentation and arrange to receive same.
- Identifies the need for a field audit examination necessary to conclude final reconciliation calculations.
- Compares reported data with industry norms as an aid to the audit scope determination.

Field audits may be conducted to verify information on the Reconciliation Report.

10.2 MEDICARE AUDIT

The Medicare intermediary may perform audits of the RHC. These audit results may be used to verify information or for statistical purposes.

10.3 INITIAL RECONCILIATION AND SETTLEMENT

An initial reconciliation is calculated after the annual reconciliation report is received. The initial reconciliation is processed approximately four months after the reconciliation report is received with the payment or recovery made at that time. Future quarterly payments are adjusted based on the information in the initial reconciliation.

10.3.A. UNDERPAYMENTS TO AN RHC

Based on the annual reconciliation, MDCH reimburses any underpayment due an RHC through a gross adjustment. This gross adjustment is shown in a Remittance Advice (RA). MDCH retains the right to withhold a portion of any initial payment based on individual circumstances.

10.3.B. OVERPAYMENTS TO AN RHC

Once a determination of overpayment has been made, the amount so determined is a debt owed to the State of Michigan and will be recovered by MDCH. The recovery starts approximately 30 days after notification to the RHC. The gross adjustment stops all payments to the RHC's physician(s) until the full amount is recovered.

10.4 Audit Adjustment Report

The Audit Adjustment Report contains a list of all Program data adjustments made to the Medicaid Reconciliation Report by MDCH audit staff.

10.4.A. RHC Accepts Audit Adjustment Report

If the RHC accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the RHC should sign the report and mail it to MDCH HHPRD. (Refer to the Directory Appendix for contact information.)

A Notice of Amount of Program Reimbursement is then mailed to the RHC. No further administrative appeal rights are available for the adjustments contained in the Audit Adjustment Report.

10.4.B. Notice of Amount of Program Reimbursement

The Notice of Amount of Program Reimbursement is the notice of final determination of an adverse action and is considered the offer of settlement for all reimbursement issues for the reporting period under consideration.

10.4.C. Acceptance of the Audit Adjustment Report

The Audit Adjustment Report must be accepted or rejected by the RHC within 30 calendar days of its mailing date. If the RHC has not responded within this time period, MDCH shall issue a Notice of Amount of Program Reimbursement that is the final determination of an adverse action. No further administrative appeal rights are available.

10.4.D. RHC Rejection of the Audit Adjustment Report

Within 30 calendar days of the mailing date of the Audit Adjustment Report, the RHC may reject any or all of the findings in the Audit Adjustment Report and request a post-audit conference.

The Post-Audit Conference is an informal process where the HHPRD staff and the RHC may resolve differences prior to an appeal and/or formal hearing. The process is initiated by the RHC after the receipt of the Audit Adjustment Report. The RHC must request in writing a Post-Audit Conference with the HHPRD and indicate in that letter the area(s) of disagreement. The letter must state the appropriate regulation and/or other appropriate decisions that support the RHC's position and be sent to MDCH HHPRD. (Refer to the Directory Appendix for contact information.)

The RHC or its representative must present, either before or at the time of the Post-Audit Conference, the audit staff with the documents and arguments that support its position relative to the disputed issue(s). The audit staff will explain to the RHC the basis for its findings. This step does not stop the recovery of monies due Medicaid.

10.5 APPEALS

RHCs have the right to appeal any adverse action taken by MDCH, unless that adverse action resulted from an action over which MDCH had no control (e.g., Medicare termination, license revocation). The appeal must be submitted in writing and mailed to MDCH Administrative Tribunal and Appeals Division. (Refer to the Directory Appendix for contact information.)

The appeal process is outlined in the MDCH Medicaid Provider Reviews and Hearings rules R400.3401 through R400.3424. Any questions regarding the appeal process should be directed to the Administrative Tribunal and Appeals Division.

RHCs may appeal their respective Notice of Program Reimbursement if the contested issue(s) are other than those precluded due to failure to appeal rate adjustment(s) in the Audit Adjustment Report according to established time frames. Appeals accepted as appropriate are also governed by the aforementioned MDCH Medicaid Provider Reviews and Hearings rules.

SCHOOL BASED SERVICES

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION

This chapter applies to Enrolled Intermediate School Districts.

This chapter describes covered medical services provided to individuals eligible under provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended in 1997 and to those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Program (IFSP). These services assist students with a disability to benefit from special education and related services. Medicaid reimbursement, through the Michigan Department of Community Health (MDCH), addresses the medical service needs of students receiving special education and related services and provides funding for those services. The Social Security Act, as amended in 1988 by the Medicare Catastrophic Coverage Act, specifically provides for medical assistance (Medicaid) to cover services which are "included in the child's IEP established pursuant to Part B of the IDEA or furnished to a handicapped infant or toddler because such services are included in the child's IFSP adopted pursuant to Part C (formerly called Part H) of such Act."

Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to handicapped children. These services may include health care services similar to those covered by the IDEA and Medicaid. These services are described in an individualized service plan and provided free of charge to eligible individuals. Medicaid reimbursement is not allowed for these services.

Coverage is based on medically necessary Medicaid-covered services already being provided by schools and enables these services provided to Medicaid-eligible students to be billed to Medicaid, thus ensuring federal participation in the cost of providing these services. Maintenance of a least restrictive and most functional education environment is an intended outcome of Medicaid enrollment as a school based services (SBS) provider. Enrollment as a Medicaid SBS provider is limited to the Intermediate School Districts (ISDs), Detroit Public Schools (DPS) and the Michigan School for the Deaf and Blind (MSDB).

Enrolled providers are required to establish an interagency agreement to facilitate coordination and cooperation with other human service agencies operating within the same service area. School Based Services are to be provided as outlined in the IEP/IFSP treatment plan and are not expected to replace or substitute for services already provided by other agencies. Enrollment as a SBS provider is not expected to result in any change in the education agency's set of existing services or service utilization. MDCH periodically evaluates the impact of Medicaid enrollment on special education programs through review of service utilization and other program data and information.

Covered services do not require prior authorization but must be documented and provided by qualified personnel as specified in the Covered Services Section of this chapter.

1.1 SCHOOL BASED SERVICES PROGRAM

The following terms have specific meanings in the School Based Services (SBS) Program:

Enrolled Provider	ISDs, DPS and MSDB that have completed the enrollment form, certified staff and signed an agreement with MDCH.

HT Modifier (Multi-disciplinary team)	The HT modifier is used when billing for an assessment, evaluation or test performed for the IDEA Assessment. Each qualified staff bills using the appropriate procedure code followed by the modifier HT (multi-disciplinary team).
IEP (Individualized Education Program)	A written plan for services for eligible students between the ages of five and 26 in Michigan, as determined by the federal IDEA statute. Medicaid funds are available to reimburse for health and medical services that are a part of a student's IEP.
IFSP (Individualized Family Services Program)	A written plan for a child with a disability who is between the ages of zero and five years, that is developed jointly by the family and appropriate qualified personnel, and is based on multi-disciplinary evaluation and assessment of the child's unique strengths and needs, as well as on a family-directed assessment of the priorities, resources and concerns. Medicaid funds are available to reimburse for health and medical services that are a part of a child's IFSP.
IDEA (Individuals with Disabilities Education Act)	The federal statute, first enacted in 1975 and most currently amended in 1997, that requires public schools to determine whether a child has a disability, develop a plan that details the education and support services that the student will receive, provide the services, and evaluate the plan at least annually. There may be federal funding available for some of these responsibilities.
IDEA Assessment	IDEA Assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if an individual is eligible under provisions of the IDEA of 1990 as amended in 1997 and are related to the evaluation and functioning of the individual.
ISD (Intermediate School District)	A corporate body established by statute in the Michigan Revised School Code (PA 451 of 1976) that is regulated by an intermediate school board. Michigan has 57 intermediate school districts.
MDE (Michigan Department of Education)	A department within the State of Michigan.
SBS (School Based Services Program)	A Michigan Medicaid program with two components, Fee-for-Service (FFS) and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Administrative Outreach. All Michigan ISDs, the DPS, and the MSDB participate in the Fee-for-Service component. All ISDs and DPS participate in the EPSDT Administrative Outreach Program.
School Clinical Record	All the written or electronic information that has been created and is necessary to fully disclose and document the services requested for reimbursement.
Special Education Transportation	Transport to and from the student's pick-up and drop-off site where school based services are provided.

TM Modifier (Individualized Education Program [IEP])	The TM modifier is used when billing for the multi-disciplinary team assessment for the development, review and revision of an IEP/IFSP treatment plan. Each qualified staff bills for this assessment using the appropriate procedure code with the modifier TM (Individualized Education Program [IEP]).
Treatment Plan	If an evaluation indicates that Medicaid-covered services are required, the qualified staff must develop and maintain a treatment plan for the student. The student's IEP/IFSP form may suffice as the treatment plan as long as the IEP/IFSP contains the required components described under the Treatment Plan subsection.

1.2 Third Party Liability

Third Party Liability (TPL) is defined as a payment resource available from both private and public insurance and other liable third parties that can be applied toward the student's health care expense. If a Medicaid-eligible student is presently covered under another health insurance policy and the district does not bill the TPL, Medicaid cannot be billed for the medical service. (Refer to the Coordination of Benefits Chapter of this manual for additional information on TPL.)

1.3 Children's Special Health Care Services

The Medicaid program reimburses services for students dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid. SBS providers are not reimbursed for students enrolled only in the CSHCS program, and must not submit claims for these students.

1.4 Medical Necessity

A school based service is determined medically necessary when all of the following criteria are met:

- Addresses a medical or mental disability;
- Assists the student to benefit from special education or a related educational program;
- Is included in the student's IEP/IFSP treatment plan; and
- Is ordered, in writing, by a physician or other licensed practitioner acting within the scope of his practice under State law. Students who require speech, language and hearing services must be referred. A referral means contact by a physician with the speech pathologist or audiologist providing the service or with an enrolled School Based Services provider for special education and related services. The written order/referral must be updated at least annually.

1.5 Covered Services

School based services that may be covered include:

- Evaluations and tests performed for assessments.
- Therapies (Occupational, Physical, and Speech, Language and Hearing).
- Assistive Technology Device (ATD) Services.
- Psychological, Counseling and Social Work Services.

- Developmental Testing.
- Nursing Services.
- Physician and Psychiatrist Services.
- Targeted Case Management (TCM) Services.
- Vision Orientation and Mobility Training.
- Special Education Transportation.

1.6 Service Expectations

The IEP/IFSP treatment plan must include the appropriate annual goals and short-term objectives, criteria, evaluation procedures and schedules for determining whether the objectives are being achieved within an appropriate period of time. All therapy services must be skilled (i.e., require the skills, knowledge, and education of a registered occupational therapist, licensed physical therapist or certified speech-language pathologist or audiologist). Interventions expected to be provided by another practitioner (e.g., teacher, registered nurse), family member or caregiver are not reimbursable as occupational, physical, and speech, language and hearing therapy by this program.

To be covered by Medicaid, occupational, physical, and speech, language and hearing therapy must address a student's medical need that affects his/her ability to learn in the classroom environment. MDCH does not reimburse for therapies that do not have medically related goals (i.e., handwriting, increasing attention span, identifying colors and numbers, enhancing vocabulary, improving sentence structure and reading, and increasing attention span).

Group therapy or treatment must be provided in groups of two to eight students. Services provided as part of a regular classroom activity are not reimbursable. When regularly scheduled attention is provided to one student who is part of the class currently in session, the service is not reimbursable.

Supplies or equipment utilized in service delivery are included as part of the service and are not reimbursed separately. Art, music and recreation therapies are not covered services.

Medicaid is required to follow the procedure code definition from the Current Procedural Terminology (CPT) and Health Care Financing Administration Common Procedure Coding System (HCPCS) manuals. Procedure codes referencing office or outpatient facility include the medical services provided in the school setting. Procedure codes that do not specify a unit of time are to be billed per session. Group therapy is billed per student.

Certain CPT/HCPCS code descriptions include a specified unit of service time. Service times are based on the time it generally takes to provide the service. If the procedure code specifies a unit of time, it may be billed when the service time equals the unit of time. Any additional time cannot be billed unless the full time specified is reached.

Consultation or consultative services are an integral part or an extension of a direct medical service and are not separately reimbursable.

1.7 Treatment Plan

Requirements	If an evaluation indicates that Medicaid-covered services are required, the qualified staff must develop and maintain a treatment plan for the student. The student's IEP/IFSP form may suffice as the treatment plan as long as the IEP/IFSP contains the required components described below. Only qualified staff may initiate, develop or change the student's treatment plan. The treatment plan must be signed, titled and dated by the qualified staff prior to billing Medicaid for services and must be retained in the student's school clinical record. (Refer to Covered Services Section of this chapter for definitions of qualified staff.)
Components	The treatment plan, which is an immediate result of the evaluation, must consist of the following components: ▪ Student's name; ▪ Description of the student's qualifying diagnosis and medical condition; ▪ Time-related goals that are measurable and significant to the student's function and/or mobility; ▪ Long-term goals that identify specific functional achievement to serve as indicators that the service is no longer needed; ▪ Anticipated frequency and duration of treatment required to meet the time related goals; ▪ Plan for reaching the functional goals and outcomes in the IEP/IFSP; ▪ A statement detailing coordination of services with other providers (e.g., medical and educational); and ▪ All services are provided with the expectation that the student's primary care provider and, if applicable, the student's case manager are informed on a regular basis.
Review	The treatment plan must be reviewed and updated at least annually as part of the IEP/IFSP multi-disciplinary team assessment process, or more frequently if the student's condition changes or alternative treatments are recommended.

1.8 Evaluations

Evaluations for medical services are covered when:

- Performed as part of the IDEA Assessment.
- The student left and is re-entering special education or related program.
- At any time when (as required above) initiation, development, review or revision of the student's IEP/IFSP treatment plan will occur.
- A change or decrease in function occurs.

1.9 DOCUMENTATION

For covered services, the school clinical record must include all of the following:

- Student's name and birth date;
- Date of service/treatment;
- Type (modality) of service/treatment;
- The student's response to the service/treatment; and
- The name and title of the person providing the service/treatment and a dated signature.

For services that have time-specific procedure codes, the provider must indicate the actual begin and end time of the service in the school clinical record. The record must indicate the specific findings or results of the diagnostic or therapeutic procedures. The student's school clinical record should include documentation of the implementation and coordination of services for the special education student.

Progress notes must be written monthly, or more frequently as appropriate, and must include:

- Evaluation of progress;
- Changes in medical or mental status; and
- Changes in treatment with rationale for change.

(Refer to the General Information for Providers Chapter of this manual for additional information regarding clinical records.)

SECTION 2 – COVERED SERVICES

2.1 INDIVIDUALS WITH DISABILITIES EDUCATION ACT ASSESSMENT AND IEP/IFSP DEVELOPMENT, REVIEW AND REVISION

Definition	The Individuals with Disabilities Education Act (IDEA) Assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if a student is eligible under provisions of the IDEA of 1990 as amended in 1997 and are related to the evaluation and functioning of the student. These services are reimbursable only after they result in the implementation of an IEP/IFSP treatment plan. If an IEP/IFSP treatment plan is not implemented within one year of the date of service, then none of the services provided are covered.
Provider Qualifications	Qualified staff may bill for assessments, tests, and evaluations performed for the IDEA Assessment. To be covered by Medicaid, the staff must have the following credentials: ▪ An occupational therapist currently registered in Michigan (OTR); ▪ A licensed physical therapist (LPT) in Michigan; ▪ A speech-language pathologist or audiologist possessing a current Certificate of Clinical Competence (CCC) and others designated in the Speech, Language, and Hearing Therapy subsection of this chapter; ▪ A fully licensed psychologist (Doctoral level) in Michigan; ▪ A limited-licensed psychologist (Master's level) under the supervision of a licensed psychologist; ▪ A Michigan-licensed professional counselor; ▪ A school psychologist with a Master's degree in psychology with a minimum of 500 clock hours of supervised internship; ▪ A social worker with a Master's degree from a graduate school of social work and a minimum of 500 clock hours of supervised practicum; ▪ A physician or psychiatrist (MD or DO) with a current State of Michigan license to practice; ▪ A registered nurse (RN) with a Michigan license; ▪ Orientation and mobility specialist certified by the Association for the Education and Rehabilitation of the Blind and Visually Impaired; or ▪ A teacher consultant with a Master's degree in education or a field of study related to special education, and a minimum of three years teaching experience, not less than two years of which must be in teaching special education.

Procedure Codes	Qualified staff may bill for three distinct types of assessments/evaluations/tests as follows. All activities, such as meetings and written reports related to the assessment/evaluation/test, are an integral part or extension of the service and are not separately reimbursable. ▪ The **HT modifier** is used with the procedure code when billing for an evaluation, assessment or test performed for the IDEA Assessment. Each qualified staff bills using the appropriate procedure code below followed by the modifier HT (multi-disciplinary team). The date of service is the date of determination of eligibility for special education or early-on services. The determination date must be included in the assessment, test, or evaluation. ▪ The **TM modifier** is used with the procedure code when billing for the multi-disciplinary team assessment to develop, review and revise an IEP/IFSP treatment plan. Each qualified staff bills using the appropriate procedure code below with the modifier TM (Individualized Education Program [IEP]). The date of service is the date of the multi-disciplinary team assessment. ▪ Evaluations, assessments or tests may be provided not related to the IDEA Assessment or the IEP/IFSP treatment plan development, review and revision. Each qualified staff bills for these activities using the appropriate procedure code below with **no modifier**. The date of service is the date the evaluation, assessment or test is completed. Procedure codes to be used to bill for the above activities are: ▪ **T1024** - Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter (TCM designated case manager). This code can only be used with the TM modifier. ▪ **99361** - Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes. ▪ **92506** - Evaluation of speech, language, voice, communication auditory processing, and/or aural rehabilitation status (speech pathologist or audiologist) ▪ **H0031** - Mental Health Assessment, by nonphysician (psychologists, counselors and social workers) ▪ **T1001** - Nursing assessment/evaluation (registered nurse [RN]) ▪ **97003** - Occupational Therapy Evaluation (Occupational Therapist) ▪ **97001**- Physical Therapy Evaluation (Physical Therapist) ▪ **96110** – Developmental testing; limited (e.g. Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report (Teacher Consultant). This code can be used by itself, or with the HT or TM modifiers. ▪ **96111** – Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized development instruments), with interpretation and report (Teacher Consultant). This code can be used by itself, or with the HT or TM modifiers.

	▪ **V2799** – Vision services, miscellaneous (Vision Orientation and Mobility Specialist). This code is to be used for assessments and can be billed without a modifier, or with the HT or TM modifiers. An occupational therapist, physical therapist and speech language pathologist or audiologist may participate in IDEA Assessment for therapy and/or ATD services.
Special Instructions for Staff Responsible for Psychological and Developmental Testing	▪ The Psychological, Counseling and Social Work subsection below defines who can perform psychological testing and the procedure codes to be used for billing. Use the HT modifier discussed above when the testing is performed for the IDEA assessment. ▪ The Developmental Testing subsection below defines who can perform developmental testing and the procedure codes to be used for billing. Use the HT modifier discussed above when the testing is performed for the IDEA assessment. ▪ For participation in the team assessment to develop, review and revise the IEP/IFSP treatment plan, staff must use the TM modifier with the procedure code specified below by discipline: ➢ Audiologist – 92506 ➢ Counselor – H0031 ➢ Occupational Therapist – 97003 ➢ Physical Therapist – 97001 ➢ Physician/Psychiatrist – 99361 ➢ Psychologist – H0031 ➢ Registered Nurse – T1001 ➢ Social Worker – H0031 ➢ Speech Pathologist – 92506 ➢ TCM Designated Case Manager – T1024 (to be used with TM modifier only) ➢ Teacher Consultant – 96110 ➢ Teacher Consultant - 96111 ➢ Vision and Mobility Specialist – V2799

2.2 Occupational Therapy

Definition	Occupational therapy (OT) must be rehabilitative, active or restorative and designed to correct or compensate for a medical problem interfering with age appropriate functional performance. Occupational therapy services must require the skills, knowledge and education of an OTR or COTA to provide therapy.
Prescription	Occupational therapy services must be prescribed by a physician and updated annually.

Provider Qualifications	OT services may be reimbursed when provided by: ▪ An occupational therapist currently registered in Michigan (OTR); or ▪ A certified occupational therapy assistant (COTA) registered in Michigan and under the supervision of a currently-Michigan-registered OTR (i.e., the COTA's services must follow the evaluation and treatment plan developed by the OTR and the OTR must supervise and monitor the COTA's performance with continuous assessment of the student's progress). All documentation must be reviewed and signed by the appropriately supervising OTR.
Evaluations	Evaluations are formalized testing and reports for the development of the student's treatment plan. They may be completed by an OTR. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the student in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The student's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the student's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the student's ability to function; ▪ Assessment of the student's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the student.
Services	Occupational therapy services include: ▪ Group therapy provided in a group of two to eight students; ▪ Manual therapies techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions; and ▪ Wheelchair management/propulsion training.
Procedure Codes	The following procedure codes may be used to bill for occupational therapy services: ▪ **97003** – Occupational therapy evaluation. This code can be used by itself, or with the HT or TM modifiers. ▪ **97110** - Therapeutic procedure one or more area, each 15 minutes. Therapeutic exercises to develop strength and endurance, range of motion and flexibility. ▪ **97150** - Therapeutic procedure(s), group (2 or more individuals).

2.3 PHYSICAL THERAPY

Definition	Physical therapy (PT) must be rehabilitative, active or restorative and designed to correct or compensate for a medical problem. Physical therapy services must require the skills, knowledge and education of an LPT or CPTA to provide therapy. Treatment is performed through the use of therapeutic exercises and rehabilitative procedures.
Prescription	A physician must prescribe physical therapy services annually.
Provider Qualifications	PT services may be reimbursed when provided by: ▪ A licensed physical therapist (LPT) in Michigan; or ▪ A certified physical therapy assistant (CPTA) in Michigan and under the supervision of a currently-Michigan-registered LPT (i.e., the LPT supervises and monitors the CPTA's performance with continuous assessment of the student's progress). All documentation must be reviewed and signed by the appropriately licensed supervising LPT.
Evaluations	Evaluations are formalized testing and reports to determine a student's need for services and recommend a course of treatment. They may be completed by an LPT. Evaluations include: ▪ The treatment diagnosis and the medical diagnosis, if different than the treatment diagnosis; ▪ Current therapy being provided to the student in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The student's current functional status (i.e., functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the student's performance components (e.g., strength, dexterity, range of motion) directly affecting the student's ability to function; ▪ Assessment of the student's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the student.
Services	Physical therapy services include: ▪ Group therapy provided in a group of two to eight students; ▪ Gait training; ▪ Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility); ▪ Stretching for improved flexibility; and ▪ Modalities to allow gains of function, strength or mobility.

Procedure Codes	The following procedure codes may be used to bill for physical therapy services: ▪ **97001** – Physical therapy evaluation. This code can be used by itself, or with the HT or TM modifiers. ▪ **97110** - Therapeutic procedure, one or more area, each 15 minutes. Therapeutic exercises to develop strength and endurance, range of motion and flexibility. ▪ **97150** - Therapeutic procedure(s), group (2 or more individuals).

2.4 Speech, Language and Hearing Therapy

Definition	Speech, language and hearing therapy must be a diagnostic or corrective service or to teach compensatory skills for deficits that directly result from a medical condition. This service is provided to students with a diagnosed speech, language or hearing disorder adversely affecting the functioning of the student. Speech, language and hearing therapy must require the skills, knowledge and education of a qualified speech-language pathologist or audiologist to provide the therapy.
Prescription	Speech, language and hearing services require an annual referral from a physician.
Provider Qualifications	Speech, language and hearing services may be reimbursed when provided by: ▪ A speech-language pathologist or audiologist possessing a current Certificate of Clinical Competence (CCC); ▪ An appropriately supervised speech-language pathologist (SLP) and/or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a CCC). All documentation must be reviewed and signed by the appropriately-credentialed supervising SLP or audiologist; ▪ Master's Degree in Speech and Language Pathology with a minimum of 300 clock hours of supervised practicum experience; or ▪ A person employed as a teacher of the speech and language impaired who met the requirements of the Michigan Special Education Rules before the effective date of the Rules amended August 13, 1980.
Evaluations	Evaluations are formalized testing and reports conducted to determine the need for services and recommendation of a course of treatment. An SLP or audiologist may complete them. Evaluations include: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the student in this and other settings; ▪ Medical history as it relates to the current course of therapy;

	▪ The student's current communication status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the student. Evaluations may also include, but are not limited to,: ▪ Articulation - standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication, and a medical diagnosis. ▪ Language - standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es). ▪ Rhythm - standardized tests that measure receptive and expressive language, mental age, oral motor skills, and measurable assessment of dysfluency, current means of communication, and a medical diagnosis. ▪ Swallowing - copy of the videofluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment, and a standardized cognitive assessment. ▪ Voice - copy of the physician's medical assessment of the student's voice mechanism and the medical diagnosis.
Services	Speech, language and hearing services include: ▪ Group therapy provided in a group of two to eight students. ▪ Articulation, language, and rhythm. ▪ Swallowing dysfunction and/or oral function for feeding. ▪ Voice therapy. ▪ Speech, language or hearing therapy. ▪ Speech reading/aural rehabilitation. ▪ Esophageal speech training therapy. ▪ Speech defect corrective therapy. ▪ Fitting and testing of hearing aids or other communication devices.

Procedure Codes	The following procedure codes may be used to bill for speech, language and hearing therapy services: ▪ **92506** – Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status. This code can be used with no modifier, or with the HT or TM modifiers. ▪ **92507** - Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehab); individual. ▪ **92508** - Therapeutic procedure(s), group (2 or more individuals).

2.5 Assistive Technology Device Services

Definition	An assistive technology device (ATD) is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, customized or developed by staff as an orthotic device that is used to increase, maintain, or improve the functional capabilities of a student. The device primarily addresses a medical condition by replacing a missing body part, preventing or correcting a physical deformity or malfunction, supporting a weak or deformed portion of the body (prosthetic function) or restoring communication skills to meet basic medical need by providing a tool to the student (rehabilitative function).
Provider Qualifications	ATD services may be reimbursed when provided by: ▪ An occupational therapist currently registered in Michigan (OTR); ▪ A licensed physical therapist (LPT) in Michigan; ▪ A speech-language pathologist or audiologist possessing a current Certificate of Clinical Competence (CCC); ▪ An appropriately supervised speech-language pathologist (SLP) and/or audiology candidate (i.e., in his/her clinical fellowship year or having completed all requirements but has not obtained a CCC). All documentation must be reviewed and signed by the appropriately-credentialed supervising SLP or audiologist; or ▪ A person employed as a teacher of the speech and language impaired who met the requirements of the Michigan Special Education Rules before the effective date of the Rules amended August 13, 1980.
Services	ATD services are intended to directly assist a student with a disability in the selection, acquisition, or use of an ATD. Services include: ▪ Selecting, providing for the acquisition of the device, designing, fitting, customizing, adapting, applying, retaining, or replacing the ATD, including orthotics. ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the student or, if appropriate, the student's parent/guardian.

	▪ Training or technical assistance for professionals providing other education or rehabilitation services to the student receiving ATD services. ▪ Neuromuscular reduction of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities. ▪ Evaluating the needs of the student, including a functional evaluation of the student.
Documentation	The need for Assistive Technology Device (ATD) services must be specified in the student's IEP/IFSP treatment plan. The service must be documented as part of a specific therapy, namely physical, occupational, speech or audiology. If the ATD service is part of physical or occupational therapy, then a physician prescription is required. If the service is part of speech therapy, then a physician referral is required. Speech related ATD services may be billed using procedure code **97535**.
Procedure Codes	The following procedure codes may be used to bill for ATD services: ▪ **97112** - Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities. ▪ **97504** - Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk, each 15 minutes. ▪ **97520** - Prosthetic training, upper and/or lower extremities, each 15 minutes. ▪ **97535** - Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.

2.6 Psychological, Counseling and Social Work Services

Definitions	Psychological, counseling and social work services include planning, managing and providing a program of face-to-face services for students with diagnosed psychological conditions. Psychological, counseling and social work services must require the skills, knowledge and education of a psychologist, counselor or social worker to provide treatment. Psychotherapy is the treatment of a mental disorder or behavioral disturbance for which the clinician provides services through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy and Insight-Oriented, Behavior-Modifying and/or Supportive Psychotherapy.

	▪ Interactive psychotherapy refers to the use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the clinician and a student who has not yet developed, or has lost, either the expressive language communication skills to explain their symptoms and response to treatment or the receptive communication skills to understand the clinician if they would use ordinary adult language for communication. ▪ Insight-oriented, behavior-modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, and the use of cognitive discussion of reality or any combination of the above to provide therapeutic change.
Provider Qualifications	Psychological, counseling and social work services may be reimbursed when provided by: ▪ Licensed physician or psychiatrist in the State of Michigan; ▪ A fully licensed psychologist (Doctoral level) in Michigan; ▪ A limited-licensed psychologist (Master's level) under the supervision of a licensed psychologist; ▪ A school psychologist with a Master's degree in psychology with a minimum of 500 clock hours of supervised internship; ▪ A social worker with a Master's degree from a graduate school of social work and a minimum of 500 clock hours of supervised practicum; ▪ Licensed professional counselor in the State of Michigan; or ▪ Limited licensed counselor under the supervision of a licensed professional counselor.
Evaluations	Evaluations or assessments include tests, interviews and behavioral evaluations that appraise cognitive, emotional, social functioning and self-concept. These may also include interpretations of information about a student's behavior and conditions relating to functioning. A qualified psychologist, counselor or social worker must complete them.
Psychological Testing	Psychological testing includes tests, interviews, evaluations and recommendations for treatment. This may also include interpretations of information about a student's behavior and conditions relating to functioning. A fully licensed psychologist, a limited-licensed psychologist, or a school psychologist may perform psychological testing. Medicaid covers psychological testing that is reasonable and necessary for diagnosing the student's condition. Medicaid does not cover the time that a student spends alone in testing. The student's school clinical record must be signed and dated by the staff that administered the tests and include the actual tests administered and completed reports. The protocols for testing must be available for review. Psychological testing may be billed per hour with a five-hour maximum per year, and a report must be generated from the results of the tests. In accordance with CPT guidelines, the service includes testing time only; it does not include writing a report. Writing the report is considered a part of the testing process and is a requirement for billing.

	The psychological testing report must include all of the following: ▪ Student name and birth date; ▪ Psychological tests administered; ▪ Summary of testing results; ▪ Treatment recommendations; and ▪ Psychologist name and dated signature.
Procedure Codes	The following procedure codes may be used to bill for psychological testing: ▪ **96100** - Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI) with interpretation and report, per hour. ▪ **96115** - Neurobehavioral status exam (clinical assessment of thinking reasoning and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour. ▪ **96117** - Neuropsychological testing battery (e.g., Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour. The following procedure codes may be used to bill for psychological, counseling and social work services. Only one individual psychotherapy procedure code (20 to 30 minutes or 45 to 50 minutes) may be billed per day: ▪ **90804** - Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility, 20 to 30 minutes, face-to-face with the patient. ▪ **90806** - Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes, face-to-face with the patient. ▪ **90810** - Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms for nonverbal communication, in an office or outpatient facility, approximately 20 to 30 minutes, face-to-face with patient. ▪ **90812** - Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms for nonverbal communication, in an office or outpatient facility, approximately 45 to 50 minutes, face-to-face with patient. ▪ **90846** - Family psychotherapy (conjoint psychotherapy) without the patient present. ▪ **90847** - Family psychotherapy (conjoint psychotherapy) with patient present. ▪ **90853** - Group psychotherapy (other than of a multiple-family group). ▪ **H0004** - Behavioral health counseling and therapy, per 15 minutes. ▪ **H0031** – Mental health assessment, by non-physician (e.g. psychologist, counselor, social worker). This code can be used by itself, or with the HT or TM modifiers.

Crisis Intervention	Crisis intervention services are unscheduled activities performed for the purpose of resolving an immediate crisis situation. Activities include crisis response, assessment, referral and direct therapy. Since these services are unscheduled activities, they are not listed in the student's IEP/IFSP treatment plan. Crisis intervention must be billed using the procedure code **S9484 -** Crisis intervention mental health services, per hour.

2.7 DEVELOPMENTAL TESTING

Definition	Developmental testing is medically related testing (not performed for educational purposes) provided to determine if motor, speech, language and psychological problems exist or to detect the presence of any developmental delays. Testing is accomplished by the combination of several testing procedures and includes the evaluation of the student's history and observation. Whenever possible and when age-appropriate, standardized, objective measurements are to be used (e.g., Denver II) for children under the age of six. Administering the tests must generate material that is formulated into a report.
Documentation	The developmental testing report must include all of the following: ▪ Student name and birth date; ▪ Tests administered; ▪ Summary of testing results; ▪ Treatment recommendations; and ▪ The dated signature, address and phone number of the person administering the tests.
Provider Qualifications	Developmental testing services may be reimbursed when provided by the following qualified staff in accordance with their professional credentials: ▪ A fully-licensed psychologist (Doctoral level) in the State of Michigan; ▪ A limited-licensed psychologist (Master's level) under the supervision of a licensed psychologist; ▪ A school psychologist with a Master's degree in school psychology with a minimum of 500 clock hours of supervised internship; ▪ A social worker with a Master's degree from a graduate school of social work program and a minimum of 500 clock hours of supervised practicum; or ▪ Teacher consultant with a Master's degree in education or a field of study related to special education and a minimum of three years teaching experience, not less than two years of which must be in teaching special education. This individual cannot be involved in any instructional activities during testing.

Procedure Codes	The following codes may be used to bill for developmental testing: ▪ **96110** - Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report. ▪ **96111** – Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.

2.8 NURSING SERVICES

Definition	Nursing services are professional services relevant to the medical needs of the student provided through direct intervention. Direct service interventions must be medically based services, that are within the scope of the professional practice of the Registered Nurse (RN) and Licensed Practical Nurse (LPN), provided during a face-to-face encounter, and provided on a one-to-one basis. Medicaid policy will follow current Michigan Public Health Code scope of practice guidelines for Nursing practices. Services include: ▪ Catheterizations or Catheter care ▪ Maintenance of tracheostomies ▪ Medication administration ▪ Oxygen administration ▪ Tube feeding ▪ Suctioning ▪ Ventilator care Services considered observation or stand-by in nature are not covered. LPN services can only be billed **if** performed under the supervision of an RN or physician.
Prescription	Direct service interventions require a physician's written order when the initial need for services is determined. Direct service interventions must be reviewed and revised annually or as medically necessary by the student's attending physician. The school nurse is responsible for notifying the attending physician of any change in the student's condition, which may result in a change or modification to the care plan.
Provider Qualifications	Nursing services may be reimbursed when provided by: ▪ A certified school nurse, i.e., RN possessing Michigan licensure and Michigan Board of Education school nurse certification; or ▪ A RN with a Michigan license; or ▪ A LPN with a Michigan license.

Evaluations	A RN must complete the evaluations/assessments and prepare a nursing care plan. An evaluation/assessment may be performed when a change in the student's medical condition occurs. LPNs cannot bill for evaluations/assessments.
Procedure Codes	To bill for nursing services, use procedure codes: **T1001** – Nursing assessment/evaluation. (Cannot be billed for LPN.) This code can be used by itself, or with the HT or TM modifiers. **T1002** - RN Services, up to 15 minutes **T1003** – LPN/LVN services, up to 15 minutes

2.9 PHYSICIAN AND PSYCHIATRIST SERVICES

Definition	Physician and psychiatrist services are services provided with the intent to diagnose, identify or determine the nature and extent of a student's medical or other health-related condition. Physician/psychiatrist services include: ▪ Evaluation and consultation with providers of covered services for diagnostic and prescriptive services; includes participation in multi-disciplinary team assessment. ▪ Record review for diagnostic and prescriptive services. Only the services provided by a physician or psychiatrist (MD or DO) through SBS may be billed and reimbursed through the enrolled SBS school district. Other physician or psychiatrist services, including those which may be delivered through other Medicaid-enrolled Provider Types 10, 11, or 77, are to be billed separately and may not be billed through the enrolled school district.
Provider Qualifications	Physician or psychiatrist (MD or DO) with a current State of Michigan license to practice medicine.
Procedure Codes	The procedure codes listed below may be used to bill for physician or psychiatrist services. Procedure codes 99361 and G9008 will not be reimbursed for the same date of service. If a physician order/referral is written as a result of a physician medical conference, the prescription/referral is considered to be a part of that service and is not separately reimbursable. **99361** - Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes. This code can be used by itself, or with the HT or TM modifiers. **G9008** – Coordinated care fee, physician coordinated care oversight services. (This code is to be used for billing the physician record review.)

2.10 TARGETED CASE MANAGEMENT SERVICES

Definition	Targeted Case Management (TCM) Services are a component of the IEP/IFSP treatment plan. TCM identifies and addresses special health problems and needs that affect the student's ability to learn, assist the student to gain and coordinate access to a broad range of medically-necessary services covered under the Medicaid Program, and ensures that the student receives effective and timely services appropriate to their needs. TCM is covered only when: ▪ There are other Medicaid-covered medical services in the IEP/IFSP treatment plan. Transportation by itself is not a qualifying Medicaid-covered service for billing TCM. ▪ Coordinating activities to assist students receiving special education or early intervention services to gain access to needed medical, social, educational, and other services. ▪ TCM services may be reimbursed when provided by a Designated Case Manager or other ISD staff who are qualified to participate in the IDEA Assessment. Staff Case Management Services may be reimbursed when they relate to the respective IEP/IFSP services that are provided by that staff person and do not duplicate services that are the responsibility of the Designated Case Manager. When a staff is qualified to provide both types of case management services and is serving as the Designated Case Manager, they may only bill as the Designated Case Manager. An integral part of all case management activities is the ongoing monitoring of needed medical, social, and educational and other services that are related to Medicaid-covered services and the delivery, adequacy and satisfaction of the treatment plan for the student.
Designated Case Manager Provider Qualifications	The Designated Case Manager is the person responsible for the implementation of the IEP/IFSP treatment plan. The Designated Case Manager must be an individual who meets one of the following criteria: ▪ A RN with a Michigan license; ▪ A baccalaureate degree with a major in a specific special education area; ▪ Has earned credit in course work equivalent to that required for a major in a specific special education area; or ▪ Has a minimum of three years personal experience in the direct care of an individual with special needs. In addition to meeting at least one of the above, the Designated Case Manager must also demonstrate knowledge and understanding of all of the following: ▪ Services for infants and toddlers who are eligible under the IDEA law as appropriate; ▪ Part C of the IDEA law and the associated regulations;

	▪ The nature and scope of services covered under IDEA, as well as systems of payments for services and other pertinent information; ▪ Provision of direct care services to individuals with special needs; and ▪ Provision of culturally competent services within the culture of the community being served.
Staff Case Manager Provider Qualifications	Staff that is qualified to participate in the IDEA Assessment may perform Staff Case Management services when the activities are related to the respective IEP/IFSP treatment plan services.
Designated Case Manager Services	The following functions are the responsibility of the Designated Case Manager. A designated case management service consists of the activities performed during the month to complete each responsibility: ▪ Assure that standard re-examination and follow-up of the student are conducted on a periodic basis to ensure that the student receives needed diagnosis and treatment; ▪ Assist families in identifying and choosing the most appropriate providers of care and services, scheduling appointments and helping families to maintain contact with providers; ▪ Follow-up to ensure that the student receives needed diagnostic and treatment services; ▪ Assure that case records are maintained and indicate all contacts with, or on behalf of, a student in the same manner as other covered services; ▪ Coordinate performance of evaluations, assessments and other services that the student needs; ▪ Prevention of duplication of services; ▪ Facilitation and participation in the development, review and evaluation of the IEP/IFSP treatment plan; and ▪ Activities that support linking and coordinating needed health services for the student.
Staff Case Management Services	The Staff Case Management Services include: ▪ Meeting with teachers and other professional staff involved with the student to discuss testing, planning, treatment, coordinating effective interventions and the student's progress. ▪ Linking and coordinating health and behavioral services related to the IEP/IFSP treatment plan. ▪ Coordinating school based services and treatment with parents.

	▪ Monitoring and recommending a plan of action. ▪ Providing modifications to the IEP/IFSP treatment plan to help the student. ▪ Coordinating with staff and other health professionals to establish a continuum of health and behavioral services in the school setting. ▪ Staff Case Management Services must total no less than 15 minutes and must be billed using the procedure code noted below.
Procedure Codes	To bill for the Designated Case Manager, use procedure code **T2023 -** Targeted case management; per month. Services are billed on a monthly basis. All services provided throughout the month must be documented. To bill for Staff Case Management, use procedure code **T1017** - Targeted case management, each 15 minutes. The Designated Case Manager must **not** use this procedure code to bill for his/her TCM services.

2.11 VISION, ORIENTATION AND MOBILITY TRAINING

Definition	Vision, orientation and mobility training services are the evaluation and training performed to correct or alleviate movement deficiencies created by a loss or lack of vision. These services include communication skills training, orientation and mobility training for all environments, visual training, independent living skills training, and additional training necessary to activate visual motor abilities. The teaching of Braille is not a covered benefit. Vision orientation and mobility training must require the skills, knowledge and education of the qualified staff listed below.
Provider Qualifications	Services may be reimbursed as vision, orientation and mobility training when provided by: ▪ Orientation and mobility specialist certified by the Association for the Education and Rehabilitation of the Blind and Visually Impaired; ▪ Teacher of special education with approval as teacher of the visually impaired; or ▪ Assistive Technology Consultant, Master's Degree in Special Education or Speech Pathology.
Procedure Codes	The following procedure codes may be used to bill for vision, orientation and mobility services: ▪ **97533** Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-to-one) patient contact by the provider, each 15 minutes. ▪ **97150** - Therapeutic procedure(s), group (two or more individuals). ▪ **V2799** – Vision services, miscellaneous (Vision Orientation and Mobility Specialist). This code can be used by itself, or with the HT or TM modifiers.

2.12 Special Education Transportation

Definition	Special education transportation services include transport to and from the student's pick-up and drop-off site where school based services are provided. It includes no more than one round-trip on a date of service. The need for special education transportation must be specified in the student's IEP/IFSP treatment plan. Medicaid may reimburse for special education transportation when a student receives a Medicaid-covered service on the same day. Medicaid does not reimburse for transportation provided in a regular or general education school bus. Also, there is no additional payment for an attendant.
Documentation	Federal requirements include documentation for transportation service claims that must be maintained for purposes of an audit trail, such as an ongoing trip log maintained by the provider of the special education transportation.
Procedure Codes	Use the following procedure codes when billing for Special Education Transportation: ▪ **A0130** - Nonemergency transportation: wheelchair van. This procedure code may be billed when a handicapped-equipped or -adapted vehicle is required. The motor vehicle is specialized (e.g., adapted bus, lift vehicle or van) for students who require accommodation for wheelchairs or other special equipment. ▪ **A0120 -** Nonemergency transportation: minibus, mountain area transports, or other transportation systems. This procedure code may be billed when a special education vehicle with no special accommodation is required. The special education vehicle may not necessarily be adapted or specially equipped to serve disabled students.

SECTION 3 – QUALITY ASSURANCE

SBS providers must have a written quality assurance plan on file. SBS providers may be reviewed/audited by the MDCH for determination of medical necessity and to verify that all services were billed and paid appropriately. The purpose of the quality assurance plan is to establish and maintain a process for monitoring and evaluating the quality and documentation of covered services, and the impact of Medicaid enrollment on the school environment. The Michigan Department of Education will conduct ongoing certification of school based services providers to assure compliance with enrollment criteria and quality assurance standards. MDCH accepts the Department of Education certification requirements.

An acceptable quality assurance plan must address each of the following quality assurance standards:

- Covered services are medically necessary, as determined and documented through appropriate and objective testing, evaluation and diagnosis.
- The IEP/IFSP treatment plan identifies which covered services are to be provided and the service frequency, duration, goals and objectives.
- A monitoring program exists to ensure that services are appropriate, effective and delivered in a cost effective manner consistent with the reduction of physical or mental disabilities and assisting the student to benefit from special education.
- Billings are reviewed for accuracy.
- Staff qualifications meet current license, certification and program requirements.
- Established coordination and collaboration exists to develop plans of care with other providers, including those from local Public Health and DHS, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) providers, Community Mental Health Services Programs (CMHSPs), the student's physician and managed care providers, and from the Medicaid Health Plans (MHPs), Hearing and Speech Centers, and Outpatient Hospitals.
- Parent or guardian and student participation exists, outside of the IEP/IFSP team process, in evaluating the impact of the SBS program on the educational setting, service quality and outcomes.

SECTION 4 – HEALTH AND ANCILLARY SERVICES REIMBURSEMENT

Reimbursement for covered services is on a fee-for-service methodology using a uniform fee schedule. Payments to a SBS provider are equal to 60 percent of the federal Medicaid funds (Federal Financial Participation [FFP]) received by the State resulting from amounts billed to MDCH by the SBS provider. Payments to school based health services providers are made on a monthly basis. To be reimbursed, all claims must be submitted within twelve months of the date of service.

SCHOOL BASED SERVICES ADMINISTRATIVE OUTREACH PROGRAM

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION

The School Based Services Administrative Outreach Program offers reimbursement for the costs of administrative activities, such as outreach, that support the Medicaid program.

The activities fall into several categories:

- Medicaid Outreach
- Facilitating Medicaid Eligibility Determination
- Medicaid-Related Training
- Health-Related Referral Activities
- Medical Service Program Planning, Policy Development, and Interagency Coordination
- Programmatic Monitoring and Coordination of Medical Services
- Arranging for Medicaid-Related Transportation and Provision of Medicaid-Related Translation.

SECTION 2 – PROVIDER ENROLLMENT

2.1 ENROLLMENT

In order to participate in the Michigan Medicaid School Based Services Administrative Outreach Program, a Michigan Intermediate School District (ISD) or the Detroit Public Schools (DPS) must enroll with the Michigan Department of Community Health (MDCH). The enrollment process is initiated through submission of a completed Medical Assistance Provider Enrollment & Trading Partner Agreement form (DCH-1625) and an Assurance of Understanding and Compliance document. These documents are available through the MDCH Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

2.2 CERTIFICATION OF QUALIFIED STAFF

The Michigan Department of Education (MDE) provides MDCH with documentation that enrolled ISDs/DPS meet the regulatory requirements set forth for all staff providing services for the Administrative Outreach Program.

Enrollment as a provider in the SBS Administrative Outreach Program is predicated on certification to the MDE that the educational and experiential requirements and credentials of all staff (i.e., licensure, certification, registration, etc.) that may be performing claimable activities have been met and are current. The MDE will assist any school district in this certification process and verify the status of its certification in writing, along with recommendations, with a copy sent to the MDCH.

SECTION 3 - CLAIMS DEVELOPMENT OVERVIEW

Using the State of Michigan's competitive bid process, MDCH will select one Contractor to implement and administer the Medicaid Administrative Claiming System (MACS) random moment time study. The Contractor will also provide the ISDs/DPS the option of performing certain time study responsibilities and claims development activities on behalf of those ISDs/DPS that choose to participate in this portion of the State contract and pay for these services.

3.1 CLAIMS DEVELOPMENT OPTIONS FOR ENROLLED PROVIDERS

Under the claiming methodology, enrolled ISDs/DPS must choose one of the approaches below to generate their quarterly claim. All ISDs/DPS will be required to use MDCH's MACS software to generate its quarterly claim and to utilize the services of the State's RMTS and Claims Development Contractor, who will conduct the statewide time studies each quarter. The 58 providers (57 ISDs and DPS) will select a level of service depending on their unique needs and their capacity to perform tasks related to this program.

3.1.A. PROVIDER RESPONSIBLE FOR CLAIMS DEVELOPMENT

ISDs/DPS may, alone or as a consortium of districts, use the information from the time studies provided by the RMTS and Claims Development Contractor and develop their claim independently or choose to hire consultants/billing agents to assist them. Either way, they must utilize the MACS software and complete the key functions required to develop and validate the claim. Each ISD/DPS, or its billing agent, must assign only one person as the designated coder for the program. The districts must also assume total responsibility for complying with all aspects of the program policy and cooperate fully with the CMS-mandated special monitoring and MDCH financial auditing systems.

The cost for the Contractor will be charged back to providers who participate in this option based on the Contractor's projected cost per ISD/DPS (after federal match).

ISDs/DPS who choose this option and who request reimbursement in the form of federal matching funds/federal financial participation (FFP) for the costs of administering this portion of the program, must obtain a written statement from the CMS that attests their respective consultants/billing agents were selected utilizing the federal procurement process per federal regulations; and that the entity is not reimbursed on a contingency fee basis. A copy of this documentation must be submitted to MDCH. A request to change this option may only be made once per year, and must be received by MDCH by July 1st.

3.1.B. STATE CLAIMS DEVELOPMENT CONTRACTOR

The State Claims Development Contractor will develop an implementation plan on behalf of its ISDs/DPS to conduct the statewide time studies each quarter, utilizing the MACS software, as well as complete all other key functions required for valid claim development. The Contractor must assign only one person as the designated coder for the program. The MDCH will oversee the Contractor and ISDs/DPS participating in this option to assure their compliance with all aspects of the program policy. The ISDs/DPS

must cooperate with the CMS-mandated special monitoring and MDCH financial auditing systems.

The cost for the Contractor will be charged back to providers who participate in this option based on the Contractor's projected cost per ISD/DPS (after federal match).

3.2 Overview of Claims Development Process

Based on federal and state statutes and regulations, below is a partial list of specific functions and tasks that must be accomplished for reimbursement of Medicaid Administrative Outreach Program services. Additional details appear in subsequent sections of this chapter.

Claims will be developed by the State's Claims Development Contractor or independent ISDs/DPS utilizing the MACS software following these basic steps:

- The quarterly RMTS sampling results are produced by the State's RMTS and Claims Development Contractor, who converts them to percentages. The percentages are applied to program costs to determine reimbursement and entered onto the first sheet of the MACS Workbook.
- The MACS cost/claim generation component automates nine Excel spreadsheets and links the spreadsheets where possible. The ISD/DPS costs are entered onto the appropriate worksheets and the software calculates and produces the claim.
- The claim is submitted to MDCH with verification of claim validity from each ISD/DPS or the lead district for the consortium.
- The ISD/DPS and/or Contractor must cooperate with any special monitoring activities conducted by the Special Monitoring Contractor, the MDCH or the CMS at any stage of the time study and claims development processes.
- The ISD/DPS and/or Contractor must comply with all conditions set forth by MDCH as SBS policy.

3.3 Implementation Plan

Each ISD/DPS must submit an Implementation Plan that identifies the claims development option selected and reflects the details of their SBS Administrative Outreach Program operation for review and approval by MDCH and by CMS. Any subsequent changes must also be reported and receive approval.

Claims may not be submitted to MDCH for reimbursement until MDCH has approved the Implementation Plan that will be utilized based on this published policy.

SECTION 4 - TIME STUDY METHODOLOGY

4.1 TIME STUDY OVERVIEW

The time study design is simple, requires limited training for participants, and logs only what the participant is doing at one moment in time. All districts that participate in the SBS Administrative Outreach Program must identify allowable Medicaid administrative costs within a given program by requiring that staff who spend a portion of their time performing outreach activities be available to participate in a quarterly time study.

There are two steps to completing a time study form. In the first step, the time study participants will provide answers to three questions (What are you doing? Who are you with? Why were you doing it?) that relate to their activities at their assigned moment that quarter. Time study participants will not code the activity they describe. There will be a central coding process for the time study forms.

For the second step, the time study forms are collected from the participants, and one designated individual (from the ISD/DPS or the State's Contractor) who has received more training, will assign the appropriate activity code for that moment based on the answers to the three time study questions. At this point, the time study form is completed and can be scanned into the MACS by the State Contractor.

4.2 TIME STUDY PARTICIPANTS

As a condition of renewed participation, the ISD/DPS providers must certify to MDE that any staff providing services under the SBS program, or participating in a time study, meets the educational, experiential and regulatory requirements of MDCH.

The following staff groups may be appropriate for inclusion in time studies if they are involved in SBS Administrative Outreach activities:

- Audiologist
- Counselor
- Occupational Therapist
- Occupational Therapist Assistant
- Orientation/Mobility Specialist
- Physical Therapist
- Physical Therapist Assistant
- Physician
- Physician Assistant
- Psychologist
- Registered Nurse
- Social Worker
- Speech/Language Therapist
- Teacher Consultant

Administrators, Program Specialists and Early Identification/Intervention Personnel may be valid time study participants based on the unique roles and responsibilities assigned to them and their regular performance of allowable activities. In this situation, the ISD/DPS may include them in their staff pool if documentation is provided that the individual regularly performs eligible Outreach activities as a part of their job.

In providing the staff pool eligible to participate in the time studies, school districts must certify the list of participants and activities to be claimed to ensure that all appropriate personnel are submitted. In short, the time study must include at least the following classes of individuals:

- Skilled professional medical personnel (SPMP) who directly perform approved Medicaid administrative outreach functions, whether they are directly employed by the ISD/DPS or are contracted personnel for which the ISD/DPS can document a de facto employer-employee relationship.
- All other personnel who perform approved Medicaid administrative outreach functions, whether they are directly employed by the ISD/DPS or are contracted personnel for which the district can document a de facto employer-employee relationship.
- Contracted SPMP for which a de facto employer-employee relationship cannot be documented. These individuals are considered "other personnel" and their activities are claimed at the 50% FFP rate.

4.3 Federal Financial Participation for Services/Activities Performed by Skilled Professional Medical Personnel (SPMP)

ISDs/DPS or their billing agent must bill SPMP administrative activities at the Federal Financial Participation (FFP) rate of 50% for allowable medically necessary administrative activities provided by SPMPs and their direct support staff if certain professional education, training, and supervision requirements are met. However, it is also necessary to continue to identify and report SPMP activities separately on the quarterly claim and not include the SPMP expenditures with the other 50% matchable expenditures. Because the results of the program will be applied to prior billing quarters when SPMP activities could be recognized at the 75% rate, it is still necessary to identify and record the SPMP amounts on the quarterly claim for the backcasting process.

The coder for a time study form completed by an SPMP should check certain activity codes (codes 8 or 11) when the time study participant states they are SPMP by answering SPMP-specific questions on the time study form.

- The activities relate directly to the administration of the medical assistance program (Medicaid) and are not direct medical services.
- An SPMP is defined as a person who has professional education and training in the field of medical care or appropriate medical practice. "Professional education and training" means the completion of a two-year or longer program leading to an academic degree or certificate in a medically-related profession with a medical license, certificate, or other document issued by a recognized national or State medical licensure or certifying organization, or a degree in a medical field issued by a college or certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care.
- The SPMP performs duties and responsibilities that require professional medical knowledge and skills.
- There exists documentation of an employer-employee relationship between the ISD/DPS and the SPMP and direct supporting staff or a documented de facto employer-employee relationship for such contracted personnel. SPMP for whom a de facto employer-employee relationship cannot be documented also must participate in a time study, and must be included in the cost and time studies for "other personnel".

- The direct supporting staff of an SPMP are defined as those who are secretarial, stenographic, copying personnel, and file and record clerks who provide clerical and support services that are directly necessary for the completion of the professional medical responsibilities and functions of the SPMP. The support staff provide direct support exclusively to the SPMP. The SPMP must directly supervise the supporting staff and the performance of the supporting staff's work. Costs associated with direct support personnel should be included with the costs of the employee that directly supervise them and are allocable and reimbursable at the same level as the employees they support. Direct support personnel are not included in the sample population since they do not directly perform Medicaid administrative activities.
- For situations in which contracted skilled professional medical personnel's de facto employer-employee relationship cannot be documented, these individuals are considered "other personnel" and their matchable activities are claimed at the 50% rate.

SECTION 5 - ACTIVITIES THAT CAN BE CLAIMED

This section lists 18 distinct activities that are likely to be performed by any of the time study participants during a typical workday. There is centralized coding of the time study forms, either through a single designated ISD/DPS/representative or a single designated staff member of the contractor. Some of these activities may be claimed under Medicaid, and some may not. To assist the coder's understanding of which activity is most appropriate to check off during a time study, there are many examples listed under each definition, and other special notes to clarify the intent of the listing.

Summary of Time Study Activities

Activity	Reimburse	Discount	FFP Rate
1. Medicaid Outreach and Public Awareness	A	No	50%
2. Non-Medicaid Outreach	U	No	
3. Facilitating Medicaid Eligibility Determination	A	No	50%
4. Facilitating Application for Non-Medicaid Programs	U	No	
5. Program Planning, Policy Development and Interagency Coordination Related to Medical Services	A	Yes	50%
6. Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services	U	No	
7. Referral, Coordination, and Monitoring of Medical Services	A	Yes	50%
8. Referral, Coordination, and Monitoring of Medical Services Performed by SPMPs	A	Yes	75%
9. Referral, Coordination, and Monitoring of Non-Medical Services	U	No	
10. Medicaid-Specific Training on Outreach, Eligibility and Services	A	Yes	50%
11. Medicaid-Specific Training on Outreach, Eligibility and Services Performed by SPMPs	A	Yes	75%
12. Non-Medicaid Training	U	No	
13. Direct Medical Services	U	No	
14. Transportation and Translation Services in Support of Medicaid-Covered Services	A	Yes	50%
15. Transportation and Translation Services in Support of Non-Medicaid-Covered Services	U	No	
16. General Administration	R	N/A	
17. School-Related and Educational Activities	U	No	
18. Not Scheduled to Work and Not Paid	U	No	

"A" = Allowable means the expense is covered by Medicaid.
"U" = Unallowable means the expense is not covered by Medicaid.
"R" = Reallocated means reimbursement across other activities.

Michigan's SBS Administrative Outreach Program activity codes are designed to reflect the actual activities that may occur in a school on any given day, and the specificity of the unique health care programs within the State that are available to families. Some activities fully support the administration of the State Plan and/or the EPSDT program in the State, and others are more related to activities performed on behalf of Medicaid-eligible students. Because these medical- or health-related activities are provided for students who are both Medicaid and non-Medicaid eligible, it is necessary to develop and apply a formula that properly allocates which students are being supported. This is referred to as the discounted Medicaid Eligibility (MAE) rate. During claims development, the discounted MAE for each ISD/DPS will be applied to certain activities that support Medicaid-eligible students.

5.1 Discounted Activities

A discount, proportional to the Medicaid eligibility rate, is applied to activities that involve:

- Referral, coordination, planning, and monitoring health services designed to be delivered through the Medicaid Program that address the health needs of children.
- Program planning and policy development of Medicaid-covered services.
- Presenting or participating in training designed to educate the audience about the various Medicaid programs and the services covered by each, and how to more effectively refer students for services.
- Assisting or arranging for an individual to obtain transportation to Medicaid-covered services.
- Assisting, arranging or providing translation services related to Medicaid-covered services.

Using the above criteria, the following activities listed in the "Summary of Time Study Activities" will be discounted by the Medicaid eligibility rate released by MDCH twice annually:

- Activity 5 - Program Planning, Policy Development and Interagency Coordination
- Activities 7 & 8 - Referral, Coordination and Monitoring of Medical Services
- Activities 10 & 11 - Medicaid-specific Training on Outreach and Eligibility Services
- Activity 14 – Transportation and Translation Services in Support of Medicaid-covered Services

5.2 Non-discounted Activities

No Medicaid discount is applied to activities that:

- Inform children, parents and families, ISD/DPS staff and the community about the benefits, availability and how to access services and programs available through the Medicaid Program.
- Involve conducting outreach campaigns to reach and identify children in the school who are in need of health and preventive services covered by Medicaid.
- Facilitate potentially eligible students and their families who may or are completing the process of enrolling in the Medicaid program.

5.3 Allowable Activities

5.3.A. Code 01-Medicaid Outreach And Public Awareness-A

This code is used when school staff are performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access Medicaid programs. This code is also used for describing the services covered under Medicaid and how to obtain Medicaid preventive services. Activities related to Child Find will not be recorded here, but under Code 02.

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Informing families and distributing literature about the services and availability of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and the many different Michigan Medicaid programs such as Healthy Kids and Children's Special Health Care Services.
- Informing and encouraging families to access Medicaid managed care systems, i.e., Medicaid Health Plans.
- Informing families about the EPSDT and Medicaid health-related programs and the value of preventive health services and periodic exams.
- Assisting the Medicaid agency to fulfill outreach objectives of the Medicaid program by informing individuals, students, and their families about health resources available through the Federal Medicaid Program.
- Conducting Medicaid outreach campaigns and activities not related to Child Find, e.g., health fairs, that provide information about services provided by such entities as the Community Mental Health Service providers, Local Health Departments, etc.
- Conducting a family planning health education outreach program or campaign, if it is targeted specifically to Medicaid-covered family planning services.
- Contacting pregnant and parenting teenagers about the availability of Medicaid services, including referral to family planning and well baby care programs and services.
- Providing referral assistance to families with information about the Medicaid program.
- Providing information about Medicaid screenings that will help improve the identification of medical conditions that can be corrected or ameliorated through Medicaid services.
- Notifying families of EPSDT program initiatives such as Medicaid screenings conducted at a school site. These screenings are distinct from other general health screenings that are covered by Code 02.
- Coordinating with the local media (newspaper, TV, radio, video) to inform the public about EPSDT screenings, health fairs and other health related services, programs and activities organized by the school.
- Coordinating or attending child health fairs that emphasize preventive health care and promote Medicaid services by presenting Medicaid material in areas with the likelihood of high Medicaid eligibility.

- Presenting and informing families about the availability of Medicaid providers of specific covered services, and how to effectively utilize services and maintain participation in the Medicaid program.
- Providing parents, on report card pick-up day or at parent conferences, information about the Medicaid program and health care services available to eligible children, including EPSDT screening services and medically necessary treatment.

5.3.B. Code 02-Non-Medicaid Outreach-U

This code is used for performing activities that inform eligible or potentially eligible individuals about social, vocational and educational programs, including special education, that are not covered by Medicaid and how to access them. Activities include describing the eligible or potentially eligible individuals, the range of benefits covered under these non-Medicaid social, vocational, and educational programs, such as WIC, SSI, MI Child and LIF, Child Find, and how to obtain them.

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Informing families about wellness programs and how to access these programs.
- Scheduling and promoting activities that educate individuals about the benefits of healthy lifestyles and practices.
- Conducting general health education programs or campaigns addressed to the general population.
- Conducting outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid.
- Assisting in early identification of children with special medical/mental health needs through various Child Find activities.
- Developing the school district's student/parent handbook.
- Coordinating with the local media (newspaper, TV, radio, video) to inform the public about upcoming events such as health fairs or screenings that focus on non-Medicaid social, vocational and educational programs, and activities such as scholarships, remedial classes, Child Find, DARE, anti-smoking campaigns, etc.
- Providing parents, on report card pick-up day or at parent conferences, information about non-Medicaid programs, social, vocational and educational, and general health care services available in the community or the school for their children.

5.3.C. Code 03-Facilitating Medicaid Eligibility Determination-A

This code is used for assisting an individual to become eligible for Medicaid. This activity does not include the actual determination of Medicaid eligibility.

It includes paperwork, clerical activities, or staff travel required to perform the following activities:

- Verifying an individual's current Medicaid eligibility status.
- Facilitating eligibility determination for Medicaid by planning and implementing a Medicaid information program.
- Participating as a provider of Medicaid eligibility outreach information.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Referring an individual or family to the local Department of Human Services (DHS) or other local office to make application for Medicaid benefits.
- Assisting individuals or families to complete the Michigan Medicaid eligibility application.
- Assisting the individual or family in collecting/gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
- Referring families to appropriate sources to obtain Medicaid applications.

5.3.D. Code 04-Facilitating Application for Non-Medicaid Programs-U

This code is used for informing an individual or family about programs such as Child Find, Food Stamps, SSI, WIC, Daycare, Legal Aid, Free and Reduced Lunch, and other social or educational programs and referring them to the appropriate agency to make application.

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Explaining the eligibility process for non-Medicaid programs.
- Assisting the individual or family to collect/gather information and documents for the non-Medicaid program applications.
- Assisting the individual or family in completing the non-Medicaid programs application(s).
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program.
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

5.3.E. Code 05-Program Planning, Policy Development and Interagency Coordination Related to Medical Services-A

This code is used for performing activities associated with the collaborative development of programs with other agencies that assure the delivery of Medicaid-covered medical/mental health services to school-age children. It applies only to employees whose position descriptions include program planning, policy development and

interagency coordination, and/or those staff specifically appointed to appropriate committees/programs performing required activities.

It includes related paperwork, clerical activities or staff travel required to perform the following activities:

- Defining the scope of each agency's Medicaid service in relation to the other, and identifying gaps or duplication of medical/mental health programs.
- Analyzing Medicaid data related to a specific program, population, or geographic area and working with Medicaid resources, such as Medicaid Health Plans, to locate and develop EPSDT health services referral relationships and expanding school medical/mental health programs to school populations of need.
- Creating a collaboration of health professionals to provide consultation and advice on the delivery of health care services to the school populations, and developing methods to improve the referral and service delivery process by Medicaid health providers.
- Containing Medicaid costs for individuals with multiple challenging disabilities by reducing overlap and duplication of Medicaid services through collaborative efforts with Medicaid Health Plans, local Community Mental Health Service providers and Local Health Departments.
- Monitoring and evaluating policies and criteria for performance standards of medical/mental health delivery systems in schools and designing strategies for improvements.
- As a part of the school health policy quality assurance system, maintain and ensure the continuity of all Medicaid health-related services, including development and monitoring contracts with private providers, agencies and/or provider groups.
- Overseeing the organization and outcomes of the coordinated medical/mental health service provision with Medicaid Health Plans.
- Developing internal referral policies and procedures for use by staff so that appropriate coordination of health services occurs between the various Medicaid providers and entities, such as Community Mental Health Service providers, Local Health Departments, Medicaid Health Plans, and those in the educational setting.
- Designing and implementing strategies to: identify students who may be at high risk for poor outcomes because of poverty, dysfunctional families, and/or inappropriate referrals, and need medical/mental health interventions, identify pregnant students who may be at high risk of poor health outcomes because of drug usage, lack of appropriate prenatal care, and/or abuse or neglect, and assuring students with any significant health problems are diagnosed and treated early.
- Presenting specific provider information about Medicaid EPSDT screening in the schools that will help identify medical conditions that can be corrected or ameliorated by services covered through Medicaid.
- Developing procedures for tracking and resolving families' requests for assistance with Medicaid services and providers. This does not include the actual tracking of requests for Medicaid services.

- Developing new health programs with local community health providers for the Medicaid population, as determined by a needs assessment and geographic mapping.
- Working with requests and inquiries from local school board members, county commissioners, or State legislators to resolve unique or unusual requests or boundary issues regarding appropriate care for certain Medicaid-eligible groups or populations.
- Coordinating with interagency committees to identify, promote and develop medical services in the school system.

These activities relate to the program and not to a specific child.

5.3.F. Code 06-Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services-U

This code is used when performing activities associated with the development of strategies to improve the coordination and delivery of community services to school-age children, and when performing collaborative activities with other agencies. Non-medical services may include social, educational, and vocational services.

It includes related paperwork, clerical activities or staff travel necessary to perform the following activities:

- Identifying gaps or duplication of other non-medical services (e.g., social, vocational and educational programs) to school-age children and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of non-medical school programs.
- Developing procedures for tracking and resolving families' requests for assistance with non-medical services and the providers of such services.
- Developing and coordinating advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services to the school populations.
- Developing non-medical referral sources.
- Analyzing non-medical data related to a specific program, population, or geographic area.
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.
- Defining the scope of each agency's non-medical service in relation to the other.
- Evaluating the need for non-medical services in relation to specific populations or geographic areas.
- Monitoring the non-medical delivery system in schools.

- Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

5.3.G. Code 07-Referral, Coordination, and Monitoring of Medical Services-A

This code is issued for developing appropriate referral sources for program-specific services for the school district, coordinating programs and services at the school or district level, and monitoring the delivery of Medicaid services within the school system.

It includes related paperwork, clerical activities or staff travel necessary to perform the following activities:

- Making referrals for, and coordinating access to, medical services.
- Identifying and referring adolescents who may be in need of Medicaid family planning services.
- Making referrals for and/or scheduling appropriate Medicaid-covered immunizations, vision, and hearing testing, but not to include the child health screenings (vision, hearing and scoliosis) and immunizations that are required for all students.
- Providing information about Medicaid EPSDT screening (e.g., dental, vision) in the schools that will help identify medical conditions that can be corrected or improved by services through Medicaid.
- Contacting Medicaid providers of pediatric services in lower income areas to determine the scope of EPSDT screening and treatment services available to meet the needs of the at-risk child.
- Reviewing clinical notes of staff by a designated clinician to identify medical referral and follow-up practices, and making recommendations to supervisors for improvements as needed.
- Conducting quality assurance reviews of specific health-related programs objectives.
- Providing both oral and written instructions about the referral policies and procedures between the various agencies to parents for appropriate coordination of health services in the educational setting and for follow-up at home.

Activities that are part of a direct service are not claimable as an administrative service. This code is not used for case management for a student with an IEP/IFSP or for actual targeted case management activities to assist student's access to medical services, such as:

- **Coordinating evaluations and/or assessments needed by the student**
- **Facilitating and participating in development of the IEP/IFSP**
- **Linking or coordinating care across agency lines**
- **Reassessing or following up on the required needs of the student**
- **Monitoring needed medical, social, educational, and other services that are a part of the student's care plan**
- **Assuring care records are maintained**

For staff performing any of the above activities, Code 13 is used. Michigan covers targeted case management for individual students

5.3.H. Code 08-Referral, Coordination, and Monitoring of Medical Services Performed by SPMPs-A

This code is used for skilled professional medical personnel who are providing medically necessary administrative activities and for which skilled professional medical knowledge is required.

This code is used for developing appropriate referral sources for program-specific services for the school district, coordinating programs and services at the school or district level, and monitoring the delivery of Medicaid services within the school system.

It includes related paperwork or staff travel necessary to perform the following activities:

- Making referrals for, and coordinating access to, medical services.
- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system.
- Coordinating the delivery of community based medical/mental health services and plans.
- Coordinating medical/mental health services with managed care plans as appropriate.
- Developing professional relationships for the purposes of referral of Medicaid-eligible students for EPSDT medical and other health-related services.
- Providing clinical information at the program level -- not for individual cases -- to providers about Medicaid policy and regulations.

- Developing a referral system that includes procedures for recording and reporting the requests and subsequent referral of families to the appropriate Medicaid service providers.
- Developing strategies for containing medical costs and improving services to children as part of the goals of the EPSDT program.
- Working with agencies providing Medicaid services to improve the coordination and delivery of clinical health care services, to expand access to specific populations of Medicaid eligibles, and to improve collaboration around the early identification of medical problems. Activities include development, implementation, and the amending of Interagency Agreements related to Medicaid services.
- Developing strategies to improve how the needs of medically-fragile individuals receiving Medicaid services are addressed.
- Developing and communicating both oral and written clinical and health care instructions to parents and school staff for appropriate coordination of health needs in an educational setting and/or follow-up at home.

Activities that are part of a direct service are not claimable as an administrative service. This code is not used for case management for a student with an IEP/IFSP or for actual targeted case management activities to assist student's access to medical services, such as:

- **Coordinating evaluations and/or assessments needed by the student**
- **Facilitating and participating in development of the IEP/IFSP**
- **Linking or coordinating care across agency lines**
- **Reassessing or following up on the required needs of the student**
- **Monitoring needed medical, social, educational, and other services that are a part of the student's care plan**
- **Assuring care records are maintained**

For staff performing any of the above activities, Code 13 is used. Michigan covers targeted case management for individual students

5.3.I. Code 09-Referral, Coordination, and Monitoring of Non-Medical Services-U

This code is used for making referrals for, coordinating, and/or monitoring the delivery of non-medical, such as educational services.

It includes related paperwork, clerical activities or staff travel necessary to perform the following activities:

- Making referrals for, and coordinating access to, social and educational services, such as childcare, employment, job training, and housing.
- Making referrals for, coordinating, and/or monitoring the delivery of immunizations and child health screenings (vision, hearing, scoliosis) that are required for all students.
- Making referrals for, coordinating, and monitoring the delivery of educational, scholastic, vocational, and other non-health-related examinations/assessments.
- Gathering any information that may be required in advance of these non-Medicaid-related referrals.
- Participating in a meeting/discussion to coordinate or review a student's need for instructional, scholastic, vocational, and non-health-related services not covered by Medicaid.
- Monitoring and evaluating the non-medical components of the individualized plan, such as parent-teacher conferences regarding a student's educational progress, or compiling attendance reports.
- Linking or referring a family to a non-medical service delivery system.
- Evaluating curriculum and instructional services, policies and procedures.
- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of those services, such as tutors or remedial education courses.
- Health networking beyond the scope of Medicaid that is necessary to coordinate or monitor health fairs or screenings that focus on non-Medicaid social, vocational or educational programs and activities, i.e., scholarships, remedial classes, Child Find, DARE, anti-smoking campaigns, etc.

5.3.J. Code 10-Medicaid-Specific Training on Outreach, Eligibility and Services-A

This code is used for coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of the Medicaid program, how to assist families to access Medicaid services, and how to more effectively refer students for services. Training for Child Find activities is NOT recorded here, but under Code 12.

It includes related paperwork, clerical activities or staff travel required to perform the following activities:

- Participating in or coordinating training that improves the delivery of Medicaid services.
- Participating in or coordinating training which enhances early identification, intervention, screening and referral of students with special health needs to EPSDT services.
- Coordinating training to assist families to access Medicaid services.
- Participating in or presenting training that improves the quality of identification, referral, treatment and care of children, e.g., talking to new staff about the EPSDT referral process, available EPSDT and health-related services.
- Conducting Medicaid outreach training of non-medical professional staff for the purpose of targeting and identifying children with special or severe health or mental health needs for appropriate referral to EPSDT screening services.
- Disseminating information on training sessions and conducting all related administrative tasks.
- Conducting seminars and presentations to teachers, parents, and community members on: appropriately identifying students concerning indications of mental health behavioral conditions (i.e., bi-polar disorders, drug/substance abuse, autism, attention deficit, mood disorders, pervasive disability disorder, suicidal tendencies, and clinical depression); identification of physical disabilities and other medical conditions that can be corrected or ameliorated by services covered through Medicaid; and providing information on where and how to seek assistance through the Medicaid system.

5.3.K. Code 11-Medicaid-Specific Training on Outreach, Eligibility and Services Performed by SPMPs-A

This code is used for skilled professional medical personnel who are providing medically necessary administrative activities and that require skilled professional medical knowledge.

This code is used for coordinating, conducting, or participating in training events and seminars for staff who do outreach services regarding the benefits of the Medicaid program, how to assist families to access Medicaid services, and how to more effectively refer students for services.

It includes related paperwork and staff travel required to perform the following activities:

- Developing, and preparing for others to utilize, information about Medicaid-covered services, specific health standards and criteria associated with identification/detection of certain illnesses required by the Medicaid program.
- Developing, participating in, or presenting training that addresses the clinical importance of pediatric standards for preventive care offered under Medicaid programs.

- Developing modules and providing training in the school setting, using clinical education and experience, to other professionals and para-professionals that describe medical protocols utilized to refer students for Medicaid-covered services that may be identified during the evaluation, assessment, or EPSDT screen.
- Developing and maintaining a system that provides information and training to parents so they may better understand the connection between health issues and Medicaid coverages that may be pertinent to their child, and the importance of seeking Medicaid services and/or treatment when needed.
- Developing modules for, or presenting, a training seminar at which information is presented to colleagues, parents and/or teachers on Medicaid coverages and therapies, such as substance abuse, speech/language, physical/occupational, orientation and mobility, or adaptive physical education for preschoolers and youth.
- Designing and providing training to assist non-medically-oriented staff to recognize symptoms exhibited by students that could result in referrals to Medicaid providers.

5.3.L. Code 12-Non-Medicaid Training-U

This code is used for coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of the programs, other than the Medicaid program, such as educational programs; for example, how to assist families to access the services of the relevant programs, and how to more effectively refer students for those services.

It includes related paperwork, clerical activities, or staff travel required to perform these activities:

- Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.
- Participating in or coordinating training that enhances IDEA Child Find Programs.
- Participating in or coordinating training that improves relationships between and among local agencies.
- Participating in training to improve computer skills to collect data.
- Training regarding educational issues.
- Training regarding other non-medical social service issues.
- Participating in or coordinating training that improves the medical knowledge and skills of skilled professional medical personnel.
- Training on general health awareness and prevention programs, such as DARE, sex education, the Michigan Model, vocational or scholarship programs, MEAP tests, etc.

5.3.M. Code 13-Direct Medical Services-U

This code is used for providing actual health care services, such as treatment, counseling or service coordination; consultations with parents and other providers about the child's health care needs; or other direct care services to an individual in order to correct or

ameliorate a specific condition. Medical evaluations or assessments that are conducted to determine a child's health-related needs for purposes of the development of the IEP/IFSP are covered under this code, as payment for some or all of those costs may be available under Medicaid through the fee-for-service component.

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Providing health/mental health services contained in an IEP.
- Medical/health assessment and evaluation as part of the development of an IEP.
- Conducting medical/health assessments/evaluations and diagnostic testing, and preparing reports.
- Providing health care/personal aide services.
- Providing speech, occupational, physical and other therapies.
- Administering first aid, or prescribed injection or medication to a student.
- Providing direct clinical and/or treatment services.
- Performing developmental assessments.
- Providing counseling services to treat health, mental health, or substance abuse conditions.
- Performing routine or mandated child health screens including, but not limited to, vision, hearing, dental, scoliosis, and EPSDT screens.
- Administering immunizations.
- Targeted Case Management, if provided as a medical service under Medicaid.
- Transportation, if covered as a medical service under Medicaid.
- Providing or participating in face-to-face interventions with either an individual student or a group (2-8 students).
- Developing/modifying specialized therapeutic materials to be used by the individual student.
- Discussing health care needs and the importance of well-baby care with adolescents.

5.3.N. Code 14-Transportation and Translation Services in Support of Medicaid-Covered Services-A

This code is used for assisting an individual to obtain transportation to Medicaid-covered services. This does not include the provision of the actual transportation service, but rather the administrative activities involved providing transportation. This code also does not include activities that contribute to the actual billing of transportation as a medical service, nor does it include accompanying the Medicaid-eligible individual to Medicaid services as an administrative activity.

This code is used for school employees who provide translation services related to Medicaid-covered services as an activity. Translation may be allowable as an

administrative activity if it is not included and paid for as part of a medical assistance service.

It includes related paperwork, clerical activities or staff travel required to perform the following activities:

- Scheduling or arranging transportation to Medicaid-covered services.
- Assisting or arranging for transportation for the family in support of the referral and evaluation activities.
- Arranging for or providing translation services that assist the individual to access transportation and medical services.
- Arranging for or providing translation services that assist the individual to "communicate" with service providers about medical services being provided.
- Arranging for or providing translation services that assist the individual to understand necessary care or treatment.
- Assisting the student to define/explain their symptoms to the physician.
- Arranging for or providing signing services that assist family members to understand how to provide necessary medical support and care to the student.

5.3.O. Code 15-Transportation and Translation for Non-Medicaid Services-U

This code is used for assisting an individual to obtain transportation to services not covered by Medicaid, or accompanying the individual to services not covered by Medicaid.

This code is used for school employees who provide translation services related to social, vocational, or educational programs and activities as an activity separate from the activities referenced in other codes.

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Scheduling or arranging transportation for social, vocational, and/or educational programs and activities.
- Scheduling or arranging transportation to and from school when no Medicaid service has been provided.
- Arranging for or providing translation services that assist the individual to access and understand non-medical services, programs, and activities.
- Arranging for or providing signing services that assist the individual's or family's access and understanding of non-medical programs and activities.

5.3.P. Code 16-General Administration-R

This code is used for time study participants performing activities that are not directly assignable to program activities.

It includes related paperwork, clerical activities, or staff travel required to perform these activities. Typical examples (not all inclusive) of general administrative activities may include:

- Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan.
- Reviewing school or district procedures and rules.
- Attending or facilitating school or unit staff meetings, training, or board meetings.
- Performing administrative or clerical activities related to general building or district functions or operations.
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance.
- Reviewing technical literature and research articles.
- Taking lunch, breaks, leave, or time not at work when staff are paid for these activities.
- Processing payroll/personnel-related documents.
- Maintaining inventories and ordering supplies.
- Developing budgets and maintaining records.
- Training (not related to curriculum or instruction), such as how to use the district's new computer system.
- Other general administrative activities of a similar nature, as listed above, which cannot be specifically identified under other activity codes.

5.3.Q. Code 17-School-Related and Educational Activities-U

This code is used for any other school-related activities that are not health-related, such as social services, educational services and teaching services, employment and job training. These activities include the development, coordination, and monitoring of a student's education plan.

It includes related paperwork, clerical activities or staff travel required to perform these activities. Examples of activities may include:

- Providing classroom instruction (including lesson planning).
- Testing, correcting papers.
- Compiling attendance reports.
- Performing activities that are specific to instructional, curriculum, student-focused areas.
- Reviewing the education records for students who are new to the school district.
- Providing general supervision of students (e.g., playground, lunchroom).
- Monitoring student academic achievement.
- Providing individualized instruction (e.g., math concepts) to a special education student.

- Conducting external communications related to school educational issues/matters.
- Compiling report cards.
- Applying discipline activities.
- Activities related to the immunization requirements for school attendance.
- Compiling, preparing, and reviewing reports on textbooks or attendance.
- Enrolling new students or obtaining registration information.
- Conferring with students or parents about discipline, academic matters, or other school-related issues.
- Evaluating curriculum and instructional services, policies, and procedures.
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction).
- Translating an academic test for a student.

5.3.R. Code 18-Not Scheduled to Work and Not Paid-U

This code is used for time study participants who are not scheduled to work and not paid on the randomly selected moment pre-printed on the time study form.

Examples of this may include:

- Participant is a part-time employee who is not scheduled to work at the selected sample time.
- The selected sample time falls before or after the participant's scheduled workday.
- School is closed due to an unpaid holiday or an unpaid school district day off (i.e., winter break, spring break, or a built-in "bad weather day").

SECTION 6 - CLAIM CALCULATIONS

6.1 RANDOM MOMENT TIME STUDY METHODOLOGY

Michigan's administrative outreach claim is based on quarterly time studies conducted to establish the proportion of designated staff wage and benefit costs devoted to support the Medicaid program and, therefore, eligible for federal matching funds. This time study approach is in contrast to claims for other Medicaid services that are reimbursed on a service-by-service basis and provided per individual Medicaid-eligible student. The proportion of appropriate wage, benefit and administrative costs qualifying for federal reimbursement will be established through a random moment time study, multiplied by the proportion of students who are Medicaid-eligible. Thus, designated staff need not submit a claim form for each outreach service delivered, but must instead participate in a time study when required.

A random moment consists of one minute of work done by one employee--both chosen at random--from among all such minutes of work that have been scheduled for all designated staff statewide. Time studies are a form of statistical surveying and thus have intrinsic, controllable errors called statistical or sampling error, and may have other types of error. Non-statistical errors may be systematic (i.e., mistakenly failing to record coffee breaks) or random (i.e., an employee unintentionally answering the questions incorrectly due to hurried form completion).

The RMTS method measures the work effort of the entire group of approved staff involved in the ISD/DPS medical and health-related services programs by sampling and analyzing the work efforts of a randomly-selected cross-section of the group. RMTS methods employ a technique of polling employees at random moments over a given time period and tallying the results of the polling over that period. The method provides a statistically valid means of determining the work effort being accomplished in each program of services. The sampling period is defined as the same three-month period comprising each quarter of the federal calendar, except there is an abbreviated sample period used in the summer quarter.

6.2 RANDOM MOMENT SAMPLING

MDCH will use the Medicaid Administrative Claiming System (MACS) software to implement its statewide claiming methodology. The MACS produces random moments concurrent with the entire reporting period, which are then paired with randomly selected members of the designated staff population. The sampling is constructed to provide each staff person in the pool with an equal opportunity or chance to be included in each sample moment. Sampling occurs with replacement so that after a staff person and a moment are selected, the staff person is returned to the potential sampling universe. Therefore, each staff person has the same chance as any other person to be selected for each moment, which ensures true independence of sample moments.

Once the random sample of staff moments has been generated, the sample is printed in the form of master and location control lists for sample administration purposes, and as time study forms for collecting the moment data. Each sampled moment is identified on its respective control list in chronological order by the name of the staff person to be sampled and the date and time at which the recording should take place.

The RMTS and Claims Development Contractor will conduct the statewide time study each quarter for all ISDs/DPS and produce a report detailing the results. This involves importing clinician information from the ISDs/DPS, to compile the statewide pool of all eligible time study participants. The Contractor then randomly selects 4,000 moments. The person's name that is associated with each moment is placed on a time study form. The Contractor distributes the control lists of their selected staff and the time study forms to the independent ISDs/DPS prior to the beginning of the reporting period. The RMTS and Claims Development Contractor will directly distribute and collect the time study forms for the ISDs/DPS who participate in the claims development portion of the State contract.

The independent ISDs/DPS and/or the Claims Development Contractor must monitor the status of each time study form so that appropriate follow-up calls can be made for delinquent moments or missing data uses in the master list. Each is responsible for ensuring that a copy of the form and instructions is distributed to staff just prior to assigned moment. The completed time study forms are returned to the independent ISD/DPS or the Claims Development Contractor, generally on a weekly basis, for data entry and tabulation.

The RMTS system utilized by MDCH meets federal reporting and documentation requirements, and is designed to permit a level of precision of +/- 5% (five percent) with a 95% (ninety-five percent) confidence level for activities matchable at 50%. Calculations verified by MDCH show that a sample of 384 moments statewide each quarter is adequate to obtain this precision. Eight hundred (800) quarterly moments will be selected each quarter statewide to account for any lost moments (observations that cannot be used for analysis, i.e., incomplete forms or forms with contradictory information).

At the end of the sampling quarter, after all data has been collected and tabulated, program precision tables will be produced by the MDCH or its Contractor that provide a means of verifying that the sample results have a sampling uncertainty of no more than 5%, with 95% confidence. For this analysis, the 95% confidence interval for the estimated matchable time staff spends on activities eligible for the 50% matching rate will have an uncertainty of 2%.

6.3 Implementation Plan

All 57 Michigan ISDs and the DPS who choose to participate in this program may form one or more consortia through agreements amongst themselves or may agree to act alone for the purposes of submitting claims for reimbursement. ISDs/DPS may change consortium membership only at the beginning of the first quarter of the State's Fiscal Year, and only after giving notice by the preceding July 1. Each ISD/DPS must develop an implementation plan for all responsibilities of the New Outreach Program, including those performed by their selected claims development contractor.

Each ISD/DPS must submit an implementation plan that reflects the details of their SBS Administrative Outreach Program for review and approval by MDCH and CMS. Any subsequent changes must also receive approval.

Each implementation plan must include explicit quality control review mechanisms to ensure full staff training and compliance, accuracy and completeness of the sample frame (designated employees), adherence to the MDCH-published methodology, editing of all moments for completeness and consistency, and accurate financial and staffing reports. Claiming entities must also fully cooperate with any review requested by the Department of Health and Human Services (DHHS), maintaining all necessary records for a minimum of six (6) years after submission of each quarterly claim.

6.4 Statewide Quality Assurance / Performance Standards

The State-selected Contractor will submit to the MDCH a written plan that includes a Quality Assurance Plan and how they will meet the performance standards required by the MDCH. The purposes of the performance standards are:

- To establish an explicit process for the ongoing monitoring of the SBS policy and its contract responsibilities;
- To assure it is monitoring ISDs'/DPS' performance in a wide variety of important quality outcomes; and
- That there is access to, and accuracy of the data that is delivered and reported.

6.5 Sanctions

It is the intent of the State to pursue, when necessary, remedial action or implement a Corrective Plan if the State-selected contractors, the ISD/DPS, or their vendors are not in compliance with the new SBS Administrative Outreach published policy. If this is not successful, a contract payment freeze will be implemented and sanctions put in place until the matter is resolved. Those independent ISDs/DPS not participating in the State's claims development contract will be held accountable for their vendor's actions.

The following are examples of causes for implementation of sanctions for all districts. The list is not all-inclusive.

- Repeated errors in completing the RMTS forms or filing of the claims.
- Providing insufficient data or incomplete reports to the Contractors.
- Failure to use the MACS software.
- Failure to cooperate with, or submit requested information, reports, or data to the Special Monitoring Contractor, CMS, MDCH, MDE, and other staff involved during site visits, reviews or audits.

6.6 Confidentiality

Aggregate time study data may occasionally be useful for other administrative tasks, i.e., planning, and may be used in that way. However, any individually identifiable information must be protected as required by all applicable state and federal statutes and regulations to ensure confidentiality and protection of privacy.

6.7 Training

Non-statistical errors in time studies usually result from failure to observe the rules of the study, and it is the responsibility of the ISD/DPS to ensure the full cooperation of all participating staff. The most important techniques for minimizing these errors are adequate training of selected staff and follow-up support for those staff.

The approved training methods, materials, information, and instructions will be tailored to each group involved in the time studies each quarter. For example, all time study participants must clearly understand how to complete the time study form. The designated coders must be able to accurately code the activity, and know how to obtain assistance if they have questions. The randomly selected time study participants who are SPMPs must be clear on how to determine if and when their professional knowledge is required to perform a function or activity, and understand the distinctions between the performance of administrative activities and performance of direct medical services.

Because there have been many changes to the SBS Administrative Outreach Program, all those involved will need to participate in the training that is designed for them.

The RMTS Contractor will be responsible for developing training programs and materials and providing follow-up assistance as needed. For training, there are some services the Contractor will provide statewide, and other services that will be provided to the independent ISDs/DPS.

The RMTS Contractor will be responsible for promoting consistency and accuracy of interpretations by the coders and will be encouraged to develop training methods that assure these outcomes. This aspect of the time study is critical for the integrity of the program and will be closely monitored by MDCH and CMS.

6.7.A. STATEWIDE

All ISDs/DPS will have a Local ISD Coordinator/representative who receives training that ensures a thorough understanding of their coordinator responsibilities, the approved time study activities and the coding system used for data collection. Local ISD Coordinators whose ISD/DPS has opted to participate using the services of the State RMTS and Claims Development Contractor will require less intensive training because their responsibilities will not be as significant. This is because many tasks, including coding the time study forms, will be completed by the State's contractor. These individuals must understand their role as liaison between the Medicaid Program, the RMTS Contractor and other staff, in addition to the basic purpose of the program, while assisting the RMTS and Claims Development Contractor to "navigate" the district as necessary.

6.7.B. INDEPENDENT ISDS

- Because these ISDs/DPS have opted to be responsible for many tasks, training for these ISDs/DPS will be different. Independent ISDs/representatives will complete the staff pool list in MACS Employee File Writer format, send it to the State contractor, and update it each quarter for the time study participant pool database. They will receive training and technical support on how to accurately complete and forward the file and update it each quarter.
- One designated ISD/representative will also code the time study forms and will receive training and technical support to ensure thorough understanding of the new activity codes and how to code staff activities correctly. The training program will ensure a thorough understanding of all responsibilities, including interpretation of the time study answers and their relationship to the activities used for data collection. Training will include a review of the sampling system, the purpose of the sampling system, a review of the time study form and instructions, procedures for problem solving and resolution, the 18 Activity Codes and definitions, standardized time study forms and detailed

instructions regarding completion of the form, and examples of possible responses for each activity code.

- The RMTS Contractor will be responsible for promoting consistency, accuracy, and minimal variations of interpretations by the coders and will be encouraged to develop training methods that assure these outcomes. This aspect of the time study is critical for the integrity of the program and will be closely monitored by MDCH and CMS.
- The final steps of creating a claim for submission to Medicaid involve specific financial information unique to each ISD/DPS and its LEAs. The combined financial data is entered into the Excel spreadsheets of the MACS system. The independent ISDs/DPS will complete their own claim, either independently or through a contract with their own representative billing company. The independent ISDs/DPS will receive a written version of the MACS instructions from the RMTS and Claims Development Contractor, receive training and ongoing technical support from the State contractor to enable them to complete the MACS Excel financial Workbook for the claims development process.

6.7.C. Time Study Participants

For time study participants, it is essential that these individuals understand the purpose of the time studies, that time is of the essence related to completion of the form and that their role is crucial. The RMTS Contractor will develop and provide detailed written information and instructions for completing the time study forms as a coversheet attached to each time study form. The coversheet will provide a "tutorial" with the aforementioned basics of the program as well as information about the Medicaid SBS Administrative Outreach Program.

6.8 Summary of Time Study Steps

6.8.A. For All ISDs Statewide

The RMTS Contractor will:

- Import eligible school district staff information
- Randomly select staff/moments to be sampled
- Generate printed RMTS forms for each moment
- Generate and distribute a master list of selected moments to the independent Local ISD/DPS Coordinators as a local control list
- Generate mailing labels addressed to randomly selected staff
- Scan completed and coded time study forms
- Transfer raw data from scanned forms to MACS
- Calculate activity percentages for each of the 18 activity codes
- Produce a quarterly report summarizing the results of the time study and forward it to the independent ISDs/representative within one month of the end of each quarter.

- The Contractor will produce periodic and special reports that provide data and information sorted by LEA, ISD/DPS, and billing consortium that are provided to the CMS, MDCH, MDE, ISDs/DPS and their auditors and the Special Monitoring contractor.

6.8.B. CLAIMS DEVELOPMENT CONTRACT ISDS

For ISDs/DPS who elect to use all the services available from the State RMTS and Claims Development Contractor (Tier II), they will receive all services listed above, as well as the following from the RMTS and Claims Development contractor:

- Create and verify the eligible staff pool for time studies from information provided by the ISDs and update it each quarter
- Distribute time study forms and collect completed time study forms
- Designate and use one coder to code the forms of participating ISDs/DPS.
- Initiate and complete the ISD/DPS claim workbooks with the RMTS results. The Contractor will obtain the financial data from each LEA, verify accuracy and compile data to complete the workbook sheets.
- ISDs may belong to a consortium group consisting of more than one ISD that submits one combined claim. If an ISD is a member of a billing consortium, the Contractor will combine the participating ISD workbooks and consolidate them into one consortium claim that is submitted to MDCH.

In providing the lists of staff eligible to participate in the time studies, school districts need to review the list of participants and activities to be claimed to ensure that all appropriate personnel are submitted. In short, the time study must include at least the following classes of individuals:

- Skilled professional medical personnel (SPMP) who directly perform approved Medicaid administrative outreach functions, whether they are directly employed by the ISD/DPS or are contracted personnel for whom the ISD/DPS can document a de facto employer-employee relationship.
- All other personnel who perform approved Medicaid administrative outreach functions, whether they are directly employed by the ISD/DPS or are contracted personnel for whom the district can document a de facto employer-employee relationship.
- Contracted SPMP for which a de facto employer-employee relationship cannot be documented. These individuals are considered "other personnel" and their activities are claimed at the 50% FFP rate.

Successful participation in the time study is a requirement of program participation. Because statistical sampling is used and sample sizes are minimized to allow for the least intrusion in regular work activities, the importance of recording all moments for all selected employees is critical to the accuracy and validity of the final results, and will be emphasized in all communications and trainings.

6.9 Summer Quarter Formula and Random Moment Time Study

The summer quarter months are July, August and September. There is a break period between the end of one regular school year and the beginning of the next regular school year during which only a few employees are working. The majority of school employees work during the school year and do not work for part of the summer quarter (9-month staff). However, there are some 9-month staff that opt to receive their pay over a 12-month period. Therefore, different factors must be applied to the summer formula in order to accurately reflect the activities that are performed by the staff.

The summer quarter will be divided into two parts producing two partial claims. The sum of both claims will be submitted to Medicaid for reimbursement for the quarter. The first part of the quarter will extend from July 1 to the date the 9-month staff return to work. The second part of the quarter will be from the date the 9-month staff return to work through September 30.

The RMTS will still be performed in the summer quarter, but will take place only after the employees start back to work and will only be applied to the costs for the second part of the summer quarter. To accurately reflect the work efforts being performed when all staff have returned to work, the RMTS will be performed during a shorter time period.

6.9.A. Part I-July 1 to the Date 9-Month Staff Return to Work

For the first part of the summer quarter, the staff pool list for the ISD will be the same RMTS staff pool list used for the preceding April-June quarter.

6.9.B. Part II-Date 9-Month Staff Return to Work Through September 30

The financial data reporting for Part II of the summer quarter will be based on the actual costs incurred during this timeframe for the staff on the August-September staff pool list.

6.10 Factors for Claims Development

MDCH will submit quarterly claims on behalf of all participating school districts to the CMS. Each claim will be based on the following factors: The cost pool, percentage of time claimable to Medicaid Outreach Program administration, the Federal Financial Participation (FFP) rate, and the discounted Medicaid eligibility percentage rate for that district. The factors for the summer quarter are described above.

6.10.A. Cost Pool

This consists of the actual costs incurred for the quarter being claimed, such as salaries, overhead, etc. Each participating ISD/DPS must certify that the claim they submit to MDCH contains sufficient non-Federal (State, county, or local) funds to match requirements and that the claim only includes actual costs.

6.10.B. Federal Financial Participation Rate

There are two different rates of reimbursement allowed by the federal regulations for Medicaid administrative activities: 50% or 75%, based on staff responsibilities, education, and training. For those staff who meet the requirements contained in the Federal Financial Participation for Services/Activities Performed by Skilled Professional Medical Personnel subsection that would qualify them as Skilled Professional Medical Personnel (SPMP) and are performing activities that require this expertise. Effective January 1, 2003, the activities performed by SPMPs are reimbursed at a 50% Federal rate. Because the results of this program will be applied to prior billing quarters when SPMP activities could be recognized at the 75% rate, it is still necessary to identify and record the SPMP amounts on the quarterly claim for the backcasting process. Other activities performed by non-SPMPs and activities performed by SPMPs that do not require special medical knowledge are also reimbursed at a 50% Federal rate.

6.10.C. Discounted Medicaid Eligibility Percentage

The discounted Medicaid eligibility percentage is determined by the percentage of the student population in each ISD/DPS who are actually Medicaid beneficiaries. The discounted Medicaid eligibility rates will be determined twice each year and applied to certain activities in the claim calculation formula. To calculate the discounted Medicaid eligibility rates, the claiming entity will obtain the September and February fourth Wednesday pupil count report list from the Center for Educational Performance and Information (CEPI). The pupil count list will include the student name and date of birth. The MDCH will provide a method for using the list to verify the number of Medicaid-eligible students. This number will be used in a calculation with the total pupil count to determine the discounted percentage of Medicaid-eligible students in the ISD/DPS. The September pupil count list will be used to determine discounted Medicaid eligibility rates for time studies conducted in the Fall and Winter quarters, and the February pupil count will be used for time studies conducted in the Spring and Summer quarters.

Based on the above factors, the claim that is sent to Medicaid is calculated as follows:

Fall, Winter and Spring Quarter Formulas for Calculating Administrative Outreach Claims

Cost pools (salaries, overhead, etc.)	X	% time claimable to Medicaid Outreach Administration from time studies	X	Discounted by the Medicaid eligibility percentage	X	% Federal Financial Participation (FFP) rate	=	The amount of the claim submitted for Medicaid reimbursement

Summer Quarter Formulas

The summer quarter will be divided into two parts. The sum of both parts will be submitted to Medicaid for reimbursement. There will be two workbooks created for the summer quarter, one for each part.

Part I - Summer Quarter from July 1 to the date the 9-month staff return to work

Cost pool (only the 9-month salaries and related costs that are paid during this time period)	X	Average % of time claimable to Medicaid Outreach Administration from the previous three quarters	X	Discounted by the Medicaid eligibility percentage	X	Percent of FFP rate	=	The amount of the partial claim for Part I of the Summer Quarter

- Salary and related costs for 9-month staff that were earned during the school year, but are paid during the summer break, will be collected in a separate cost pool. Salaries paid during this period for 12-month employees are not included in the cost pool.
- The cost pool containing the salaries and related costs of 9-month staff who are paid over 12 months will be claimed based on the average time study results and Medicaid Eligibility (MAE) rate from the previous three quarters.

Part II - Remainder of the Summer Quarter – Begins on the date 9-month staff return to work through September 30

Cost pools (include all allowable salaries, overhead, etc.)	X	% of time claimable to Medicaid Outreach from the Summer Quarter time study	X	Discounted by the Medicaid eligibility percentage	X	Percent of FFP rate	=	The amount of the claim for Part II of Summer Quarter

- Salary and related costs of all employees eligible for the time study are included in the cost pool, along with other allowable overhead.
- An RMTS is performed and applied to determine the percent of time claimable for Outreach during Part II of the summer quarter.

MACS will add the Summer Quarter Part I and Part II claim amounts together to reach the dollar amount of the total Summer Quarter claim submitted to MDCH for reimbursement.

6.11 Financial Data

The financial data (salaries, benefits, supplies, etc.) used to calculate the Administrative Outreach claim are to be based on actual detailed expenditure reports obtained directly from the participating ISDs'/DPS' financial accounting system. The financial accounting system data is to be applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Administrative Outreach claim are to include only actual expenditures incurred during the claiming period, except for the summer quarter.

6.12 Funding Sources

Claims for approved Medicaid SBS Administrative Outreach functions may not include expenditures of:

- Federal funds received by the district directly
- Federal funds that have been passed through a State or local agency
- Non-Federal funds that have been committed as local match for other Federal or State funds or programs

Funds received by an ISD/DPS for school based direct health services under the fee-for-service component are not Federal funds. They are reimbursement for prior expenditures and become, upon receipt, local funds.

6.13 Allocation of Salaries and Benefits of Personnel Providing Direct Care Services

Actual expenditures for salaries and benefits of all personnel included in an Administrative Outreach claim are to be obtained from each participating ISD/DPS financial accounting system. Expenditures related to the performance of approved Medicaid Administrative Outreach functions by contracted service providers (e.g., occupational therapists, physical therapists) who also provide direct care services must also be obtained from each participating ISD/DPS financial accounting system.

6.14 Documentation and Recordkeeping / Audit File Requirements

ISDs/DPS or their billing agent must billing SPMP administrative activities at the 50% matching rate. However, to deal with the unique circumstances of recording SPMP activities that could be reimbursed at the enhanced 75% rate, it is also necessary to continue to identify and report SPMP activities separately on the quarterly claim and not include the SPMP expenditures with the other 50% matchable expenditures. Because the results of the program will be applied to prior billing quarters when SPMP activities could be recognized at the 75% rate, it is necessary to identify and record the SPMP amounts on the quarterly claim for the backcasting process.

ISDs/DPS must maintain documentation necessary for MDCH to determine that such claimed administrative outreach activities required the medical expertise of SPMP. These documents should include: (a) the type and purpose of the activity that was completed, (b) the provider of the activity, (c) the date of the activity, (d) the amount of time the activity took, and (e) the medical need of individuals that the activity met.

School districts must also maintain and update, as necessary, their staff pool lists and submit any changes to their claims development contractor. Such records should, at a minimum, contain:

- Quarterly lists of individuals in each eligible classification for time study participants and SPMPs labeled separately;
- Documentation that each SPMP possesses the required education, training, and current credentials;
- Documentation of the supervisory relationship of all claimed direct supporting staff associated with each specific SPMP, such that the support staff provide direct support exclusively to the sampled participants; and
- Documentation of the district's determination of the de facto employer-employee relationship for each of the contracted (SPMP or direct support) staff claimed as such.

RMTS Documentation

Each participating school district will maintain a separate audit file for each quarter billed. The following minimum documentation will be required:

- Financial data used to establish cost pools and factors.
- A copy of the quarterly sample results, produced by either the State's RMTS and Claims Development Contractor or ISD/DPS/their vendor.
- A completed quarterly claim, produced by MACS and signed by the Chief Financial Officer of the ISD/DPS.
- A copy of the warrant, remittance advice or Electronic Funds Transfer (EFT) documentation, verifying that payment from MDCH was received.

Districts must cooperate fully with any review requested by the MDCH, the CMS, and special monitoring staff and maintain all necessary records for a minimum of six (6) years after submission of each quarterly claim.

Any changes in Federal regulations related to claims for administrative expenditures are incorporated by reference into this document.

6.15 Audit Activities to be Performed by MDCH Office of Audit Staff

MDCH audit review of selected ISD/DPS cost reports for the Administrative Outreach Program may include the following activities:

- Verification that the salaries listed for employees/positions included in the Random Moment Time Study (RMTS) staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the AOP staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period.

- Verification that any other salaries and costs for supplies, etc., are of direct benefit to the employees on the staff pool list, and therefore, allocable to the AOP in the same percentage as the AOP-eligible employees.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on AOP cost reports and that AOP costs were not accepted for cost sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts should also be expected.
- Any other area deemed necessary.

The ISD/DPS should be prepared to direct the auditor to any document used to support and identify the reported AOP costs.

6.16 Non-Student Specific/Pre-Medicaid Eligibility Determination

There are some Administrative Outreach activities and expenditures that are approved by Medicaid that have not been addressed thus far. They are:

- Provided to the entire "at-risk" population,
- Not identifiable to individual students, and
- Provided before Medicaid eligibility is determined.

These activities are to be allocated to the approved Medicaid administrative outreach claim based on the results of the time study conducted during the claiming period.

6.17 Student-Specific Administrative Functions Expenditures

There are some Administrative Outreach functions that are identifiable to individual students after Medicaid eligibility has been determined. These functions are to be allocated in the administrative claim based on both the time study results conducted during the claiming period and the applicable discounted Medicaid eligibility rate.

6.18 Non-Salary Expenditures

Expenditures for materials and supplies related to the approved Medicaid administrative outreach activities may be included in the claim if they can be attributed directly to individuals who are claimed. The principles for claiming expenditures and cost allocation, including correct depreciation of assets as published in the Federal Office of Management and Budget (OMB) Circular A-87, must be followed. Examples include conference fees, registration fees, mileage, pagers, printing fees (i.e., for business cards), furniture, equipment, copy machine expenses, etc. Such expenditures are to be based on actual detailed departmental expenditure reports obtained directly from the participating ISD/DPS financial accounting system. These expenditures may not include items identified as indirect costs, such as central

business office operations, general building maintenance and repair costs, or any other costs classified as an indirect cost.

6.19 Indirect Costs

Allocable indirect costs are the product of the school district aggregate, calculated, approved Medicaid administrative outreach claim amount, multiplied by the ISD/LEA unrestricted indirect cost rate, as approved annually by the Michigan State Board of Education (MSBE). The ISD/LEA unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget Circular A-87 "Indirect Cost Allocation Principles". The methodology used to determine the indirect cost rate specific to each district has been approved by the Federal cognizant agency. The indirect cost rates are updated annually by the Michigan Department of Education.

6.20 Activity Code Discount Processes

Michigan's Administrative Outreach Program activity codes are designed to reflect the Medicaid State Plan, the actual activities that may occur in a school on any given day, and the specificity of the unique health care programs within the State that are available to families. Some activities fully support the administration of the State Plan and/or the EPSDT program in the State, and others are more related to activities performed on behalf of Medicaid-eligible students. Because these medical- or health-related activities are provided for students who are both Medicaid- and non-Medicaid-eligible, it is necessary to develop and apply a formula that properly allocates which students are being supported. This is referred to as the discounted Medicaid eligibility rate. During the claims development, providers will apply the Medicaid eligibility rate to certain activities that support Medicaid-eligible students.

In general, activities will be reimbursed using the following criteria:

- No Medicaid discount applied to activities that:
  - Inform children, parents and families, ISD/DPS staff and the community about the benefits, availability and how to access services and programs available through the Medicaid Program.
  - Involve conducting outreach campaigns to reach and identify children in the school who are in need of health and preventive services covered by Medicaid.
  - Facilitate potentially eligible students and their families who may or are in the process of enrolling in the Medicaid program.
- Apply a discount using the Medicaid eligibility rate to activities that involve:
  - Referral, coordination, planning, and monitoring health services designed to be delivered through the Medicaid Program that address the health needs of children.
  - Program planning and policy development of Medicaid-covered services.
  - Presenting or participating in training designed to educate the audience about the various Medicaid programs and the services covered by each, and how to more effectively refer students for services.
  - Assisting or arranging for an individual to obtain transportation to Medicaid-covered services.

- Assisting, arranging or providing translation services related to Medicaid-covered services.

Using the above criteria, the following activities will be discounted by the Medicaid eligibility rate released by the MDCH twice annually. (Also refer to the "Summary of Time Study Activities" table in the Activities That Can be Claimed Section)

- Activity 5 - Program planning, policy development and interagency coordination
- Activities 7 & 8 - Referral, coordination and monitoring of Medicaid services
- Activities 10 & 11 - Medicaid-specific training on outreach and eligibility services
- Activity 14 -Transportation and translation services in support of Medicaid-covered services

6.21 Claim Certification

The accuracy of the submitted claims must be certified by the chief financial officer, the superintendent of the district, or the consortium's lead ISD/DPS designee. Such certification is to be documented on an MDCH-approved certification form, and conform to the certification requirements of 42 CFR 433.51. Detailed claim analyses and supporting documentation will be maintained by the ISD/DPS for audit or future reference purposes according to the terms identified in the interagency agreement between the district and the MDCH.

Reimbursement will be paid after the claim has been submitted to, reviewed by, and determined to be acceptable and accurate by MDCH and CMS.

6.22 Annual Reconciliation

At the end of the district's fiscal year, and after its annual financial audit is completed, a reconciliation of the filed administrative outreach claims, with the financial accounting records and supporting documentation, must be performed. Adjustments to future administrative claims must be made based on the results of the reconciliation analyses to consider any year-end adjustments to accounting entries of any items which might have impacted the claim amounts.

6.23 Fiscal Provisions

School districts must use an appropriate Revenue Code to identify the Medicaid SBS Administrative Outreach Program funds within their accounting records.

6.24 SAS 70 Audit Requirement

The State's RMTS and Claims Development Contractor, and any billing agent hired by a Tier I ISD and/or the DPS for claims development is required to have a Type II Statements on Auditing Standards (SAS) 70 audit to provide the necessary assurances that the claiming process (e.g., methodology, time studies, cost allocations, etc.) has been properly applied.

A SAS 70 audit is an independent audit performed for the purpose of evaluating and issuing an opinion on a service organization's operational processes and controls. The auditor of the service organization is required to issue a report on controls placed in operation and tests of operating effectiveness, which is commonly referred to as a "Type II report", in accordance with the American Institute of Certified Public

Accountants (AICPA) Statements on Auditing Standards (SAS) No. 70-Reports on the Processing of Transactions by Service Organizations, as amended by SAS No. 88-Service Organizations and Reporting Consistency.

The State's RMTS and Claims Development Contractor must undergo a SAS 70 audit annually. Billing agents hired by a Tier I ISD and/or DPS must undergo a SAS 70 audit, at a minimum once every two years. If significant system changes, or changes in methodology have occurred, a SAS 70 audit must be completed in the year of the change. Once the SAS 70 audit has been performed under the new program, the school district's auditor should extend their audit procedures to a review of the billing company's process in the years that a SAS 70 audit is not completed, if the program is selected for testing as a major program under the requirements of OMB Circular A-133.

The initial SAS No. 70 audit under the new program must cover a six-month period (January 1, 2004 through June 30, 2004). After the initial audit, the subsequent audits must cover at a minimum the most recent six months. The SAS 70 audit must be submitted within 90 days after the end of the examination period.

Five (5) copies of the audit should be forwarded to the MDCH SBS Administrative Outreach Program Policy Specialist. (Refer to the Directory Appendix for contact information.)

6.25 Submission of Claims

The ISDs/DPS, either individually or as a consortium, must submit claims using the MACS reporting format (structured spreadsheet template) and approved certification forms.

The claim package for the consortium must consist of completed MACS Excel workbooks for each individual ISD/DPS in the consortium. The completed workbooks for each ISD/DPS participating in the consortium are to be combined and consolidated into one claim that is submitted to MDCH.

All claims are to be submitted in accordance with the reporting requirements established by the MDCH. It is imperative that districts work closely with their Claims Development Contractor to provide pertinent financial, enrollment and personnel data and meet their deadlines and any other technical specifications. Claims not submitted on time must be submitted the following quarter as an adjustment to the prior missed quarter and will be processed for that following quarter. Claims not conforming to reporting requirements will not be accepted or processed.

6.26 Periodicity of Reporting

Districts must submit claims for expenditures related to approved Medicaid administrative outreach activities to the MDCH on a quarterly basis. The claim is due to MDCH on or before 120 calendar days after the end of the reporting quarter.

Timeframes to Submit Administrative Outreach Claims to MDCH

	REPORTING PERIOD		CLAIM DUE TO MDCH	CLAIM SUBMITTED TO CMS BY MDCH
	BEGIN DATE	ENDING DATE		
Summer	July 1	September 30	January 31	March 31
Fall	October 1	December 31	April 30	June 30
Winter	January 1	March 31	July 31	September 30
Spring	April 1	June 30	October 31	December 31

SPECIAL PROGRAMS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers.

The Michigan Department of Community Health (MDCH) administers the Medicaid Program, Children's Special Health Care Services (CSHCS), Adult Benefits Waiver (ABW), Maternity Outpatient Medical Services (MOMS) and other special programs described elsewhere in this manual. In addition to these traditional programs MDCH administers many other programs/coverages to meet the healthcare needs of Michigan's medically indigent population. Programs vary in scope and eligibility requirements and are funded through various sources, including federal, state, and/or private. Some of the programs offer comprehensive or reduced Medicaid benefits as indicated. Additional information regarding these programs may be available on the MDCH website.

Contact information for the various programs is listed in the Directory Appendix.

SECTION 2 – PROGRAMS THAT TARGET SPECIFIC MEDICAL CONDITIONS

2.1 BREAST AND CERVICAL CANCER CONTROL PROGRAM

2.1.A. ELIGIBLE BENEFICIARIES

The Breast and Cervical Cancer Control Program (BCCCP) covers uninsured low-income women of all ages, especially but not limited to, women aged 40-64. Certain income restrictions do apply.

- Insured women may apply if certain insurance, age, and income requirements are met.
- Women who are enrolled in a managed care program, health maintenance organization (HMO) or have Medicare Part B are not eligible.

2.1.B. COVERED SERVICES

Covered services include:

- Clinical breast exams
- Pap smears
- Pelvic exams
- Screening mammogram, and
- Appropriate referral to community providers for follow up of abnormalities.

Breast biopsy, colposcopy-directed services, colposcopy service, diagnostic mammograms, and loop electrosurgical excision procedure (LEEP) may be provided based upon medical needs, financial and insurance status, and availability of federal grant funds or Michigan tobacco tax dollars**.**

2.2 TRAUMATIC BRAIN INJURY REHABILITATION PROGRAM

2.2.A. ELIGIBLE BENEFICIARIES

The Traumatic Brain Injury (TBI) Rehabilitation Program covers adults age 18 or older, who are U.S. citizens, and have incurred a traumatic brain injury in the past 15 months or have experienced a significant change within the last three months, but are medically stable. Individuals must be a RANCHO 5-6 and currently Medicaid eligible. There must be a documented need for comprehensive, specialized rehabilitative services.

Individuals must be bowel and bladder trained and able to actively participate in 21 hours of therapy a week. Services must be provided under a physician approved plan of care and rendered in a residential or outpatient program that is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and has an agreement with a Medicaid approved nursing facility.

2.2.B. Covered Services

In addition to regular Medicaid coverage, the TBI Rehabilitation Program provides:

- Hearing & speech/language services
- Occupational therapy
- Physical therapy
- Physician services
- Psychological services
- Social work.

Vocational and educational services are not reimbursable by Medicaid.

SECTION 3 – GENERAL COVERAGE PROGRAMS

3.1 ELDER PRESCRIPTION INSURANCE COVERAGE PROGRAM

3.1.A. ELIGIBLE BENEFICIARIES

Low-income, noninstitutionalized Michigan residents who are age 65 and over without prescription drug benefits (except for Medicare) are eligible for the Elder Prescription Insurance Coverage Program (EPIC). Residency and income requirements apply. A nonrefundable $25.00 processing fee is required when applying for the program

3.1.B. COVERED SERVICES

The EPIC program provides assistance in purchasing the majority of the individual's prescription drugs for a year.

3.2 MEDICARE SAVINGS PROGRAM

3.2.A. ELIGIBLE BENEFICIARIES

Low income Medicare beneficiaries and those individuals who are eligible for Medicare but do not enroll due to the cost may participate in the Medicare Savings Program (MSP). Financial and nonfinancial requirements and restrictions do apply.

3.2.B. COVERED SERVICES

The MSP pays Medicare coinsurance, deductible, and premiums. Refunding of beneficiary-paid Medicare Part B premiums is performed on an annual basis in certain cases.

3.3 SPECIAL N SUPPORT

3.3.A. ELIGIBLE BENEFICIARIES

Families that received the low-income families (LIF) Medicaid but are no longer eligible due to an increase in child support may qualify for Special N Support. Most of the health coverage is provided by Medicaid Health Plans (MHPs) and the majority of the beneficiaries are already enrolled in a MHP.

3.3.B. COVERED SERVICES

Special N Support beneficiaries receive regular Medicaid coverage for four months.

3.4 Freedom To Work

3.4.A. Eligible Beneficiaries

Medicaid-eligible disabled adults, aged 16 through 64 years old, with earned income may be eligible. A beneficiary must move into this Medicaid category from another Medicaid category. SSI beneficiaries whose SSI eligibility may end due to financial factors are among those eligible to be considered for this program.

To be eligible, the beneficiary must be employed on a regular and continuing basis. There may be temporary breaks in employment up to 24 months if they are the result of involuntary layoff or are determined to be medically necessary.

For a married beneficiary, the spouse's income and assets are not considered when determining eligibility for this Medicaid category. The beneficiary's total countable unearned income cannot exceed 100 per cent of the Federal Poverty Level (FPL). The beneficiary's countable assets are limited to $75,000. In addition, the beneficiary is allowed to have IRS-recognized retirement accounts (including IRAs and 401[k]s) of unlimited value.

3.4.B. Covered Services

Freedom To Work beneficiaries receive regular Medicaid coverage.

3.4.C. Premiums

If the beneficiary's earned income is below 250 per cent of the FPL, there is no premium required for coverage. If the beneficiary's earned income is between 250 per cent of the FPL and $75,000 per year, the premium is based on the sliding fee scale. If the total countable earned income exceeds $75,000 per year, the beneficiary must pay a premium equal to 100 per cent of the cost of Medicaid coverage.

3.5 Medicaid for Supplemental Security Income Beneficiaries

3.5.A. Eligible Beneficiaries

Supplemental Security Income (SSI) covers disabled children whose families have low income, and low-income adults who are aged, disabled or blind. The Social Security Administration determines eligibility and awards monthly SSI payments based on income and assets requirements. Beneficiaries awarded SSI are automatically eligible for regular Medicaid coverage.

3.5.B. Covered Services

SSI Beneficiaries are eligible for regular Medicaid. In some cases Medicare premiums are paid by Medicaid based upon certain individual situations and previous work histories.

3.6 Transitional Medical Assistance

3.6.A. Eligible Beneficiaries

Transitional Medical Assistance (TMA) covers families who are U.S. citizens that are no longer eligible for the low-income family (LIF) Medicaid because the parent(s) has too much income from employment. The family must have received low-income family Medicaid for at least three months of the previous six months to be eligible for TMA. Most of the health coverage is provided by HMOs contracted by MDCH. The majority of the beneficiaries are already enrolled in a MHP. A renewal of the application to TMA is not necessary.

3.6.B. Covered Services

TMA provides regular Medicaid coverage, or a comprehensive health care package that includes vision, dental and mental health services if beneficiary has been enrolled in a MHP for 12 months.

3.7 Transitional Medical Assistance Plus

3.7.A. Eligible Beneficiaries

Transitional Medical Assistance Plus (TMA-Plus) covers adults in families who are U.S. citizens that are unable to purchase employer sponsored health care coverage. Income restrictions and requirements do apply. Adults can apply for TMA-Plus after being enrolled in TMA for twelve months. A renewal of the application to TMA-Plus is not necessary. Monthly premiums are based on number of adults covered and how long they have been in TMA-Plus.

3.7.B. Covered Services

TMA-Plus provides regular Medicaid coverage, or a comprehensive health care package, which includes vision, dental and mental health services if beneficiary has been enrolled in a MHP for twelve months. This is not a benefit for children.

SECTION 4 – COMMUNITY-BASED LONG TERM CARE

4.1 MI CHOICE WAIVER (HOME AND COMMUNITY-BASED WAIVER FOR THE ELDERLY AND DISABLED)

4.1.A. ELIGIBLE BENEFICIARIES

The MI Choice Waiver provides services to aged and physically disabled individuals 18 years old and over who are U.S. citizens, who want to stay in their homes or another residential setting, but without the provision of waiver services would require the level of care only available in a nursing facility. Income and assets requirements and restrictions apply. Individuals must be currently Medicaid approved or be Medicaid eligible if they were to enter a nursing facility. MDCH contracts with local agencies to administer this program.

4.1.B. COVERED SERVICES

In addition to regular Medicaid coverage, enrollees receive waiver services that include:

- Adult day care
- Chore services
- Counseling
- Environmental modifications
- Home delivered meals
- Homemaker services
- Medical supplies and durable medical equipment beyond those covered by regular Medicaid
- Personal care supervision
- Personal emergency response systems
- Private duty nursing (if age 21 or older)
- Respite
- Training in a variety of independent living skills
- Transportation

4.2 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a comprehensive service delivery system for frail, elderly individuals that meet Medicaid's functional/medical criteria for nursing facility level of care. For most PACE participants, the comprehensive service package permits them to continue living at home while receiving services rather than being institutionalized. The program uses an Adult Day Care model to provide most services. There is currently only one PACE provider in Michigan — Henry Ford Health System-Center for Senior Independence.

4.2.A. Eligible Beneficiaries

PACE participants must meet the following criteria:

- Meet Medicaid's functional/medical criteria for nursing facility level of care
- Be at least 55 years of age
- Live within the approved geographic area of the PACE organization
- Not residing in a nursing facility at the time of enrollment
- Not be concurrently enrolled in the Medicaid MI Choice Waiver
- Not be concurrently enrolled in a Health Maintenance Organization (HMO)

4.2.B. Covered Services

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses the participants' needs, develops care plans and delivers all services, including acute care services, hospital services and, if necessary, nursing facility services. PACE programs provide social and medical services primarily in an adult day care health center, supplemented by in-home and referral services in accordance with the participants' needs.

Refer to the Program of All-Inclusive Care for the Elderly Chapter of this manual for additional information.

SECTION 5 – MICHILD

5.1 ELIGIBLE BENEFICIARIES

Children under age 19 who are U.S. citizens or documented aliens not eligible for Medicaid, who do not have health coverage and whose families meet certain income requirements and restrictions are eligible for MIChild. Health coverage is provided by HMOs contracted by MDCH. A $5.00 monthly premium per family is required and there are no co-payments or deductibles.

5.2 COVERED SERVICES

The following services are covered for MIChild beneficiaries:

- Dental
- Emergency care
- Hearing
- Inpatient and outpatient hospital
- Laboratory
- X-rays
- Mental health and substance abuse services
- Pharmacy
- Physician
- Prenatal care and delivery
- Vision

SECTION 6 – CHILD AND ADOLESCENT HEALTH CENTERS AND PROGRAMS

Under an agreement with the MDCH, Child and Adolescent Health Centers and Programs (CAHCPs) provide medical services and outreach on behalf of the Medicaid Health Plans (MHPs) to school-aged children. Refer to the Medicaid Health Plan Chapter for additional information.

TRIBAL HEALTH CENTERS

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SECTION 1 – GENERAL INFORMATION

Under the Indian Self-Determination and Education Assistance Act (Public Law 93-638), tribal facilities, including Tribal Health Centers (THCs), are those owned and operated by American Indian/Alaska Native tribes and tribal organizations under contract or compact with the Indian Health Service (IHS).

The Michigan Department of Community Health (MDCH), which administers the State Medicaid Agency, has the authority to enter into reimbursement agreements with THCs to establish a payment mechanism for Medicaid beneficiaries receiving outpatient services through a THC. The reimbursement agreement is called a Memorandum of Agreement (MOA). THCs have the option of signing either the THC MOA or the Federally Qualified Health Center (FQHC) MOA. The MOA is effective when both MDCH and a THC have signed the agreement. Outpatient benefits covered under the MOA are outlined in the Michigan Medicaid State Plan.

Information in this chapter is to be used by THCs that have signed the THC MOA. This chapter is to be used in combination with other chapters in this manual.

Under the Michigan Medicaid State Plan, THCs have the option of choosing from one of three reimbursement mechanisms. The THC may elect to be reimbursed under only one of the options listed below and the selected option applies to all beneficiaries receiving services at the THC. The options are:

- A THC may choose to be certified as an IHS facility, sign the THC MOA and receive the IHS encounter rate in accordance with the terms of the MOA.
- A THC may choose to be certified as an FQHC, sign the FQHC MOA, and receive the encounter rate set by the State in accordance with federal requirements.
- A THC may elect neither the THC nor the FQHC MOA. In this event, reimbursement to the THC defaults to the basic encounter rate outlined for FQHCs under Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA). (Refer to the Federally Qualified Health Centers Chapter of this manual for additional information.)

SECTION 2 – MEDICAID ENROLLMENT

2.1 PROVIDER ENROLLMENT

Each THC employed or subcontracted physician, dentist, optometrist, podiatrist, chiropractor, certified nurse practitioner (CNP) (who has a collaborative agreement with a physician), and certified nurse midwife (CNM) must be enrolled as a Medicaid provider to bill for services rendered on behalf of the THC. Each provider must have a completed and signed Medical Assistance Provider Enrollment and Trading Partner Agreement (DCH-1625) on file with MDCH Provider Enrollment Unit to be reimbursed for covered services rendered to Medicaid beneficiaries.

THCs must give written notice to MDCH (to both the Provider Enrollment Unit and the Hospital & Health Plan Reimbursement Division [HHPRD]) of any contracted or subcontracted Medicaid provider who terminates employment with the THC. (Refer to the Directory Appendix for contact information.) This notification letter must include the provider's name, Medicaid provider ID number, termination date and the affiliated THC.

THCs with several CMS-approved locations must have provider identification (ID) numbers for each eligible provider rendering services at those locations. Information regarding provider enrollment is provided in the General Information for Providers Chapter of this manual. Provider enrollment inquiries may be directed to the Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

2.2 NONENROLLED PROVIDERS

All THCs may bill professional services provided by THC clinical social workers, clinical psychologists, certified addiction counselors, other therapists (i.e., occupational and physical), and physician's assistants. However, these providers are not enrolled Medicaid providers and do not have their own Medicaid provider ID numbers. Services provided by these professionals should be billed under the supervising physician's Medicaid ID number. The supervising physician is responsible for the medical necessity and appropriateness of these services.

SECTION 3 - BENEFITS

3.1 COVERED SERVICES

THC services are reimbursed at the THC MOA rate (if the THC rate is elected) when provided to fee-for-service (FFS) Medicaid beneficiaries. THC Medicaid services include:

- Physician (MD, DO) services.
- Podiatrist (DPM) services.
- Chiropractor (DC) services.
- Optometrist (OD) services.
- Dental (DDS) services.
- Certified nurse practitioner (CNP) services.
- Certified nurse midwife (CNM) services.
- Physician assistant (PA) services.
- Services and supplies incident to the services rendered by the provider:
  - Pharmacy services administered by the provider and billed under the provider's Medicaid ID number.
  - Laboratory services billed under the provider's Medicaid ID number.
  - Diagnostic services billed under the provider's Medicaid ID number.
- Therapies (i.e., Occupational, Physical, and Speech, Hearing, and Language Evaluation and Therapy) rendered under the physician's ID number.

The services listed may be modified in accordance with benefits covered under the Medicaid State Plan. MDCH notifies providers of changes (additions/deletions) in Medicaid covered services through the Medicaid bulletin process. Providers should refer to these documents to verify that benefits are covered prior to rendering services.

For clarification of covered services:

Physician Services	Physician services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDCH Bulletins.
Podiatrist Services	Podiatrist services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDCH Bulletins.
Chiropractor Services	Chiropractor services must comply with the coverages and limitations published in the Chiropractor Chapter of this manual and MDCH Bulletins.
Certified Nurse Midwife (CNM)	CNM services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDCH Bulletins.

Maternal Infant Health Program (MIHP)	THCs providing Maternal Infant Health Program (MIHP) must be certified through MDCH. Information specific to the coverages and limitations for MIHP services are detailed in the MIHP Chapter of this manual. If the THC subcontracts any MIHP services, no duplicate billing is permitted.
Physician's Assistant	Physician's assistant services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDCH Bulletins. Physician's assistant services are billed under a supervising physician Medicaid ID number.
Pharmacy Services	Pharmacy services billed under the practitioner Medicaid ID number are included in the encounter rate but do not constitute a separate encounter for reimbursement at the THC MOA rate as they are considered part of the office visit. Under the THC MOA, practitioner pharmacy services do not include drugs provided by a pharmacy. THCs with pharmacies enrolled as Provider Type 50s may continue to bill prescription claims to MDCH's pharmacy benefit manager (PBM). MDCH contracts with a PBM for processing of all fee-for-service (FFS) pharmacy claims for Medicaid. The PBM also enrolls new pharmacy providers. (Refer to the Pharmacy Chapter of this manual for an explanation of coverages and limitations.)
Laboratory Services	The Practitioner Chapter of this manual explains the coverages and limitations of the Medicaid laboratory benefit. Laboratory services billed under the practitioner's Medicaid ID number are included in the THC encounter rate but do not constitute a separate encounter for reimbursement purposes as they are considered part of the office visit. THCs cannot bill for any services rendered by an outside laboratory provider or for an outside laboratory's employees performing tests.
Diagnostic Services	Diagnostic testing performed as part of an office visit must be directly related to the presenting condition and substantiated in the medical records. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for billing information.) Diagnostic testing services do not constitute a separate encounter. These services are regarded as part of the office visit and are included in the encounter reimbursement. Examples of diagnostic tests are allergy testing, audiologic function tests, x-rays, and EKGs.
Therapies	Physical therapy, speech therapy, and occupational therapy are covered when performed at the THCs. Refer to the appropriate chapter of this manual and MDCH Bulletins for an explanation of current coverages and limitations. The Billing & Reimbursement for Professionals Chapter of this manual describes the billing requirements for services provided. Therapies provided on the same date of service as a physician visit are included in the encounter reimbursement.

3.2 Dental Coverages and Limitations

THC dental services are covered if provided in the THC and must comply with coverages and limitations for dental services as specified in the Dental Chapter of this manual. Dental benefits covered for beneficiaries under the age of 21 differ from those covered for beneficiaries age 21 and over.

Information for billing dental services is published in the Billing & Reimbursement for Dental Providers Chapter of this manual.

The Healthy Kids Dental Program is administered by a contractor in 37 Michigan counties. (Refer to the Directory Appendix for contact information.) Claims for services provided to beneficiaries enrolled in the Healthy Kids Dental Program should be submitted to the contractor. Payment is made based on the contractor's fee schedule. No additional reimbursement is made by MDCH.

3.3 Vision Coverages and Limitations

Vision services are covered if provided at the THC. Vision providers are ophthalmologists and optometrists. The vision services provided by an ophthalmologist or optometrist must comply with coverages and limitations published in the Vision Chapter of this manual.

MDCH contracts for the volume purchase of frames and lenses from an optical house. Frames and lenses covered by the program must be ordered through the contractor and are listed in the Vision Chapter of this manual.

Some vision services require prior authorization (PA) before they can be rendered. The Vision Services Approval/Order Form (DCH-0893) is used to obtain PA. (Refer to the Vision Chapter for information on services that require PA and to the Forms Appendix for a copy of the form.)

3.4 Services Provided to Medicaid Health Plan Enrollees

For Medicaid-covered services provided to Medicaid beneficiaries enrolled in a Medicaid Health Plan (MHP), THCs receive payment from the MHP based on an agreement or contract with the MHP. No additional reimbursement from Medicaid is made to the THC for MHP members, in accordance with the THC MOA.

3.5 Medicare and Medicaid Beneficiaries

For dually eligible Medicare and Medicaid beneficiaries, Medicaid reimburses coinsurance and deductible amounts on Medicare-approved claims up to Medicare's IHS encounter rate.

SECTION 4 - SUBSTANCE ABUSE

Outpatient substance abuse services provided by physicians, clinical social workers, clinical psychologists, and certified addiction counselors are reimbursed. These services may include:

- Initial complete physical
- Medical history
- Social history
- Psychiatric history
- Individual, family, and group counseling
- Outpatient substance abuse treatment
- Intensive outpatient counseling
- Therapies (i.e., Psychiatric occupational/recreational therapy) in a Tribal-operated substance abuse treatment center are covered services provided they are active, restorative, and designed to prevent, correct, or compensate for a specific medical problem.
- Methodone and Levomethadyl Acetate HCL (LAAM)

4.1 REQUIREMENTS FOR PARTICIPATION

All programs must meet the following criteria to bill Medicaid for services:

- Licensed by the state licensing agency to provide each type of substance abuse service; and
- Accredited as an alcohol and/or drug abuse program by one of the five national accreditation bodies:
  - Joint Commission on Accreditation of Health Care Organizations (JCAHCO);
  - Commission on Accreditation of Rehabilitation Facilities (CARF);
  - American Osteopathic Association (AOA);
  - Council on Accreditation of Services for Families and Children (CASFC); or
  - National Committee on Quality Assurance (NCQA).

4.2 AUTHORIZATION

Services provided at the THC to American Indian and Alaska Native beneficiaries do not require the authorization of Substance Abuse Coordinating Agencies (CAs).

4.3 AMERICAN INDIAN AND ALASKA NATIVE SERVICES

American Indians and Alaska Natives who are Medicaid beneficiaries can obtain substance abuse services directly from the THC. These services are not included in the MDCH's 1915(b) Waiver for Medicaid Prepaid Inpatient Health Plans and Substance Abuse Services. THCs should contact their regional Substance Abuse CA to determine the appropriate process for accessing other funding sources or other service providers for those individuals requiring substance abuse services not covered by the THC.

4.4 Services Provided to Non-American Indians and Alaska Natives

MDCH's Prepaid Inpatient Health Plan (PIHP) for Specialty Developmental Disabilities, Mental Health and Substance Abuse services assumes responsibility for certifying admission/continuing stays and reimbursing claims for the specialized substance abuse services of non-American Indians and Alaska Natives. Refer to the Mental Health/Substance Abuse Chapter of this manual for further information on PIHPs, Mental Health and Substance Abuse Services. Substance abuse services for non-American Indians and Alaska Natives must not be billed under CPT and HCPCS codes.

4.5 Service Limits

THCs may exceed the substance abuse treatment limits for American Indian and Alaska Native beneficiaries as long as the medical record and plan of care documents the medical necessity.

4.6 Noncovered Services

The following substance abuse services are not covered when provided through THCs:

- Emergency and nonemergency transportation;
- Initial emergency screening and medical stabilization;
- Acute medical detoxification services;
- Medications prescribed in the management or treatment of methadone and LAAM; or
- Room and Board.

SECTION 5 - MENTAL HEALTH

Outpatient mental health services provided by physicians, clinical social workers, and clinical psychologists are covered. These services may include:

- Health assessment
- Psychiatric evaluation
- Psychological testing
- All other assessments and testing
- Case management
- Child therapy
- Crisis interventions
- Crisis residential services
- Intensive crisis stabilization services
- Individual psychotherapy
- Family psychotherapy
- Group psychotherapy
- Interpretation or explanation of data to family
- Medication administration
- Medication review
- Therapies (i.e., psychiatric occupational/recreational therapy) in a mental health treatment center are a covered service provided they are active, restorative, and designed to prevent, correct, or compensate for a specific medical problem.

5.1 NONENROLLED PROVIDERS

Professional services provided by clinical social workers and clinical psychologists are covered. Individuals who meet Michigan licensure/certification requirements for social workers and psychologists may provide services.

See billing instructions for nonenrolled providers listed in the Uniform Billing of Paper and Electronic Formats Section of this chapter.

5.2 AUTHORIZATION

Mental Health services provided at the THC to American Indian and Alaska Native beneficiaries do not require the authorization of PIHPs/CMHSPs.

5.3 American Indian and Alaska Native Services

American Indians and Alaska Natives who are Medicaid beneficiaries can obtain mental health services directly from the THC. THC services are not included in MDCH's 1915(b) Waiver for Medicaid Prepaid Inpatient Health Plans (PIHPs) and Substance Abuse Services. THCs may refer tribal members to the PIHP/CMHSP for mental health services not provided at the THC.

5.4 Non-American Indian Services

PIHPs/CMHSPs assume responsibility for community-based mental health and developmental disability services covered through Medicaid for non-American Indians. Refer to the Mental Health/Substance Abuse Chapter of this manual for policies and procedures. Non-American Indian mental health services must not be billed under CPT or HCPCS codes.

5.5 Noncovered Services

Mental Health services that are **not** the responsibility of the THC are as follows:

- Home-based mental health services
- Nursing facility (NF) mental health monitoring
- Emergency and nonemergency transportation

SECTION 6 – ENCOUNTERS

THCs signing one of the MOAs are eligible to receive an encounter (per visit) rate as reimbursement for Medicaid covered services provided at the THC for Medicaid beneficiaries not in enrolled in managed care.

The IHS outpatient all-inclusive rate (AIR) is determined by the Centers for Medicare and Medicaid Services (CMS) and is published in the Federal Register. The FQHC encounter rate under the FQHC MOA is an alternative methodology that was based on the prospective payment system (PPS) outlined in the Medicare, Medicaid and SCHIP Benefits Improvement Act (BIPA) of 2000.

6.1 DEFINITION

An encounter is a face-to-face visit between a Medicaid beneficiary and the THC provider of health care services who exercises independent judgment in the provision of Medicaid-covered services. The THC provider may be credited with no more than one face-to-face encounter with a given beneficiary per day, except when the beneficiary, after the first encounter, suffers a separate or different illness or injury requiring additional diagnosis or treatment.

For a service to be defined as an encounter, the Medicaid-covered service must be recorded in the patient's record.

6.2 MHP ENROLLEES

Services provided to MHP enrollees are not recognized as encounters for reimbursement purposes under the THC MOA.

6.3 SERVICES BUNDLED IN THE ENCOUNTER

Ancillary Medicaid services (e.g., labs, x-rays, injections, etc.) are included in the per visit encounter. These ancillary services are described as being provided incident to the office visit. For example, lab services billed under the physician's Medicaid ID number would not be considered a separate encounter.

Ancillary services provided at another facility are not bundled under the office visit encounter. For example, services provided by the local hospital are not included in the encounter.

SECTION 7 - BILLING

Refer to the Billing & Reimbursement for Professionals Chapter of this manual for information needed to submit professional claims to MDCH for Medicaid, as well as for information about how MDCH processes claims and notifies the THC of its actions.

MDCH strongly encourages electronic submission of claims.

It is the responsibility of the THC to properly bill all Medicaid fee-for-service (FFS) claims. Since the annual reconciliation and final reimbursement are based on approved Medicaid claims, incorrect or improper billing may adversely affect reimbursement.

MDCH approved claims are subject to audit and verifications. Evidence of misuse of services is forwarded to the Attorney General's Health Care Fraud Division for investigation.

7.1 COORDINATION OF BENEFITS

Billing instructions related to coordination of benefits are published in the Coordination of Benefits (COB) Chapter of this manual. Other insurance and all other payments received for services rendered to a Medicaid beneficiary must be reported. If payment received from other insurance exceeds the amount Medicaid would have paid, the THC must still submit a claim to Medicaid with the appropriate procedure code in order for the visit to be counted as an encounter under the MOA.

7.2 MEDICARE AND MEDICAID CLAIMS

Refer to the Billing & Reimbursement for Professionals Chapter of this manual for specific instructions regarding Medicare and Medicaid claims. If the Medicare payment exceeds the Medicaid fee screen, the appropriate FFS procedure code should still be billed to Medicaid for encounter and reconciliation purposes.

7.3 PAYER OF LAST RESORT

The IHS is the payer of last resort for persons defined as eligible for contract health services under the regulations in 42 CFR, Part 36a, Subpart G, Section 36.61, notwithstanding any State or local law or regulation to the contrary.

7.4 CO-PAYMENTS

Co-payments that are required from Medicaid beneficiaries for some Medicaid-covered services are waived for American Indians and Alaska Natives. Services requiring co-payments are listed in the General Information for Providers Chapter of this manual.

7.5 BILLING LIMITATION

The same billing limitations explained in the General Information for Providers Chapter of this manual pertain to encounters as well as claim submission.

7.6 Place of Service

THC services provided to beneficiaries at the THC are reconciled to the THC outpatient facility all-inclusive encounter rate or according to the signed MOA. The appropriate place of service (POS) code must be used on the claim form when billing. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for a list of POS codes.)

The THC may bill for services that are not provided at the THC. However, these services must be billed with the appropriate POS code in compliance with the coverages and limitations specified in the Practitioner Chapter of this manual. Except for Maternal and Infant Support Services provided in the home, only services billed with the THC POS code will be reconciled to the all-inclusive encounter rate.

Services billed to Medicaid are subject to audit and verifications.

SECTION 8 – MEDICAID PAYMENTS, ANNUAL RECONCILIATION AND APPEALS

8.1 QUARTERLY PAYMENTS

Under the MOA, quarterly payments are made to the THC at the beginning of each quarter. The payment is based on an estimate of the difference between the amount the THC receives for Medicaid services from FFS claims and other third party payments (including Medicare) during the year and the amount due the center based on the THC encounter rate.

8.2 INITIAL RECONCILIATION AND SETTLEMENT

An annual reconciliation ensures that reimbursement is at the rates agreed to in the THC MOA. The initial reconciliation and settlement is calculated approximately six months after the THC's fiscal year end. The number of encounters is determined from Medicaid fee-for-service (FFS) approved claims. Any difference between the THC rate and the amount paid to the THC from FFS payments, other insurance and quarterly payments is paid to or recovered from the THC. Future quarterly payments are adjusted based on the information in the initial reconciliation.

8.3 FINAL RECONCILIATION AND SETTLEMENT

A final reconciliation and settlement is calculated approximately one year after the THC's fiscal year end. This will allow time for all claims to clear the payment system.

8.4 APPEALS

A Medicaid provider has the right to appeal any adverse action taken by MDCH unless that adverse action resulted from an action over which MDCH had no control (e.g., Medicare termination, license revocation). The appeals process is outlined in the Administrative Tribunal Policy and Procedures Manual that can be found on MDCH's website, and in MDCH's Medicaid Provider Reviews and Hearings rules R400.3401 through R400.3424, filed with the Secretary of State on March 7, 1978. Any questions regarding this appeal process should be directed to the Administrative Tribunal. (Refer to the Directory Appendix for contact information.)

VISION

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SECTION 1 – GENERAL GUIDELINES AND REQUIREMENTS

The Michigan Department of Community Health (MDCH) contracts for the volume purchase of frames and lenses from an optical laboratory, referred to in this chapter as the contractor.

Vision providers, (e.g., opticians and dispensing ophthalmologists, and optometrists) must order frames and lenses from the contractor. A list of lenses is available in the Vision Services Database located on the MDCH website. A list of available frames is available from the contractor, currently Classic Optical Laboratories. (Refer to the Directory Appendix for contact information.)

Orders placed with the contractor must be postmarked no later than 30 days after the date of order. If orders are placed beyond the 30 days, the contractor returns the order to the provider, who must explain to Medicaid why submission was delayed and request an exception from the time limit.

Procurement of contact lenses, low vision aids, and prosthetic eyes must be obtained from the vision provider's own source and are subject to prior authorization (PA) requirements as described in this chapter.

1.1 BENEFICIARY ELIGIBILITY AND CO-PAYMENTS

Providers must verify beneficiary eligibility via the Eligibility Verification System (EVS) prior to rendering services or ordering materials. If a beneficiary's eligibility expires prior to the date the material is delivered, reimbursement is made **only** if the beneficiary was eligible on the date the material was ordered by the vision provider and the date of order is used when billing. (Refer to the Beneficiary Eligibility Chapter of this manual for further instructions and the Directory Appendix for contact information.)

A $2.00 beneficiary co-payment is required for each separately reimbursable:

- Ophthalmological service performed by an optometrist or ophthalmologist; and
- Dispensing service for glasses or contact lenses billed by dispensing ophthalmologists (enrolled as Provider Type 86) or optometrists.

Co-payment is not required for beneficiaries:

- Under age 21;
- Residing in a nursing facility (NF); or
- Having Medicare when Medicare covers the service.

Providers may not refuse to render service if a beneficiary is unable to pay the co-payment amount at the time the service is provided. However, the uncollected co-payment is considered a bad debt which allows the provider to refuse to provide future services according to Michigan's State Plan. Providers who elect not to provide services based on a history of bad debt, including unpaid co-payments, must give beneficiaries appropriate verbal notice and a reasonable opportunity for payment.

(Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional information.)

1.2 Prior Authorization

Some vision services and materials require prior authorization (PA) before they can be rendered. Applicable sections or subsections in this chapter indicate whether a specific service and/or material requires PA. In addition, the Vision Services Database on the MDCH website indicates if a service/material requires PA by the status code "P". (Refer to the Directory Appendix for website information.)

The Vision Services Approval/Order Form (DCH-0893) is used to obtain PA. A copy of the DCH-0893 and completion instructions can be found in the Forms Appendix of this manual. Complete and mail or fax the DCH-0893 to Prior Authorization Division at MDCH. (Refer to the Directory Appendix for contact information.) PA requests must be postmarked no later than 30 calendar days after the date of order. If beyond the 30 days, the provider must include a detailed explanation of why the submission was delayed.

When requesting prior approval, providers should make a photocopy of the completed form for the beneficiary file. Upon completion of the PA process, MDCH returns one copy of the DCH-0893 to the provider.

An electronic copy of the DCH-0893 is available on the MDCH website. (Refer to the Directory Appendix for website information.)

1.3 Coding of Services

The American Medical Association's (AMA) Current Procedural Terminology (CPT) is the national coding standard for healthcare professional services. Vision providers must use CPT codes in effect on the DOS to describe and identify the services and procedures performed. Optometrists must be Therapeutic Pharmaceutical Agent (TPA) certified in order to use many of these codes.

Providers must use the International Classification of Diseases, 9th Revision, and Clinical Modification (ICD-9-CM) for diagnostic coding of diseases, injuries, and conditions. Codes must be used at the highest level of specificity.

Health Care Financing Administration Common Procedure Coding System (HCPCS) is a system developed by the Centers for Medicare and Medicaid Services (CMS) to report materials, supplies, and certain services not covered by the CPT codes. HCPCS codes are to be used when applicable.

1.4 Medicare

All vision services are subject to editing for Medicare coverage. MDCH reimburses vision providers for coinsurance and deductible amounts on Medicare-approved claims up to Medicaid's reimbursement limit.

If a service requires PA by Medicaid and is covered by Medicare, vision providers do not have to obtain PA, nor does the vision provider have to obtain lenses and/or frames through the volume purchase program.

(Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional information.)

1.5 Contractor Guarantee

Frames and lenses furnished by the contractor are guaranteed for 60 days. If any material is found to be unsatisfactory due to contractor error or defective workmanship or materials, the materials and work order form should be returned to the contractor. The contractor is required to correct, adjust, or replace the materials.

If the vision provider supplies the contractor with incorrect specifications that results in eyeglasses being fabricated which the beneficiary cannot use, the vision provider is responsible for payment to the contractor for the remake. The contractor may not charge the vision provider more than what they would charge MDCH for the remake. MDCH does not pay for the remake (e.g., eyeglasses, lenses, or frames) due to vision provider error.

1.6 Complaint Process

To resolve problems (such as an overdue shipment, error in an order, or defective workmanship), vision providers should first contact the contractor. The current contractor is Classic Optical Laboratories. (Refer to the Directory Appendix for contact information.)

If the lenses and/or frames are not received from the contractor within 21 days from the date they were ordered, vision providers are responsible for contacting the contractor to determine the cause of the delay.

If difficulties are encountered with the contractor in resolving a problem, vision providers should call the Vision Contract Administrator. (Refer to the Directory Appendix for contact information.) Vision providers must be prepared to report the beneficiary's name and Medicaid ID number, and a detailed explanation of the problem(s) they have experienced.

MDCH reviews the complaint, takes necessary action to correct the problem, and notifies the vision provider of the resolution.

SECTION 2 – DIOPTER CRITERIA

2.1 INITIAL LENSES

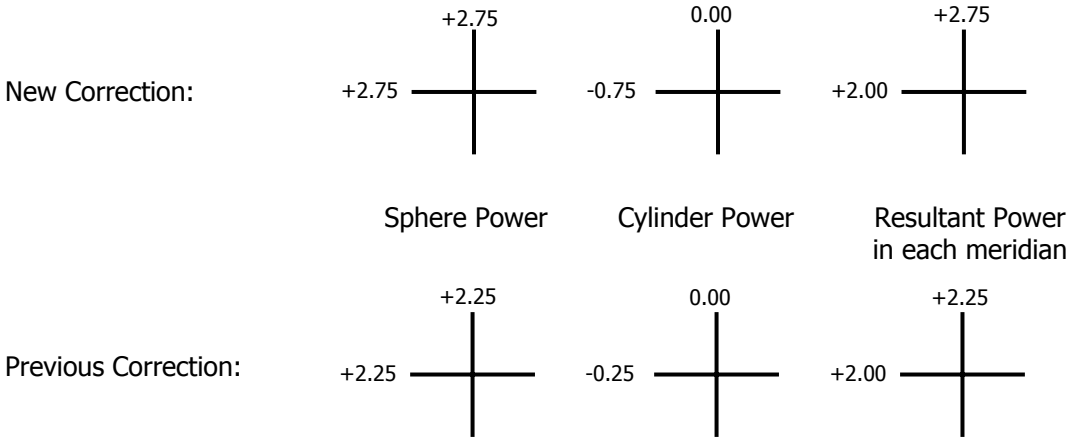
Initial lenses are considered to be the first prescription lenses ever worn by a person regardless of how they were obtained (e.g., through Medicaid, other insurance, or private pay). Initial lenses are a Medicaid benefit and do not require PA if the following minimum diopter criteria are met:

Age Group 42 Years and Younger			Age Group 43 Years and Older	
▪ 0.50D myopia ▪ 0.50D astigmatism	▪ 0.75D anisometropia ▪ 0.75D hyperopia		▪ 0.50D myopia ▪ 0.50D astigmatism ▪ 0.75D anisometropia	▪ 0.50D hyperopia ▪ 0.50D presbyopia

2.2 SUBSEQUENT LENSES

Regardless of age group, subsequent lenses are medically necessary lenses that are provided after initial lenses. Subsequent lenses are a Medicaid benefit and do not require PA if there is a change in the refractive error of 0.75D or more in the meridian of greatest change, or a change in the cylinder axis of at least 10 degrees for cylinders of 1.00D or more. These lenses must also meet minimum dioptric criteria as specified above. The change need only be present in one eye.

The following example illustrates how this requirement is assessed for a new correction (+2.75-0.75 ax 092) and a previous correction (+2.25-0.25 ax 090). The dioptric power in each meridian can be portrayed in the form of cross diagrams.



This is an example of where the change in dioptric power for subsequent lenses has not been met. Note that the resultant powers in the vertical meridians of the "new" and "previous" correction are +2.75 and +2.25 respectively. There is only a 0.50D change in the vertical meridian and no change in the horizontal.

For periods greater than 24 months from the date of the previous prescription, subsequent lenses may be ordered for diopter changes less than those specified above.

SECTION 3 – SERVICES

This section provides information on both Medicaid covered and noncovered services.

3.1 DIAGNOSTIC SERVICES

In providing services, it is the responsibility of the optometrist or ophthalmologist to determine that the services are medically necessary, appropriate, within the scope of current medical practice and Medicaid limitations. The prescribing optometrist or ophthalmologist is held responsible if he orders excessive or unnecessary services, regardless of who actually renders the services. The prescribing optometrist or ophthalmologist may be subject to corrective action related to these services, including recovery of funds.

Documentation Guidelines for Evaluation and Management Services, 1995, 1997, or latest version thereof, developed jointly by CMS and the AMA, must be adhered to when using the CPT/HCPCS procedure codes.

Eye Examinations	▪ A routine eye examination once every two years is a Medicaid benefit and does not require PA. Examinations include, but are not limited to, case history, determination of visual acuity (each eye), ophthalmoscopy, biomicroscopy, ocular motility, tonometry, refraction, diagnosis, treatment program and disposition. (Use appropriate CPT/HCPCS procedure codes for routine eye exam.) Applicable diagnostic codes (ICD-9-CM) are 367.00 - 367.9. ▪ Nonroutine eye examinations are a Medicaid benefit for the purpose of evaluation and treatment of chronic, acute, and/or sudden onset of abnormal ocular symptoms. (Use appropriate CPT/HCPCS procedure codes.)
Glaucoma Screenings	Glaucoma screenings are covered without PA on an annual basis for beneficiaries who: ▪ Have no ocular complaints or prior history of glaucoma and who have diabetes; ▪ Have a family history of glaucoma; or ▪ Are African-American age 50 or older. This screening entails a dilated eye examination, tonometry, and direct ophthalmoscopy or slit lamp examination. If this screening is provided as part of another billable service, separate reimbursement for this screening is not allowed. (Use the appropriate CPT/HCPCS procedure code for glaucoma screening.) The applicable diagnostic code is Supplementary Classification ICD-9-CM code V80.1. If the beneficiary presents with a visual or ocular complaint, the glaucoma screening code should not be used. The procedure code which best describes the visit should be selected from the CPT evaluation and Management (E/M) codes or General Ophthalmological codes.

3.2 Dispensing Services

Dispensing services are a Medicaid benefit and do not require PA. Vision providers may bill a dispensing fee for dispensing prescription lenses, prescription lenses with frames, or replacing a complete frame.

Reimbursement for the dispensing service includes the vision provider's services in selecting, ordering, verifying, and aligning/fitting of eyeglasses as described above. Routine follow-up and post-prescription visits (e.g., for minor adjustments) are considered part of the dispensing service and are not separately reimbursable.

3.3 Nursing Facility Beneficiaries

Covered and noncovered vision services, as well as PA requirements, apply to vision services provided to beneficiaries residing in a nursing facility (NF).

Performance of vision services (except replacement of a frame part for eyeglass repair) must be upon the written request of the beneficiary, a member of the beneficiary's family, or other beneficiary representative and upon the written order of the beneficiary's attending physician (MD, DO) prior to the date of the vision provider's visit.

If service is provided in the NF, a copy of the request and written order must be retained by the facility as part of the beneficiary's record.

Vision services are not considered a part of the facility's per diem rate. The vision provider or contractor must bill MDCH for vision services rendered.

No additional payments are made to vision providers for a visit(s) to the NF. Appropriate procedure codes must be utilized.

3.4 Ophthalmic Frames and Lenses

A complete pair of eyeglasses is a Medicaid benefit and does not require PA when:

- The eyeglasses being prescribed are the beneficiary's first pair of eyeglasses ever worn. These eyeglasses are considered to be initial eyeglasses and must meet minimum diopter criteria for initial lenses.
- The beneficiary's correction meets diopter criteria for subsequent lenses and the frames are unusable.
- A previously used frame requires oversized lenses. (Oversized lenses are not a Medicaid benefit, therefore, a complete pair of eyeglasses must be ordered.)
- Prescription lenses remain usable, but the original frame is broken beyond repair and the original frame is not a Medicaid benefit.
- The beneficiary's correction meets diopter criteria for subsequent lenses and the frames remain usable, but the vision provider or beneficiary elects not to send the frames to the contractor or the contractor feels that the previously used frames will break or otherwise be damaged during lens insertion.

- The beneficiary's eyeglasses have been lost, stolen, or broken beyond repair and the number of replacements have not exceeded Medicaid limits which are:
  - For beneficiaries age 21 and over, one pair of replacement eyeglasses per year.
  - For beneficiaries under age 21, two pair of replacement eyeglasses per year.

  One year is defined as 365 days from the date the first pair of eyeglasses (initial or subsequent) was ordered.

The DCH-0893 must be used when ordering frames and/or lenses. A copy of the form is available in the Forms Appendix of this manual and on the MDCH website. (Refer to the Directory Appendix for website information.) Initial or replacement eyeglasses that do not exceed Medicaid's replacement limits do not require PA. These orders must be sent directly to the contractor. Orders may be mailed or faxed. (Refer to the Directory Appendix for contact information.) The contractor fills the vision provider's order in accordance with the lens and frame specifications indicated on the DCH-0893. The order form is returned to the provider if the eligibility information is not completed.

Procedure codes that are designated with the status code "P" in the Vision Services Database on the MDCH website require PA, and must first receive approval from the Prior Authorization Division. (Refer to the Prior Authorization subsection above for instructions on obtaining PA.)

The contractor monitors orders to assure that Medicaid replacement limitations, diopter criteria, and PA requirements are being maintained. The contractor returns an order if the order exceeds the replacement limits, does not meet diopter criteria, or requires PA.

The contractor bills MDCH for the frames and/or lenses ordered by vision providers. Vision providers subsequently bill for a dispensing service for dispensing the frames and/or lenses.

If the beneficiary has other insurance that covers frames and/or lenses, the material may still be obtained through the contractor. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual when billing for the dispensing service if other insurance is involved.)

3.4.A. LENSES

Lenses must conform to the *American National Standard Recommendations for Prescription Ophthalmic Lenses, ANSI Z80.1-1999*, or the latest edition thereof.

Plastic and glass lenses are a Medicaid benefit and only require PA for lenses in the Vision Services Database on the MDCH website which have status code "P".

- Plastic and glass bifocals are available in Round 22, FT-25, FT-28, FT-35, and Executive style.
- Plastic and glass trifocals are available in FT-7x25 and FT-7x28 segments.

Photochromic, Tinted and Dyed Lenses	PA is required for these lens features. Appropriate documentation of medical necessity must be attached to the DCH-0893 when submitted to the Prior Authorization Division.

Polycarbonate Lenses	Polycarbonate lenses are a Medicaid benefit and do not require PA when diopter criteria are met and the lenses are inserted into a safety frame, marked "Z 87" or "Z 87-2".

Oversized lenses, no-line, or progressive style multi-focals are not Medicaid benefits.

3.4.B. Ophthalmic Frames

Frames must conform to the *American National Standard Requirements for the Dress Ophthalmic Frames, ANSI Z80.5-1997*, or the latest edition thereof.

Ophthalmic frame styles that are a Medicaid benefit are available from the contractor. Vision providers may order sample frames directly from the contractor. The vision provider is charged for sample frames at the same price stated in the current contract. Neither the provider nor the contractor may charge Medicaid for sample frames.

Vision providers must offer a beneficiary the opportunity to select a frame from at least 80 percent of the total authorized frame styles. A vision provider who fails to comply with this requirement is subject to termination of enrollment in Medicaid.

If a frame manufacturer discontinues production of a frame that is listed as a benefit, vision providers may utilize the discontinued frame from their sample kit. If lenses are required, they must be ordered from the contractor. Submit the DCH-0893 to the Prior Authorization Division for approval. (Refer to the Directory Appendix for contact information.)

Safety Frames	Safety frames are a Medicaid benefit. A list of authorized safety frame styles is available from the contractor. These frames conform to ANSI Z87.1-2003 standards, and samples can be purchased from the contractor at contract prices. Only polycarbonate lenses of 2 millimeter minimum thickness shall be used in frames marked "Z 87" or "Z 87-2".
Frame Repairs	Frame repairs (e.g., aligning temples, insertion of screws, adjusting frames) are not a separately reimbursable service and cannot be billed.

3.4.C. Subsequent Lenses Placed in Previously Used Frames

Subsequent lenses that are to be placed in a beneficiary's previously used frame are a Medicaid benefit and do not require PA. Previously used frames are defined as ophthalmic frames in which the beneficiary has had previous corrective lenses incorporated and which were previously worn.

All noncontract previously used frames require PA.

To order subsequent lenses for insertion into a previously used frame, vision providers must complete the DCH-0893, indicating all information necessary for proper fabrication. Vision providers have the option of having the contractor insert the lenses, in which case the provider must supply the previously used frame to the contractor, or inserting the newly fabricated lenses into the frames in their office.

If the previously used frames are sent to the contractor for lens insertion, the contractor is required to fabricate the lenses and mail the frames and lenses to the vision provider within nine working days after receiving the frames. If a special prescription requires more than nine working days to complete, the contractor must notify the vision provider. If the provider does not receive the materials within three weeks from the date the order was sent, he should contact the contractor.

If the vision provider or beneficiary elects not to send the previously used frames as might be requested by the contractor, or if the contractor feels that the previously used frames may break or otherwise be damaged during lens insertion, the vision provider is requested to order a complete pair of eyeglasses.

If frames are sent to the contractor, either at the contractor's request or the vision provider's preference, the vision provider is responsible for paying the postage necessary to ship the frames. Also, vision providers are responsible for paying for frames lost or damaged in transit.

If a previously used frame requires lenses that are not a Medicaid benefit (e.g., oversize lenses), a complete pair of eyeglasses that are a benefit must be ordered.

3.4.D. Replacement

Eyeglasses	When ordering a complete pair of eyeglasses to replace eyeglasses that have been lost, stolen, or broken beyond repair, the eyeglasses may be ordered directly from the contractor if replacement limits have not been exceeded. The replacement eyeglasses must be an identical replacement of the previously issued Medicaid eyeglasses.
Lenses Only	Replacement of a corrective lens(es), without frames, for one that is damaged or broken is a benefit, if that lens(es) is covered by Medicaid and the replacement limits have not been exceeded. A replacement lens(es) must be an identical copy of the damaged or broken lens. It does not require PA. Vision providers must order the lens(es) directly from the contractor. For periods greater than 24 months from the date of the previous prescription, when ordering subsequent lenses or complete eyeglasses, see Subsequent Lenses subsection above for appropriate diopter criteria.

Frames Only	Replacement of a complete frame (front and temples) is a Medicaid benefit only when the original frame is broken beyond repair, the prescription lenses remain usable, and the replacement limits have not been exceeded. The replacement frame must be an identical replacement. If an identical frame is not listed as a Medicaid benefit, the beneficiary must select a frame that is a covered benefit. The contractor bills Medicaid for the complete frame. The vision provider inserts the lenses into the frame and bills Medicaid for the dispensing service.

3.4.E. Two Pairs of Eyeglasses

Two pairs of single vision eyeglasses (one for near visual tasks and the other for distance visual tasks) are a Medicaid benefit in either of the following instances:

- When the beneficiary has clearly demonstrated the inability to adjust to bifocals after a reasonable trial period.
- When the beneficiary's physical condition does not allow bifocal usage.

PA is required when requesting two pairs of eyeglasses. Appropriate documentation must be attached to the DCH-0893 and submitted to the Prior Authorization Division.

Providing both multi-focal and single vision eyeglasses for interchangeable usage is not a Medicaid benefit.

3.4.F. Nondeliverable Eyeglasses

If a beneficiary fails to return to the vision provider for dispensing of eyeglasses, the vision provider should make every effort to locate the beneficiary, including contacting the local Department of Human Services (DHS) office in the beneficiary's area.

If the beneficiary still cannot be located, the eyeglasses should be sent to the local DHS office (or local nonprofit agency if the DHS office refuses to accept them) in the beneficiary's area within 90 days of placing the order with the contractor. Do not send the nondelivered lenses and/or frames to MDCH unless requested to do so by MDCH.

To bill for dispensing, the provider must use the date of order for the lenses and/or frames.

Medicaid does not reimburse vision providers for postage and handling.

3.4.G. Eyeglass Case

One eyeglass case for every complete pair of eyeglasses ordered is a Medicaid benefit and must be provided by the contractor. Vision providers cannot bill for eyeglass cases.

3.5 Low Vision Services

Evaluation	A low vision evaluation is a benefit when the beneficiary presents with moderate visual impairment, severe visual impairment, or profound visual impairment as defined in the ICD-9-CM. Under these conditions, a low vision evaluation does not require PA. This evaluation includes, but is not limited to, a detailed case history, effectiveness of any low vision aids in use, visual acuity in each eye with best spectacle correction, steadiness of fixation, assessment of aids required for distance vision and near vision, evaluation of any supplemental aids, evaluation of therapeutic filters, development of treatment, counseling of beneficiary; and advice to family (if appropriate). The CPT E/M or General Ophthalmology procedure code which best describes this service should be utilized.
Aids	High add bifocals do not require PA. For high add bifocals, complete the DCH-0893 and submit to the contractor. The prescription and fitting of low vision optical aids (such as telescopes, microscopes, and certain other low vision aids) require PA. **Only basic and essential low vision aids are a Medicaid benefit.** The Provision of Low Vision Services and Aids Support Documentation (MSA-0891) form outlines the information required when requesting PA for low vision services and aids. A sample of this form is provided in the Forms Appendix. It can also be obtained through the MDCH website. (Refer to the Directory Appendix for website information.) This form must be attached to DCH-0893 and submitted as part of the PA process. (Refer to the Prior Authorization subsection above.) Reimbursement for a low vision aid is based on the manufacturer's charge for the aid plus a professional fee. Procurement of the low vision aid is done through the vision provider's own source. The professional fee includes procurement, verification, and fitting of the aid. Only an optometrist or a dispensing ophthalmologist can bill for a low vision aid. A dispensing ophthalmologist must be enrolled as a Provider Type 86.
Rehabilitative Services	Low vision rehabilitative services include instructions, training, and assistance to the beneficiary in the most effective use of the low vision aid. Documentation for these services should be included when requesting the low vision aid.

3.6 CONTACT LENSES

Evaluation	A comprehensive contact lens evaluation is a Medicaid benefit and does not require PA when the beneficiary presents with one of the following conditions and visual performance is expected to be significantly improved with the application of a contact lens(es): (Use appropriate HCPCS comprehensive contact lens evaluation code.) ▪ Aphakia (congenital or surgical) ▪ Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses) ▪ Anisometropia or Antimetropia (of two diopters or greater that results in aniseikonia) ▪ Congenital cataracts up to age six ▪ Other conditions which have no alternative treatment
Prescription and Fitting	The prescription and fitting of contact lenses is a Medicaid benefit and requires PA, except for beneficiaries under age six with a qualifying diagnosis. ▪ The prescription for contact lenses requires the complete description of contact lens specifications. ▪ Fitting includes the supply of contact lenses, verification of lens characteristics, carrying case, solutions, instructions, training, and incidental modification of the lenses during the three-month adaptation period. Procurement of contact lenses is to be done through the vision provider's own source. The Documentation of Medical Necessity for the Provision of Contact Lenses (MSA-0892) form outlines the information required when requesting contact lens PA. A sample of this form is provided in the Forms Appendix and can also be obtained through the MDCH website. (Refer to the Directory Appendix for website information.) This form must be attached to the DCH-0893 and submitted to MDCH as part of the PA process. (Refer to Prior Authorization subsection above.) One contact lens replacement in a year for each eye is allowed for beneficiaries **age 21 and over.** Two replacements in a year are allowed for each eye for beneficiaries **under age 21.** (One year is defined as 365 days from the date the first pair of contact lenses [initial or subsequent] was ordered.) Except as indicated previously, contact lens supplies (e.g., wetting and cleaning solutions, carrying cases) are not Medicaid benefits.

3.7 STRABISMUS AND/OR AMBLYOPIA EXAMINATION

Strabismus and/or amblyopia examination (sensorimotor examination) is a Medicaid benefit and does not require PA.

3.8 Orthoptics and/or Pleoptics Training

Orthoptics and Pleoptics Training	Orthoptics and pleoptics training are Medicaid benefits only when there is a diagnosis of exotropia, esotropia, heterotropia, strabismus, or amblyopia exanopsia. ▪ For beneficiaries under age 21, PA is not required. ▪ For beneficiaries age 21 and over, PA is required. When requesting PA, the following documentation must be attached to the DCH-0893 and submitted to the Prior Authorization Division: ▪ Visual acuity, each eye, with best spectacle correction; ▪ Magnitude and direction of the subjective and objective angle of strabismus at distance and near; ▪ Refractive error of each eye; ▪ Degree of fusion; ▪ History of strabismus, including onset, duration, prior treatment; and ▪ Other relevant information. In addition to the above documentation, a detailed plan indicating the training procedures and equipment to be employed, frequency of office visits, home training aids, and prognosis must be attached to the DCH-0893. This training plan may be authorized for a period of up to three calendar months. If continued training beyond the period that was authorized is necessary, a new request for PA must be submitted with the following information: ▪ Update of the above-listed items; ▪ Report of the results of previous training; and ▪ Indication for further treatment with a detailed plan.
Orthoptic Training Aids	Orthoptic training aids are a Medicaid benefit when incorporated in an orthoptics or pleoptics training plan (as described above) and require PA. The following documentation must be included with the vision provider's detailed plan when requesting the purchase of an aid: ▪ How the aid is to be used; ▪ Complete description of the aid; ▪ Name of the manufacturer; and ▪ Manufacturer's charge. Reimbursement for a training aid is based on the manufacturer's charge to the vision provider plus a professional fee. The professional fee includes procurement, instruction in use, and fitting when applicable. Procurement of the training aid is done through the vision provider's own source. Purchase of orthoptic training aids must be billed only by an optometrist or dispensing ophthalmologist enrolled as a Provider Type 86.

3.9 Prosthetic Eyes

A prosthetic eye (plastic/custom) or shell is a Medicaid benefit and does not require PA.

For an enlargement or reduction of an ocular prosthesis, PA is required. PA is also required when requesting a prosthesis other than a plastic/custom eye. When requesting PA, the DCH-0893 should be completed with documentation attached and submitted to the Prior Authorization Division. Procurement of the prosthesis should be obtained from the provider's own source.

Reimbursement for a prosthesis is made on a per case basis, which includes, but is not limited to:

- Trial fitting
- Supply of prosthesis
- Solutions
- Training in insertion and removal
- Instruction in care
- Subsequent office visits to achieve maximum wearing time and optimal cosmetic fit
- Any necessary modification during the adaptation period of six months

ACRONYM APPENDIX

Acronym	Meaning
AAP	American Academy of Pediatrics
AAR	Access Assessment of Referral
ABC	American Board for Certification of Orthotics and Prosthetics, Inc.
ABR	Auditory Brainstem Response
ABW	Adult Benefits Waiver
ACIP	US Public Health Service Advisory Committee Immunization Practices
ACRC	Admissions and Certification Review Contractor
ACT	Assertive Community Treatment
ADA	American Dental Association; Americans with Disabilities Act
AFC	Adult Foster Care
AFC/HFA	Adult Foster Care Facility/Home for the Aged
AFO	Ankle-foot orthosis
AHI	Apnea-Hypoxnea Index
AIMS	Attachment-Interaction-Mastery-Support
AIS	Alternative Intermediate Services
ALD	Alternative Listening Device
ALMB	Additional Low Income Medicare Beneficiary
ALS	Advanced Life Support

Acronym	Meaning
ALTF	Apparent Life Threatening Event
AMA	American Medical Association
AOA	American Osteopathic Association
AOD	alcohol and other drug
APTA	American Physical Therapy Association
ARR	Annual Resident Review
ASAM	American Society of Addiction Medicine
ASM	American Society for Microbiology
ASQ	Ages and Stages Questionnaire
ATD	Assistive Technology Device
BCCCP	Breast and Cervical Cancer Control Program
BIPA	Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
BLS	Basic Life Support
BMI	Body Mass Index
BMP	Beneficiary Monitoring Program
BSN	Bachelor of Science in Nursing
BY	Base Year
CA	Coordinating Agency (re: Substance Abuse)

Acronym	Meaning
CAAMS	Commission on Accreditation of Air Medical Services
CAFAS	Child and Adolescent Functional Assessment Scale
CAHCP	Child and Adolescent Health Center and Program
CALOCUS	Child and Adolescent Level of Care Utilization System
CAP	College of American Pathologists
CAPD	Continuous Ambulatory Peritoneal Dialysis (hospital)
CARF	Commission of Accreditation of Rehabilitation Facilities
CBC	Complete Blood Count
CCC	Certificate of Clinical Competence
CCI	Medicare Correct Coding Initiative
CDC	Center for Disease Control
CDT	Current Dental Terminology
CENA	Competency Evaluated Nurse Aide
CF	Cystic Fibrosis
CFY	Clinical Fellowship Year
CHAP	Community Health Accreditation Program
CHP	County Health Plan
CIP	Capital Interim Payment
CLIA	Clinical Laboratory Improvement Act

Acronym	Meaning
CLS	Community Living Supports
CMCF	County Medical Care Facilities
CMHC	Community Mental Health Center
CMHSP	Community Mental Health Services Program
CMN	Certificate of Medical Necessity
CMP	Civil Money Penalty
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
CNP	Certified Nurse Practitioner
COA	Council on Accreditation of Services for Families and Children
COB	Coordination of Benefits
CON	Certificate of Need
CORF	Comprehensive Outpatient Rehabilitation Facility
COTA	Certified Occupational Therapist Assistant
CP	Claims Processing
CPAP	Continuous Positive Airway Pressure
CPH	Community Public Health
CPS	Children's Protective Services
CPT	Current Procedural Terminology

Acronym	Meaning
CPTA	Certified Physical Therapy Assistant
CRN	Claim Reference Number
CRNA	Certified Registered Nurse Anesthetist
CRP	Collaborative Remediation Project
CSHCS	Children's Special Health Care Services
CSW	Certified Social Worker
CT	Computerized Axial Tomography
CTLSO	Cervical-Thoracic-Lumbar-Sacral Orthosis
CWP	Children's Home and Community Based Services Waiver Program
CY	Current Year
DD	Developmental Disabilities
DDO	Dentist
DEA	Drug Enforcement Administration
DEG	Data Exchange Gateway
DESI	Drug Efficacy Study Implementation
DHS	Department of Human Services (formerly Family Independence Agency)
DIT	Directed In-Service Training
DMB	Department of Management and Budget
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics & Supplies

Acronym	Meaning
DME	Durable Medical Equipment
DPNA	Denial of Payment for New Admissions
DO	Doctor of Osteopathy
DOB	Date of Birth
DOS	Date of Service
DPM	Doctor of Podiatric Medicine
DPOC	Directed Plan of Correction
DPS	Detroit Public Schools
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSME	Diabetes Self-Management Education
DUB	Designated Unavailable Beds
DUR	Drug Utilization Review
E/M	Evaluation and Management
EAA	Environmental Accessibility Adaptations
ECG	Electrocardiogram
ECR	Electronic Cost Report
ED	Emergency Department

Acronym	Meaning
EEG	Electroencephalogram
EFT	Electronic Funds Transfer
EIN	Federal Employee ID number
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Active Labor Act
EOAE	Evoked Otoacoustic Emissions
EOB	Explanation of Benefit
EPIC	Elder Prescription Insurance Coverage Program
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ESO	Emergency Services Only
ESRD	End Stage Renal Disease
ESR	Erythrocyte Sedimentation Rate
EVS	Eligibility Verification System
F/T	Full Time
FDA	Federal Drug Administration
FFS	Fee-for-Service
FHSC	First Health Services Corporation
FIA	Family Independence Agency (now known as the Department of Human Services/DHS)
FNP	Family Nurse Practitioner

Acronym	Meaning
FPL	Federal Poverty Level B67
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
GAF	Global Assessment of Functioning
GME	Graduate Medical Education
HAA	Hospital Access Agreement
HBP	Hospital Based Provider
HCPCS	Healthcare Common Procedure Coding System
HELP	Hawaii Early Learning Profile
HFA	Home for the Aged
HFCWO	High Frequency Chest Wall Oscillation
HHA	Home Health Agency
HHS	Health and Human Services (U.S. Department of)
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
HKAFO	Hip-Knee-Ankle-Foot Orthosis
HLTCU	Hospital Long Term Care Unit
HMO	Health Maintenance Organization
HSW	Habilitation/Supports Waiver

Acronym	Meaning
HUAM	Home Uterine Activity Monitor
ICA	Indigent Care Agreement
ICD	International Classification of Diseases
ICD-9-CM	International Classification of Diseases, Ninth Edition, Clinical Modification
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ID	Identification
IDA	Infant-Toddler Developmental Assessment
IDEA	Individuals with Disabilities Education Act
IDG	Interdisciplinary Group
IEP	Individualized Educational Program
IFDSH	Indigent Fund Disproportionate Share Hospital
IHCP	Individualized Health Care Plan
IME	Indirect Medical Education
INS	Immigration and Naturalization Services (INS)
IOP	Intensive outpatient
IS	Intensity of Service
ISD	Intermediate School District
ITFI	Infant-Toddler Family Instrument
IV	Intravenous; Indigent Volume

Acronym	Meaning
JCAHO	Joint Commission for Accreditation of Healthcare Organizations
KAFO	Knee-Ankle-Foot Orthosis
LAAM	Methadone or Levo-Alpha-Acetyl-Methadol
LEEP	Loop Electrosurgical Excision Procedure
LHD	Local Health Department
LIF	Low-Income Families
LLP	Limited Licensed Psychologist
LOC	Level of Care
LOCM	Low Osmolar Contrast Material
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LPT	Licensed Physical Therapist
LRD	Lifetime Reserve Days
LSD	Local School District
LSO	Lumbar-Sacral Orthosis
LTC	Long Term Care
LTE	Less Than Effective
MAC	Monitored Anesthesia Care; Maximum Allowable Cost
MCC	Managed Care Carriers

Acronym	Meaning
MCF	Medical Care Facility
MCIR	Michigan Childhood Immunization Registry
MCM	Medicare Carrier's Manual
MCO	Managed Care Organization
MD	Medical Doctor
MDCH	Michigan Department of Community Health
MDE	Michigan Department of Education
MDS	Minimum Data Set
MERF	Medical Eligibility Report Form
MHP	Medicaid Health Plan
MI	Mental Illness
MI Choice	Home and Community Based Waiver for the Elderly and Disabled
MI Enrolls	Michigan Enrolls
MIHP	Maternal Infant Health Program (formerly known as Maternal and Infant Support Services)
MIP	Medicaid Interim Payment
MI-VRP	Michigan Vaccine Replacement Program
MMIS	Medicaid Management Information System
MOMS	Maternity Outpatient Medical Services
MOU	Memorandum of Understanding

Acronym	Meaning
MPH	Masters of Public Health
MPPL	Michigan Pharmaceutical Product List
MR	Mental Retardation
MRI	Magnetic Resonance Imaging
MSA	Metropolitan Statistical Area
MSHDA	Michigan State Housing Development Authority
MSP	Medicare Savings Program
MSW	Master of Social Work
MTF	Military Treatment Facility
MTU	Miscellaneous Transaction Unit
NCPDP	National Council for Prescription Drug Program
NCQA	National Committee on Quality Assurance
NDC	National Drug Code
NF	Nursing Facility
NICU	Neonatal Intensive Care Unit
NOC	Not Otherwise Classified
NP	Nurse Practitioner
NRC	Nuclear Regulatory Commission
NUBC	National Uniform Billing Committee

Acronym	Meaning
OASIS	Outcome and Assessment Information Set
OB Profile	Routine prenatal laboratory services
OBRA 90	Omnibus Budget Reconciliation Act of 1990
OCR	Office of Civil Rights; Optical Character Reader
OMA	Office of Medical Affairs
OPAT/CSAT	Office of Pharmacological and Alternative Therapies/Center for Substance Abuse Treatment
OPH	Outpatient Hospital
OR	Operating Room
OSA	Office of Services to the Aging; Obstructive Sleep Apnea
OT	Occupational Therapy
OTA	Occupational Therapist Assistant
OTC	Over the Counter
OTR	Occupational Therapist currently registered in Michigan
P&O	Prosthetics and Orthotics
P/T	Part Time
PA	Prior Authorization
PACE	Program of All-Inclusive Care for the Elderly
PACER	Pre-Admission and Certification Evaluation Review
PAS	Pre-admission Screening

Acronym	Meaning
PASARR	Pre-admission Screening/Annual Resident Review
PBM	Pharmacy Benefits Manager
PC Pool	Primary Care Pool
PCP	Primary Care Physician
PDN	Private Duty Nursing
PECFAS	Preschool and Early Childhood Functional Assessment Scale
PEDS	Parent's Evaluation of Developmental Status
PERS	Personal Emergency Response Systems
PHS	Public Health Service
PIHP	Prepaid Inpatient Health Plan
PNP	Pediatric Nurse Practitioner
POC	Plan of Care; Plan of Correction
POL	Physician's Office Laboratory
POS	Point of Service, Plan of Service, Place of Service
PPI	Proton Pump Inhibitor
PPO	Preferred Provider Organizations
ProDur	Prospective Drug Utilization Review
PT	Physical Therapy; Provider Type
PTCA	Percutaneous Transluminal Coronary Angioplasty

Acronym	Meaning
Q/U/RM	Quality, Utilization and Risk Management
QDWI	Qualified Disabled Working Individual
QMB	Qualified Medicare Beneficiary
QMHP	Qualified Mental Health Professional
QMRP	Qualified Mental Retardation Professional
RA	Remittance Advice
RAI	Resident Assessment Instrument
RAP	Refugee Assistance Program
RAPS	Resident Assessment Protocols
RD	Registered Dietitian
RDRP	Rapid Dispute Resolution Process
RetroDur	Retrospective Drug Utilization Review
RFP	Request for Proposal
RN	Registered Nurse
RSV	Respiratory Syncytial Virus
RVU	Relative Value Units
SADMERC	Statistical Analysis DME Regional Carrier
SARF	Screening, Assessment, Referral, and Follow-up
SBS	School Based Services

Acronym	Meaning
SGD	Speech Generating Device
SI	Severity of Illness
SI / IS	Severity of Illness and Intensity of Service
SIDS	Sudden Infant Death Syndrome
SLMB	Specified Low Income Medicare Beneficiary
SLP	Speech-Language Pathologist
SMP	State Medical Plan
SNNU	Special Newborn Nursery Unit
SOM	State Operations Manual
SQC	Substandard Quality of Care
SS	Social Security
SSA	Social Security Administration; State Survey Agency
SSI	Supplemental Security Income
SSN	Social Security Number
ST	Speech-Language Therapy
STD	Sexually Transmitted Disease
SUBC	State Uniform Billing Committee
SVDCU	Sub-acute Ventilator-Dependent Care Unit
TABS	Temperament and Atypical Behavior Score

Acronym	Meaning
TB	Tuberculosis
TBI	Traumatic Brain Injury
TC	Technical Component
TCM	Targeted Case Management
TEFRA	Tax Equality and Fiscal Responsibility Act of 1982
TENS	Transcutaneous Electrical Nerve Stimulator
TIN	Tax Identification Number
TLSO	Thoracic-Lumbar-Sacral Orthosis
TMA	Transitional Medical Assistance
TMA-Plus	Transitional Medical Assistance-Plus
TPA	Therapeutic Pharmaceutical Agent
TPL	Third-Party Liability
TPN	Total Parenteral Nutrition
TTP	Thrombotic Thrombocytopenic Purpura
U&C	Usual and Customary
USPHS	U.S. Public Health Service
USTF	Uniform Service Treatment Facility
VFC	Vaccine for Children
VPI	Virginia Polytechnic Institute

Acronym	Meaning
WBC	White Blood Cell
WIC	Women, Infants and Children Program
YTD	Year-to-Date

DIRECTORY APPENDIX

This directory provides contact information referenced in the various chapters of the Medicaid Provider Manual, and is divided into the following topic areas:

- Provider Assistance
- Beneficiary Assistance
- Eligibility Verification
- Prior Authorization
- Billing Resources
- Claim Submission/Payment
- Policy/Forms/Publications
- Appeals
- Health Plan Information
- Provider Resources
- Hospice Resources
- MH/SA Resources
- Nursing Facility Resources
- Pharmacy Resources
- Private Duty Nursing Resources
- School Based Services
- Vision Services Resources
- Reporting Fraud, Abuse, or Misuse of Services
- Other Health Care Resources/Programs
- Miscellaneous Contact Information

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
PROVIDER ASSISTANCE			
Provider Inquiry M-F 8 am to 5 pm EST	800-292-2550	MDCH/Provider Inquiry PO Box 30731 Lansing, MI 48909-8231 providersupport@michigan.gov	Provider resource for policy clarification, billing assistance (including out-of-state and non-enrolled provider claims)
Provider Enrollment	517-335-5492 Fax 517-241-8233	MDCH/Medicaid Payments Division Provider Enrollment Unit PO Box 30238 Lansing, MI 48909	Provider enrollment forms and information, update provider information, billing agent authorizations
Children's Special Health Care Services (CSHCS)	517-241-7186 Fax 517-241-8970	CSHCS Program PO Box 30479 Lansing, MI 48909-7979	General information regarding CSHCS program
CSHCS Customer Support	517-335-8983 (Requests for hospice, respite, PDN) Fax 517-334-9491 (submission of medical reports, updates from local health departments, and all other information)	CSHCS Customer Support PO Box 30734 Lansing, MI 48909 cshcs-css@michigan.gov	Information about medical eligibility determinations, application process, coverage, requests for retroactive coverage, hospice, respite, private duty nursing (PDN) requests, or submission of client information updates.
BENEFICIARY ASSISTANCE			
Beneficiary Help Line M-W 8 am to 7 pm Th-F 8 am to 6 pm	800-642-3195	MDCH Enrollment Services Section PO Box 30479 Lansing, MI 48909-7979	Beneficiary resource for all programs administered by the MDCH, billing problems, **mihealth** card replacements, etc.
Beneficiary Help Line (Pharmacy)	877-681-7540	First Health Services Corporation	Beneficiaries can receive answers to general pharmacy questions.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MIEnrolls (Michigan Enrolls) M-W 8 am to 7 pm Th-F 8 am to 6 pm	888-367-6557 TTY: 888-263-5897	Michigan Enrolls PO Box 30412 Lansing, MI 48909	Health plan enrollment, provider participation information, and health plan change.
MIChild/Healthy Kids	888-988-6300 or 888-858-5929	DHS Office Services Division Grand Tower, Ste 203 PO Box 30037 Lansing, MI 48909 On-line application https://eform.state.mi.us/michild/intro1.htm	Applications and eligibility information
CSHCS Parent Participation Program Family Phone Line M-F 8 am to 5 pm	800-359-3722 fax 313-456-4379	CSHCS Parent Participation Program Cadillac Place, Suite 3-350 3056 W. Grand Blvd. Detroit, MI 48202	**For parent use only.** Information regarding CSHCS, statewide Family Support Network, other resource information, transferring calls to CSHCS staff and providers.
Healthy Kids Dental	800-482-8915	Delta Dental Customer Services	Information related to Healthy Kids Dental enrollees and services
ELIGIBILITY VERIFICATION			
Eligibility Verification System (EVS) – Automated Voice Response System (AVRS)	888-696-3510	For more information on the EVS and/or to obtain an AVRS user manual: www.michigan.gov/mdch >>Providers >> Information for Medicaid Providers >> The MI Eligibility Verification System	Toll-free number for MI Medicaid providers to call and verify eligibility for Medicaid, CSHCS, MOMS, ABW, and MIChild within 12 months of the date of query. There is no cost to use the AVRS.
MediFAX Electronic Data Interchange (EDI) – EVS Products Eligibility Verification	800-819-5003	MediFAX EDI E-Mail: marketing@medifax.com www.medifax.com (Information and EDI user manual)	MediFAX offers EDI products for providers to purchase for verifying Medicaid, CSHCS, MOMS, ABW, and MIChild eligibility. These products are easy to use, have quick response time, batch processing, date of service span, and the ability to print the eligibility response. MediFAX also offers magnetic swipe technology. There is a charge to the provider for these EDI products.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Web-DENIS	1-877-BLUE-WEB (1-877-258-3932) fax 248-486-2214	Blue Cross Blue Shield of MI Electronic Business Interchange Group, L830 53200 Grand River New Hudson, MI 48165 www.bcbsm.com	Web-DENIS is BCBSM's secure browser-based internet site for eligibility verification. Medicaid providers can verify Medicaid, ABW, MOMS, CSHCS, and MIChild eligibility via the internet within 12 months of the date of query. Users can submit single request or roster request (up to 10 requests at one time). If a single date of service is entered, the user receives eligibility for the entire month. For more information, including access information, refer to the MDCH website at www.michigan.gov/mdch >>Providers>>Information for Medicaid Providers>>The MI Eligibility Verification System (EVS).
Healthcare Data Exchange (HDX) Electronic Data Interchange (EDI) – Services for Eligibility Verification	1-866-HDX-EDI1 (1-866-439-3341) fax 610-219-1384 General Information: 610-219-1600	Healthcare Data Exchange 65 Valley Stream Parkway Malvern, PA 19355 www.hdx.com email: Webmaster@hdx.com	HDX offers integrated EDI eligibility verification services. There is a charge to the provider for these EDI services.
Newborn ID Numbers	Fax 517-373-1437	MDCH Enrollment Services Section PO Box 30479 Lansing, MI 48909-7979 msaess@michigan.gov	Fax or e-mail requests to obtain newborn ID numbers for billing Medicaid only when an EVS query does not locate the newborn. Eligibility information must be obtained on the EVS using the ID number provider by MDCH. When submitting a request, include newborn's name, gender, date of birth, mother's name, and mother's Medicaid ID number.
MOMS Eligibility	Fax 517-241-8556	Customer Services Division Attn: MOMS Program	ONLY if MOMS ID number is not available through EVS or **mihealth** card. Request must be on provider letterhead and include provider's phone number and contact person.
Eligibility Verification (out-of-state providers)	517-335-5477		For out-of-state providers to verify eligibility for Medicaid, CSHCS, MOMS, and ABW within the last 12 months
MediFAX EDI Customer Support	800-333-0263	customer.service@medifax.com	Providers can contact Customer Support if they are experiencing technical problems with the AVRS and/or a MediFAX EDI product.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
PRIOR AUTHORIZATION (Authorization of Services)			
Prior Authorization Division (FFS Medicaid & CSHCS)	800-622-0276 fax 517-335-0075	MDCH Prior Authorization Division PO Box 30170 Lansing, MI 48909	Prior authorization for all services except dental, hospital, and pharmacy
Prior Authorization (CHP or MHP)	See Health Plan list on MDCH website	Obtain specific health plan contact information at: www.michigan.gov/mdch >>Health Care Coverage >>Medicaid, Michigan Medicaid Health Plans	For beneficiaries enrolled in a health plan, providers are to contact the plan for authorization of services
Prior Authorization - Dental	800-622-0276 or 517-335-5090 fax 517-335-0075	MDCH Dental Prior Authorization PO Box 30154 Lansing, MI 48909	Prior authorization of dental services for Medicaid and CSHCS
Prior Authorization (PACER) – Med/Surg Inpatient Admissions (Admission & Certification Review Contractor)	800-727-7223	Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611	Prior authorization for Medicaid, CSHCS, and ABW admissions
Prior Authorization – Psychiatric Inpatient Admissions	Refer to local Community Mental Health Services Program		
Prior Authorization – Private Duty Nursing FFS Medicaid & CSHCS **(added 4/1/06 per MSA 06-06)**	800-622-0276 fax 517-241-0743	MDCH Prior Authorization Division PO Box 30170 Lansing, MI 48909	Prior authorization for FFS Medicaid and CSHCS PDN services.
Prior Authorization – Private Duty Nursing Children's Waiver & Habilitation Supports Waiver **(added 4/1/06 per MSA 06-06)**		Contact beneficiary's case manager/ supports coordinator at their local Community Mental Health Services Program (CMHSP)	Prior authorization for Children's Waiver and Habilitation Supports Waiver PDN services.
Prior Authorization – Private Duty Nursing MI Choice Waiver **(added 4/1/06 per MSA 06-06)**	517-241-8474 fax 517-241-7816	MDCH Administrative Support & Contract Development Services PO Box 30479 Lansing, MI 48909	Prior authorization for MI Choice PDN services.
Prior Authorization – Ventilator Dependent Care Units **(updated 4/1/06)**	800-622-0276 fax 517-241-7813	MDCH Prior Authorization Division PO Box 30170 Lansing, MI 48909	Authorization for Medicaid reimbursement in contracted ventilator dependent care units
Prior Authorization – NF MOUs **(updated 4/1/06)**	800-622-0276 fax 517-241-7813	MDCH Prior Authorization Division PO Box 30170 Lansing, MI 48909	Authorization for increased NF per diem for complex care
Prior Authorization – Pharmacy 24/7/365	877-624-5204 fax 877-888-6370	First Health Services Corp. 4300 Cox Rd. Glen Allen, VA 23060	PBM Technical Call Center for Pharmacies
Pharmacy Clinical Call Center 8 am – 5 pm EST, M - F	877-864-9014 fax 888-603-7696	First Health Services Corp. 4300 Cox Rd. Glen Allen, VA 23060	PMB Clinical Call Center for Prescribers

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
BILLING RESOURCES			
Automated Billing Unit/ Electronic Billing Resources		Automated Billing Unit PO Box 30731 Lansing, MI 48909 AutomatedBilling@michigan.gov	Information regarding becoming an electronic biller and submitting electronic claims to the MDCH. 835 & 837 Companion Guides, Testing Instructions, and MDCH Electronic Submission Manual are available at www.michigan.gov >>Providers>>Information for Medicaid Providers>>Electronic Billing
CDT Coding Manual (American Dental Assoc.)	800-947-4746		Procedure codes required for dental claims.
Centers for Medicare & Medicaid Services (CMS)		www.cms.gov	Download HCPCS codes
CPT Coding Manual HCPCS Coding Manual ICD-9-CM Coding Manual	800-621-8335 (AMA Press) 800-999-4600 (Medicode)		Procedure and diagnosis coding required for professional and institutional claims.
Dental Paper Replacement and Void/Cancel Claims	800-292-2550	MDCH/Provider Support Attn: Dental Claim Replacements PO Box 30731 Lansing, MI 48909	Submission of dental paper replacement and void/cancel claims.
MDCH Procedure Code Databases/Fee Screens, Documentation Requirements, OPH Code Lists, etc.	517-241-7903 fax 517-335-5136	www.michigan.gov/mdch >>Providers>> Information for Medicaid Providers>> Provider Specific Information	MDCH-covered procedure codes, parameters, and fee screens for each provider type available on-line.
MDCH Referring Provider List		www.michigan.gov/mdch >> Providers >>Information for Medicaid Providers >> Referring Provider List	List of ID numbers for use in identifying referring/prescribing providers. It does **not** contain billing ID numbers.
MDCH Sanctioned Providers List		www.michigan.gov/mdch >>Provider >>Information for Medicaid Providers >>List of Sanctioned Providers	List of providers that are excluded from participation in the Michigan Medicaid Program
National Uniform Billing Manual		American Hospital Association National Uniform Billing Committee 29th floor, One North Franklin Chicago, IL 60606 www.nubc.org	To obtain a National UB-92 manual
Other Insurance Carrier List		www.michigan.gov/mdch click on Providers, Information for Medicaid Providers, Third Party Liability	List of insurance carriers
State Uniform (UB-92) Billing Manual	517-323-3443	Michigan Health & Hospital Association Attn: UB-92 Manual Subscription 6215 W. St. Joseph Hwy Lansing, MI 48917	To obtain a State UB-92 manual
Statistical Analysis DME Regional Carrier (SADMERC)		www.palmettogba.com	Enteral Product Classification List

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Washington Publishing Co.		PMB 161 5284 Randolph Rd Rockville, MD 20852-2116 www.wpc-edi.com	Information regarding HIPAA compliant claim formats and code sets
CLAIM SUBMISSION/PAYMENT			
Claim Attachment Submission (Hospitals only)		MDCH/Medicaid Payments Division PO Box 30732 Lansing, MI 48909-8232	Hospitals may send attachments for claims submitted electronically.
Electronic Funds Transfer		Department of Management & Budget www.cpexpress.state.mi.us	Initiate receipt of electronic Medicaid payments
Friend of the Court	517-373-5975 Fax 517-373-8740	Friend of the Court Bureau State Court Administrative Office Michigan Hall of Justice PO Box 30048 Lansing, MI 48909 focb@courts.michigan.gov	Qualifying medical support orders
MDCH Cashier's Unit		MDCH/Cashier's Unit PO Box 30437 Lansing, MI 48909	Refund payments to MDCH, purchase Medicaid manual subscription
Medicare Buy-In Unit	517-335-5488 Fax 517-335-0478	MDCH/Buy-In Unit Lewis Cass Bldg 320 S Walnut Lansing, MI 48913 Buy_In_Unit@michigan.gov	
OCR Coordinator	517-335-9342 Fax 517-335-8881	MDCH Attn: OCR Coordinator 3423 N Martin Luther King Jr. Blvd Lansing, MI 48909 OCRCoordinator@michigan.gov	Information related to paper claim readability
Paper Claim Submission		MDCH PO Box 30043 Lansing, MI 48909	HCFA 1500, UB-92, and ADA 2000 claims are to be mailed to the address indicated. No other paper claim formats are accepted.
Pharmacy Paper Claim Submission		First Health Services Corporation 4300 Cox Road Glen Allen, VA 23060	Address to submit paper pharmacy claims.
Sterilization & Hysterectomy Form Submission	Fax 517-241-7856		Fax completed form to MDCH. Form may be downloaded from the MDCH website at: www.michigan.gov/mdch >>Providers >>Information for Medicaid Providers >>Medicaid Provider Forms and Other Resources
Third Party Liability Section	800-292-2550 (option #4) fax 517-346-9817	MDCH/TPL PO Box 30479 Lansing, MI 48909-7979 TPL_Health@michigan.gov	Coordination of benefits issues

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
POLICY/FORMS/PUBLICATIONS			
Draft Medicaid Policy	517-241-7903	msadraftpolicy@michigan.gov	Proposed policies are distributed for a 30-day public comment period. Copies of proposed policies may be requested via e-mail or obtained from the MDCH website at www.michigan.gov/mdch >> Providers >>Information for Medicaid Providers >>Proposed Medicaid Changes
Medicaid Forms Distribution	517-373-6401 Fax 517-241-1164	MDCH/Forms Distribution Lewis Cass Bldg. 320 S. Walnut Lansing, MI 48913	Many required forms are available in the Forms Appendix of this manual and on-line at: www.michigan.gov/mdch >> Providers >>Information for Medicaid Providers >>Medicaid Provider Forms and Other Resources
Medicaid Policy Manuals, Bulletins and Numbered Letters	517-241-7903 fax 517-335-5136	MSAPolicy@michigan.gov	Copies of policy bulletins and numbered letters. This information is also available on-line at www.michigan.gov/mdch >> Providers >>Information for Medicaid Providers
Medicaid Publications		MDCH/Health Promotions & Publications 320 S. Walnut Lansing, MI 48933 www.michigan.gov/mdch >> Providers >>Information for Medicaid Providers >>Ordering Publications	Medicaid brochures and other publications
APPEALS			
Appeals (Beneficiary)	877-833-0870 or 517-334-9500 Fax 517-334-9505	MDCH Administrative Tribunal & Appeals Division PO Box 30763 Lansing, MI 48909	Beneficiaries may request a hearing on benefit denial or placement in the Beneficiary Monitoring Program.
Appeals (Provider)	517-334-9500	MDCH Administrative Tribunal & Appeals Division PO Box 30763 Lansing, MI 48909	Ambulatory, hospital, and nursing facility appeals
State Hospital Appeals Panel Coordinator		State Hospital Appeals Panel Coordinator MDCH Administrative Tribunal & Appeals Division PO Box 30763 Lansing, Michigan 48909	Hospitals wishing to waive right to appeal through the administrative rules, R400.3406 through R400.3424, may elect to request a hearing before the State Hospital Appeal Panel
HEALTH PLAN INFORMATION			
Medicaid Health Plan & County Health Plans	517-335-5500	www.michigan.gov/mdch >>Health Care Coverage >>Medicaid	Information regarding Medicaid Health Plans and County (ABW) Health Plans, and contract managers

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Pre-paid Inpatient Health Plan Contract Managers	517-241-5066	www.michigan.gov/mdch >>Mental Health & Substance Abuse>>Mental Health>>Community Mental Health Services	Information regarding Mental Health and Substance Abuse Pre-paid Inpatient Health Plans
Delta Dental Customer & Claims Services Department	800-482-8915		Information related to Healthy Kids Dental enrollees, services, and claims
PROVIDER RESOURCES			
MDCH Diaper & Incontinence Supply Contract	800-737-0045 Fax 800-737-0012 TTY: 800-737-0084	J & B Medical 4305 Pineview Dr, Ste 100 Commerce Township, MI 48390	Volume purchase contract for select incontinence supplies. Refer to the Medical Supplier Chapter for additional information.
MDCH Blood Lead Laboratory		MDCH Blood Lead Laboratory PO Box 30035 Lansing, MI 48909	Submit samples for blood lead testing
MDCH Childhood Lead Poisoning Prevention Project		PO Box 30195 Lansing, MI 48909	Education and outreach related to blood lead poisoning
MDCH Communicable Disease Epidemiology Division	517-335-8165 Fax 517-335-8263		
MDCH Division of Family and Community Health	Fax 517-335-8294	MDCH Division of Family & Community Health PO Box 30195 Lansing, MI 48909	Certification/accreditation for MIHP program providers.
MDCH Lead Hazard Remediation Program	517-335-9390	PO Box 30195 Lansing, MI 48909	Obtain Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels, a list of certified risk assessors, applications for training and certification, and education materials
MDCH Contract Management Section	517-241-3299	320 S. Walnut St. Lansing, MI 48909	LHD reimbursement for administrative activities
Nursing Facility Level of Care Determination		www.michigan.gov/mdch >>Providers >>Information for Medicaid Providers >>Michigan Medicaid Nursing Facility Level of Care Determination	Information and forms necessary to complete functional/medical assessment to determine eligibility for NF level of care.
MDS		www.cms.hhs.gov/medicaid/mds20/	Mandated assessment for NF residents
OASIS		www.cms.hhs.gov/OASIS	Mandated assessment for Home Health services
Center for Information Management	734-930-0855		Assistance in transmitting OASIS data to the state repository
Office of Medical Affairs	517-335-5181	MDCH/Office of Medical Affairs PO Box 30479 Lansing MI 48909	
Reimbursement & Audit	517-335-5330	MDCH/Hospital & Health Plan Reimbursement Division PO Box 30479 Lansing, MI 48909-7979	Information on hospital and health plan rates and audits

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
State Survey Agency	517-241-4160 fax 517-241-3354	Health Facility Licensing & Certification Division Bureau of Health Systems PO Box 30664 Lansing, MI 48909 Delivery: 611 W. Ottawa, 1st Floor Lansing, MI 48933	Hospital, ESRD, OPT/CORF, Rural Health Clinic licensing, survey, and certification, Psychiatric Hospital licensing, and Substance Abuse Agency licensing.
HOSPICE RESOURCES			
MDCH Enrollment Services Section (hospice)	Fax 517-373-1437		Submission of Hospice Membership Notice form (DCH-1074)
MDCH Hospice Enrollment Coordinator	517-335-5567		Contact only if hospice services began prior to a health plan enrollment.
Bureau of Health Systems, Specialized Services Unit	517-241-3830	Bureau of Health Systems PO Box 30664 Lansing, MI 48909 Delivery: 611 W. Ottawa, 1st Floor Lansing, MI 48933	State survey agency for hospice and home health
MENTAL HEALTH/SUBSTANCE ABUSE RESOURCES			
PIHP Provider Registry	517-373-2568	MDCH/Division of Quality Management Mental Health & Substance Abuse Administration 320 S. Walnut Street Lansing, MI 48913	Information regarding how to register a new service provider, delete a service provider or change information about the service provider.
PIHP Special Program Approval	517-373-2568	MDCH/Division of Quality Management Mental Health & Substance Abuse Administration 320 S. Walnut Street Lansing, MI 48913	Information regarding how to obtain approval of new special programs: ACT, PSR, crisis residential, day program site, and intensive crisis stabilization.
NURSING FACILITY RESOURCES			
Certificate of Need Commission	517-241-3344 fax 517-241-2962	MDCH/CON Health Facilities Evaluation Section 320 S. Walnut, 3rd floor Lansing, MI 48913 www.michigan.gov/mdch >>Providers >>Certificate of Need	
Nursing Facility Best Practices		www.michigan.gov/mdch >>Health Systems & Licensing >>Health Care Facilities >>Nursing Homes, Hospital & Long Term Care Units	Information on best practices of nursing facilities, hospital LTC units, end of life care/plan management
LTC Ombudsman	800-292-7852		Advocacy for nursing facility residents
MDCH, LTC Services	517-241-4293	LTC Services PO Box 30479 Lansing, MI 48909-7979	Using patient-pay amount for noncovered services, complex care MOUs, vent unit placements, Medicaid NF bed certification

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Nurse Aide Customer Service	800-752-4724	www.michigan.gov/mdch >>Health Systems & Licenses >>Licensing for Health Care Professionals >>Nurse Aide	Questions regarding nurse aide training and testing
Nurse Aide Registry	800-748-0252	www.michigan.gov/mdch >>Health Systems & Licenses >>Licensing for Health Care Professionals >>Nurse Aide	List of certified nurse aides
Nursing Facility Forms & Instructions, Calculation Examples		www.michigan.gov/mdch >>Providers, >>Information for Medicaid Providers >>Long Term Care Provider Forms	New Provider Information Packet, Medicaid State Plan, cost reporting forms, NF provider list, nurse aide testing reimbursement for facility and individual CNA.
Nursing Facility Rate Setting	517-335-5356 fax 517-335-5443	MDCH/LTC Reimbursement & Rate Setting PO Box 30479 Lansing, MI 48909-7979 Delivery: Capitol Commons Ctr, 5th flr 400 S. Pine Lansing, MI 48933	Nursing facility rate setting and cost reporting information. New Provider Information Packet.
Payee Registration Helpline	888-734-9749 or 517-373-4111	www.cpexpress.state.mi.us	Enroll with Contracts & Payment Express for payment issued outside claims processing
RAI Coordinator	989-732-8837 fax 989-732-8958	RAI Coordinator Bureau of Health Systems Division of Nursing Home Monitoring 400 Main St, Suite 108 Gaylord, MI 49735	Assistance with nursing facility MDS
State Survey Agency (Nursing Facilities)	517-334-8408 fax 517-334-8473	Division of Nursing Home Monitoring Bureau of Health Systems PO Box 30664 Lansing, MI 48909 Delivery: 1808 W. Saginaw Lansing, MI 48915	Nursing facility licensing, survey, and certification
Informal Deficiency Dispute Resolution (IDR)/ Enforcement Unit	517-241-2650 fax 517-241-2635	Enforcement Unit Division of Operations Bureau of Health Systems PO Box 30664 Lansing, MI 48909 www.michigan.gov/mdch >>Health Systems & Licensing >>Bureau of Health Systems >>Nursing Home Monitoring	Process for submitting informal deficiency dispute resolution requests. Nursing facility enforcement and complaint investigations.
MDCH OBRA Office	517-241-5881	MDCH/OBRA Office 5th Floor, Lewis Cass Building 320 S. Walnut Lansing, MI 48933	PASARR information, follow-up on submitted DCH-3878 (Level II evaluation)
Department of Management & Budget (DMB)		www.michigan.gov/dmb >>Agency Services>>Travel>>Travel Rates	Approved private vehicle mileage rate information.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Clinical Laboratory Improvement Amendment (CLIA)		www.fda.gov/cdrh.CLIA	List of lab tests waived under CLIA.
Centers for Medicare and Medicaid Services	1-800-633-4227	Centers for Medicare & Medicaid Services 7500 Security Blvd Baltimore, Maryland 21244 http://cms.hhs.gov/manuals/cmstoc.asp	Medicare Principles of Reimbursement (42 CFR 413), MCS Provider Reimbursement Manual (PRM-15 or Pub 15)
PHARMACY RESOURCES			
MDCH Pharmacy Benefit Manager (PMB) 24/7/365	877-624-5204	First Health Services Corporation 4300 Cox Road Glen Allen, Virginia 23060 www.michigan.fhsc.com	General information See Prior Authorization Section of this Directory for additional PBM contact information.
MDCH PMB 8:15 am – 4:45 pm EST M - F	804-965-7729	First Health Services Corporation 4300 Cox Road Glen Allen, Virginia 23060 www.michigan.fhsc.com	Pharmacy enrollment
MAC Pricing Information 9 am - 5 pm EST, M – F	866-856-7206 Fax 877-323-7026	M.A.C.-Managers Program 3900 W. 12 Mile Rd., # 225 Berkley, MI 48072-1118 mi@mac-manager.com	Maximum allowable cost (MAC) pricing information.
Refunds, Overpayments, PBM Claims Processing Manual	877-624-5204 fax 877-888-6370	First Health Services Corp. 4300 Cox Rd. Glen Allen, VA 23060	Instruction regarding how to submit claims, refunds and overpayments.
List of Rebate-Participating Labelers		http://cms.hhs.gov/medicaid/drugs/drug7.asp	
List of Participating Entities in 340B Program		http://bphc.hrsa.gov/opa/howto.htm	
Pharmacy Audit	804-644-8707	Heritage Information Systems, Inc. 410 W. Franklin St. Richmond, Virginia 23220	
Drug Rebate Specialist		MDCH Pharmacy Program Bureau of Medicaid Operations & Quality Assurance PO Box 30479 Lansing, MI 48909-7979	PHS and DSH hospitals to have claims excluded from the drug rebates.
Provider Liaison Meeting Calendar **(added 4/1/06)**		www.michigan.fhsc.com	Schedule of liaison meetings and contact information for questions and submission of agenda items.
PRIVATE DUTY NURSING RESOURCES			
MI AuthentiCare		www.michigan.gov/mdch >>Providers >>Information for Medicaid Providers >>MI AuthentiCare	MI AuthentiCare Manual, Fact Sheet, and Frequently Asked Questions. Also access provider reports, worker information, and manage users of MI AuthentiCare.
Other Insurance for PDN	Fax 517-335-8868 Or 517-335-9272		Submit letters of explanation or EOB when required.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
SCHOOL BASED SERVICES			
SBS Administrative Outreach Program Policy Specialist	517-241-5159 Fax 517-335-5136	SBS Administrative Outreach Specialist MDCH Medicaid Policy Division PO Box 30479 Lansing, MI 48909-7979 dipplep@michigan.gov	Submission of SAS 70 audit.
VISION SERVICES RESOURCES			
Vision Contract Manager		Vision Contract Manager MDCH/Prior Authorization Division PO Box 30170 Lansing MI 48909	Submit copy of DCH-0893
Vision Contractor (Classic Optical Laboratories)	888-522-2020 fax 330-759-8300	Classic Optical 3710 Belmont Ave. PO Box 1341 Youngstown, OH 44501-1341	Contractor for provision of eyewear frames and lens
REPORTING FRAUD, ABUSE, OR MISUSE OF SERVICES			
Beneficiary Monitoring Program	517-335-5239 fax 517-241-9087	MDCH Program Investigation Section PO Box 30479 Lansing, MI 48909-7979	Report **beneficiary** fraudulent, overuse, or misuse of Medicaid services
MDCH Program Investigation Section	866-428-0005 517-335-5239	MDCH/Program Investigation Section PO Box 30479 Lansing, MI 48909-7979 www.michigan.gov/mdch >>Inside Community Health, Fraud & Abuse	Report suspected Medicaid provider fraud and/or abuse
Health Care Fraud Unit	800-242-2873 fax 517-241-6515	Health Care Fraud Division Department of the Attorney General Medicaid Fraud Control Unit PO Box 30218 Lansing, MI 48909 HCF@AG.michigan.gov	Report Medicaid provider fraud
Health Facility Complaint Line	800-882-6006		Complaints on quality of care by nursing facilities, hospitals, home health agencies
MDCH OBRA Office	517-373-8091	MDCH/OBRA Office 5th Floor Lewis Cass Building 320 S. Walnut Lansing, MI 48933	Complaints/concerns about local CMHSP services to nursing facility residents
Bureau of Health Services, Allegations Section	517-373-9196		Complaints about licensed healthcare professionals (e.g. physicians, nurses, therapists, NF administrators)
Michigan Department of Civil Rights	800-482-3604		Report violations of handicapper rights.
Michigan Disability Rights Coalition	800-760-4600		
Office of the Inspector General	313-226-4258	Office of the Inspector General Room 512 – Federal Courthouse Detroit, MI 48226	Report violations of federal law

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Welfare Fraud Hotline	800-222-8558 517-335-3900	Office of the Inspector General Office of Investigation 235 S. Grand, Ste. 218 Lansing, MI 48933	Report suspected beneficiary fraud.
U.S. Department of Justice, Office of Civil Rights	800-552-6843		Report violations of handicapper rights.
OTHER HEALTH CARE RESOURCES/PROGRAMS			
Breast & Cervical Cancer Control Program	800-922-6266		Information regarding program services, eligibility, and enrollment
Children's Waiver Program	517-241-5757	MDCH/Division of Mental Health Services to Children and Families Mental Health & Substance Abuse Administration 320 S. Walnut Street Lansing, MI 48913	Information regarding the Children's Waiver program
EPIC Member Services	866-747-5844		Information regarding program services, eligibility, and enrollment
Freedom to Work	Local DHS office	Local DHS office	Information regarding program eligibility
Habilitation Supports Waiver for Persons with Developmental Disabilities	517-241-3044	MDCH/Bureau of Community Mental Health Services Mental Health & Substance Abuse Administration 320 S. Walnut Street Lansing, MI 48913	Information regarding certification and re-certification of HSW enrollees; and HSW coverages.
Medicare Savings Program	local DHS office		Information regarding program eligibility and enrollment.
Medicare Part D	800-Medicare (800-633-4227)	www.medicare.gov	Questions on Medicare Part D by providers or beneficiaries.
Mental Health Home-based Program	517-241-5772	MDCH/Division of Mental Health Services to Children and Families Mental Health & Substance Abuse Administration 320 S. Walnut Street Lansing, MI 48913	Information regarding how to obtain approval of new Mental Health Home-based Programs for children and families
MI Choice Waiver		www.michigan.gov/mdch >>Healthcare Coverage >>Services for Seniors >>MI Choice Waiver Program	Information regarding waiver services and regional contact information
MIChild	888-988-6300	Local DHS or Health Department www.michigan.gov/mdch >>Health Care Coverage >>Children & Teens	Apply at local DHS or LHD, or apply on-line at MDCH website
MDCH Prenatal Smoking Cessation Program	517-335-9750		Information regarding the Smoke-Free Baby and Me intervention model.
Program of All-Inclusive Care for the Elderly (PACE)	517-335-5202	MDCH Long Term Care and Operations Support Section PO Box 30479 Lansing, MI 48909	Information regarding PACE Program. Information regarding PACE and PACE providers is also available at www.michigan.gov/mdch >> Providers >>Information for Medicaid Providers >>Program of All-Inclusive Care for the Elderly.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Special N Support	Local DHS office	Local DHS office	Information regarding program eligibility and enrollment
Supplemental Security Income (SSI)	Local DHS office	Local DHS office	Information regarding program eligibility and enrollment
Transitional Medical Assistance	Local DHS office	Local DHS office	Information regarding program eligibility and enrollment
Traumatic Brain Injury Program	800-642-3195	Local DHS office	Information regarding program eligibility and enrollment
MISCELLANEOUS CONTACT INFORMATION			
CDC website (growth charts)		www.cdc.gov/growthcharts	
Federal Registers		www.access.gpo/su-docs/aces/aces140.html	
MI Choice Waiver - regional maps		www.miseniors.net/search >>Caregivers Corner >> MI Choice Waiver.	
Sickle Cell Detection and Information Center	313-864-4406	19516 James Couzens Detroit, MI 48235	Obtain sickle cell tests, tubes, forms, and envelopes
SS and SSI Information Line	800-772-1213		
State of Michigan Operator	517-373-1837		Telephone numbers for State of Michigan offices/employees.
Provider Liaison Meeting Calendar		www.michigan.gov/mdch >>Providers >>Information for Medicaid Providers >>Provider Liaison Meetings	Schedule of liaison meetings and contact information for questions and submission of agenda items.

GLOSSARY APPENDIX

Glossary Term	Definition
Acquisition Costs	The manufacturer's invoice price, minus any discounts, and includes actual shipping costs.
Borderland	A county that is contiguous to the Michigan border and includes several major cities beyond the contiguous county lines.
Durable Medical Equipment (DME)	Items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and can be used in the beneficiary's home.
The Emergency Medical Treatment and Active Labor Act (EMTALA)	42 USC 1395dd, that requires a Hospital to perform a medical screening examination of any individual presenting in its emergency department to determine if an emergency medical condition exists and to stabilize the individual's medical condition.
Encounter	A face-to-face contact between a patient and the provider of health care services who exercises independent judgment in the provision of health care services.
Hospital	Hospital means the licensed entity that executed the Hospital Access Agreement, which has the inpatient capacity necessary to provide covered services.
Hospital Based Provider (HBP)	A hospital employed M.D., D.O., Certified Registered Nurse Anesthetist (CRNA), dentist, podiatrist, optometrist, or nurse-midwife.
Medical Supplies	Items that are required for medical management of a beneficiary, are disposable, or have a limited life expectancy and can be used in the beneficiary's home.
Medicaid Deductible	Beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by the local DHS worker to qualify for Medicaid. Previously referred to as Medicaid Spenddown.
Medicaid Health Plan (MHP)	A Medicaid managed care plan that provides medical assistance through the delivery of Covered Services to Beneficiaries and that holds a Comprehensive Health Care Program Medicaid Contract with the State of Michigan.
Noncompliance	Failure or refusal to follow instructions related to improving or stabilizing a condition.

Glossary Term	Definition
Noncovered Service	A medical or health care service that is: ▪ Not covered by Medicaid; ▪ Not medically necessary; ▪ Not described in a Map's Certificate of Coverage; ▪ Provided before or after a beneficiary is an Enrollee in a MHP; or ▪ Nonemergency services for which the Hospital did not secure PA.
Nursing Facility	A nursing home, county medical care facility, or hospital long-term care unit, with Medicaid certification.
Orthotics	Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly, or malfunctioning portion of the body.
Outpatient Hospital	A portion of a hospital, which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require inpatient hospitalization or institutionalization.
Physician (MD or DO)	An individual who possesses a current license to practice medicine in the State of Michigan, a Michigan Controlled Substances license, and a Drug Enforcement Agency (DEA) registration.
Practitioner	A MD, DO, Podiatrist, Dentist with specialty in oral surgery, Physician's Assistant, Nurse Practitioner, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Physical Therapist, Psychologist, Occupational Therapist, Speech Therapist, and Audiologist.
Prosthetics	Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body.
Provider	An individual, firm, corporation, association, agency, institution, or other legal entity which is providing, has formerly provided, or has been approved to provide medical assistance to a beneficiary pursuant to the medical assistance program.
Provider Type	Two-digit code assigned by MDCH to indicate the classification (e.g., MD, DO, inpatient hospital, medical supplier, etc.) of an enrolled Medicaid provider.
Public Facility	A public facility is defined at one of the following sections of the Michigan Public Health Code (PA 368 of 1978, as amended): Section 333.2413, Section 333.2415, or Section 333.2421.

Glossary Term	Definition
Rapid Dispute Resolution Process	The process implemented by MDCH to administer and resolve claim disputes.
Readmission	Any admission/hospitalization of a beneficiary within 15 days of a previous discharge, whether the readmission is to the same or different hospital
Sanctioned Provider	A provider who has been suspended, terminated or excluded from providing Medicaid services.
Spenddown	See Medicaid Deductible.
Sterilization	Any medical procedure, treatment, or operation for the sole purpose of rendering an individual (male or female) permanently incapable of reproducing.
Third Party Liability	A payment resource available from both private and public insurance and other liable third parties that can be applied toward the beneficiary's health care expense.
Transfer Trauma	Any adverse psychological and/or physical effects occasioned by the transfer of a nursing home patient who would be materially detrimental to the physical or mental health of the patient.
U & C Charge	The usual and customary charge to the general public.

FORMS APPENDIX

INTRODUCTION

The Forms Appendix contains all MDCH forms referenced within the Michigan Medicaid Provider Manual. Detailed instructions are provided for forms that are not self-explanatory (refer to the table below). The bookmarks link to each form. The Forms field in the table below also links to the appropriate forms. Hold the cursor over form number (the hand cursor will turn into a pointing finger). Double click the cursor to access the form directly from the table. Use the navigation arrows to move from page to page and form to appendix.

All forms are also available on the MDCH website (refer to the Directory Appendix for the website information). Most are available in PDF format as well as in a downloadable Word-enabled format.

Form Number	Form Name	Instructions Included
MSA-2218	Acknowledgment of Receipt of Hysterectomy Information	No
MSA-1653-C	Augmentative Communication Device (ACD) Evaluation	No
MSA-1302	Beneficiary Monitoring Primary Provider Referral Notification/Request	Yes
MSA-4240	Certification for Induced Abortion	No
MSA-1326	Certified Nurse Assistant Training Reimbursement	No
MSA-1680-B	Dental Prior Approval Request Authorization	Yes
MSA-0892	Documentation of Medical Necessity for the Provision of Contact Lenses	No
MSA-2565-C	Facility Admission Notice	Yes
DCH-1164	Guarantee of Payment Letter for Pregnancy Related Services	Yes
DCH-1074	Hospice Membership Notice	Yes
DCH-1199	Infant Support Services (ISS) Discharge Summary	No
DCH-1195	Infant Support Services Initial Assessment	No

Form Number	Form Name	Instructions Included
DCH-1196	Infant Support Services Plan of Care	No
DCH-1194	Infant Support Services Risk Screening Tool	No
MSA-1959	Informed Consent to Sterilization	Yes
DCH-1190	Maternal and Infant Support Services Program Authorization and Consent to Release Protected Health Information	No
DCH-1197	Maternal and Infant Support Services Program Professional Visit Progress Note	No
DCH-1193	Maternal Infant Health Program Prenatal Plan of Care	No
MSA-1200	Maternal Infant Health Program Prenatal Risk Factor Eligibility Screening Form	No
DCH-1192	Maternal Infant Health Program Prenatal Services Assessment	No
DCH-1198	Maternal Support Services (MSS) Discharge Summary	No
DCH-1191	Maternal Support Services Risk Screening Tool	No
MSA-1634	Medicaid Ventilator Dependent Care Assessment	No
MSA-1635	Medicaid Ventilator Dependent Care Authorization	No
MSA-4114	Medical Eligibility Report (MERF)	Yes
DCH-3878	Mental Illness/Developmental Disability Exemption Criteria Certification (For Use in Claiming Exemption Only)	Yes
MSA-1324	Nurse Aide Training and Testing Program Interim Reimbursement Request	Yes
MSA-115	Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization	Yes

Form Number	Form Name	Instructions Included
DCH-3877	Preadmission Screening (PAS)/ Annual Resident Review (ARR) (Mental Illness/Developmental Disability Identification)	Yes
MSA-0732	Prior Authorization for Private Duty Nursing (PDN), Children's Special Health Care Services (CSHCS)	Yes
MSA-0891	Provision of Low Vision Services and Aids Support Documentation	No
MSA-1550	Recipient Verification of Coverage	No
MSA-1576	Request for Prior Authorization for a Complex Care Memorandum of Understanding for Nursing Facilities and MDCH	No
SAMPLE	Sample of Notice of Non-Coverage	No
MSA-1653-B	Special Services Prior Approval – Request/Authorization	Yes
DCH-0893	Vision Services Approval/Order	No

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Michigan Department of Community Health

RECIPIENT STATEMENT:

I, _____, was told before the
(Print or Type Recipient Name)

hysterectomy was done that after the hysterectomy I would not be able to become pregnant.

_____ _____
(Recipient or Representative Signature) (Date)

_____ _____
(Interpreter Signature, if required to inform the recipient of the above information) (Date)

PHYSICIAN STATEMENT:

The hysterectomy for the above named recipient is solely for medical indications. This hysterectomy is not primarily or secondarily for family planning reasons, to render the above named recipient permanently incapable of reproducing, i.e. sterilization. It was explained to the above named recipient prior to the hysterectomy that the hysterectomy will render her permanently incapable of reproducing.

_____ _____
(Physician Signature) (Date)

Authority: Title XIX of the Social Security Act Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.	The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Family Independence Agency office in your county.

MSA-2218 (Rev. 5-97) Formerly DSS-2218 which may be used

Augmentative Communication Device (ACD) Evaluation Form

Michigan Department of Community Health - Medical Services Administration

Instructions: A completed ACD Evaluation Form (MSA-1653-C) must accompany the MSA-1653-B when requesting an ACD. Use of the MSA-1653-C should not limit the type of evaluation or professional judgment utilized within the evaluation process; it serves only as a method of reporting data necessary for the review process. Documentation to support all information provided on the MSA-1653-C should be maintained within the beneficiary's file with the evaluating Speech Pathologist (Provider Type 80). Additional documentation on any item may be attached and must contain a reference to the appropriate section number.

Mail or fax completed form with the MSA-1653-B to:
MEDICAL SERVICES ADMINISTRATION
REVIEW AND EVALUATION DIVISION
PO BOX 30170
LANSING, MICHIGAN 48909

FAX (517) 335-0075

Beneficiary_____ **Parent Name**_____ **D.O.B.** _____

Address _____

Referring Physician_____ **Specialty** _____

Medical Diagnosis _____ **Onset Date** _____

Speech Diagnosis _____ **Onset Date** _____

Evaluation Team Indicate all who provided information for this evaluation and type of input.

Name	Profession	Credentials	License/Reg. #	
Name	Profession Speech/Lang	Credentials	License/Reg. #	☐ Report Only ☐ On-site Participant
Name	Profession OT/PT	Credentials	License/Reg. #	☐ Report Only ☐ On-site Participant
Name	Profession PSYCH.	Credentials	License/Reg. #	☐ Report Only ☐ On-site Participant
Name	Other:	Credentials	License/Reg. #	☐ Report Only ☐ On-site Participant

If any selected box on this form has an asterisk (*), a further explanation or description is required.

SECTION I: BACKGROUND INFORMATION

Provide pertinent history relative to diagnosis, prognosis and communication skills:

Current Hearing Status: Within normal limits with best correction? ☐ YES ☐ NO

Does hearing status influence the client's communication and/or the choice or use of a device? ☐ YES* ☐ NO
Explain: *

Current Vision Status: Within normal limits with best correction? ☐ YES ☐ NO

Does vision status influence the client's communication and/or the choice or use of a device? ☐ YES* ☐ NO
Explain: *

I-A. Current Educational Status

☐ Student:	Special Ed. Certification:	Education Level completed to date:
Indicate grade _____	☐ EMI ☐ TMI ☐ Speech & Language I ☐ SMI ☐ POHI ☐ SXI ☐ Other _____	

I-B. Current Vocational Status

Employed? ☐ YES Specify type: ☐ Unemployed due to disability/medical status
☐ NO ☐ Other: Explain

Day Program? ☐ YES Specify type and level of participation:
☐ NO

I-C. Current Level of Therapy or Support Services

Type of Therapy/Service	Frequency (#/month)	Duration	Site (Outpatient, School, etc.)	Objectives

I-D. Psychological Assessment and Status

Standardized Assessment Tool	Result/Developmental Level	Evaluator	Date of Test
Non-Standardized Testing			

SECTION II: SPEECH AND LANGUAGE STATUS Evaluated by Speech and Language Pathologist.

Speech and Language Diagnosis _____
Briefly describe the beneficiary's speech and language therapy history:

II-A. Communication Assessment: Include both expressive and receptive testing results

Standardized Assessment Tool	Result/Developmental Level	Evaluator	Date of Test
Non-Standardized Testing			
Oral Examination Test instrument used:			
Prognosis for functional oral speech	☐ **Good** ☐ **Fair** ☐ **Poor**		

II-B. Experience with Various Communication/Technology

(May attach report.)

Please include or attach client's current vocabulary sample with and without technology.

	No Experience	Unable	Past Experience, no in current uset	Current Use, limited function*	Current Use, Functional
Gestures					
Explain: *					
Written Communication: (describe)					
Explain: *					
Sign Language					
Explain: *					
Word/Picture/Symbol Board: (describe)					
# of words ____ # of pictures ____ # of symbols ____ # of phrases ____ # of sentences ____ Response communicator? ☐ **YES** ☐ **NO** Explain: * Initiates communication? ☐ **YES** ☐ **NO**					
Dedicated Communication System: (describe)					
# of words ____ # of pictures ____ # of symbols ____ # of phrases ____ # of sentences ____ Response communicator? ☐ **YES** ☐ **NO** Explain: * Initiates communication? ☐ **YES** ☐ **NO**					
Verbal Communication:					
# of words ____ # of phrases ____ # of sentences ____ Response communicator? ☐ **YES** ☐ **NO** Explain: * Initiates communication? ☐ **YES** ☐ **NO**					
Other: describe					
Explain: *					

SECTION III: MOTOR/POSTURAL/MOBILITY STATUS

This section must be evaluated by occupational or physical therapist if there is any limitation of motor, posture or mobility skills that affect the choice or use of an ACD.

Functional Ambulation/Mobility (please check)

- ☐ Independent ambulation
- ☐ Modified independent ambulation (devices, limited distance/control)
  Specify: _____
- ☐ Dependent manul wheelchair user
- ☐ Manual wheelchair user, functionally independent
- ☐ Power wheelchair user: Specify type/site of activation device:
- ☐ Wheelchair currently being used needs to be modified/ replaced in the near future. Specify anticipated changes in seating and time line:

Positioning ACD to be used in the following positions (check all that apply)

- ☐ Standing or walking
- ☐ Seated in wheelchair
- ☐ Seated in chairs other than wheelchair
- ☐ Posture in sitting unable to be fully corrected with devices or seating orthosis. Specify limitation: _____
- ☐ Lying prone or supine
- ☐ Other

Is control of access affected by positioning? ☐ NO ☐ Yes*
Explain: *

Client's ability to directly access the requested ACD

- ☐ No Limitation **
- ☐ Able, but unwanted activations/errors
- ☐ Able, but requires extra time/effort
- ☐ Able, but requires accommodation
- ☐ Unable

** If "No Limit" to access, go to the **Rationale for Prescribed Device** section

Limited/impaired ability to access due to *

- ☐ Impaired vision
- ☐ Impaired strength or range
- ☐ Decreased sensation
- ☐ Abnormal or fluctuating muscle tone
- ☐ Other: Explain

* Describe type/severity:

Access/Control type currently used

- ☐ Direct select without device modification
- ☐ *Check here if anticipated use for requested ACD is different.
  Explain:*
- ☐ Morse code
- ☐ Direct select with modifications. Specify:
- ☐ Multiple Switch: Specify type: Specify sites:
- ☐ Single Switch: Specify type: Specify sites:

Yes *	No	
		Will ACD be integrated with other technology (w/c controls, ECUs, etc.)
		Will wheelchair or other mount be required?
		Does the client transfer into/out of his wheelchair independently?

Explain: *

Describe optimal access technique(s) including specific type and placement of switches and method by which optimal access technique was selected.

_____

_____

Rate of production with current communication system: (e.g., keystokes/minute) _____
Rate of production with requested communication system: (e.g., keystrokes/minute) _____
Rate of accuracy (% incorrect activations) _____

SECTION IV: RATIONALE FOR PRESCRIBED DEVICE Identify all ACDs considered for the client. Choice of ACDs to consider should reflect a range from low to high tech, as appropriate. Recommended device should be the least costly alternative that meets the client's need for functional communication.

Device: Describe setup and any modifications or accommodations:	☐ Ruled out without trying due to: ☐ Ruled out following trial due to: ☐ Tried and considered appropriate Type of communication demonstrated: ☐ Spontaneous ☐ Response
___ # of words ___ # of pictures ___ # of symbols	___ # of phrases ___ # of sentences
Device: Describe setup and any modifications or accommodations:	☐ Ruled out without trying due to: ☐ Ruled out following trial due to: ☐ Tried and considered appropriate Type of communication demonstrated: ☐ Spontaneous ☐ Response
___ # of words ___ # of pictures ___ # of symbols	___ # of phrases ___ # of sentences
Device: Describe setup and any modifications or accommodations:	☐ Ruled out without trying due to: ☐ Ruled out following trial due to: ☐ Tried and considered appropriate Type of communication demonstrated: ☐ Spontaneous ☐ Response
___ # of words ___ # of pictures ___ # of symbols	___ # of phrases ___ # of sentences
Device: Describe setup and any modifications or accommodations:	☐ Ruled out without trying due to: ☐ Ruled out following trial due to: ☐ Tried and considered appropriate Type of communication demonstrated: ☐ Spontaneous ☐ Response
___ # of words ___ # of pictures ___ # of symbols	___ # of phrases ___ # of sentences
Client and cargiver's preference for device: Rationale:	

Type of current communication behaviors

☐ Response to questions only ☐ Initiates occasionally ☐ Spontaneously initiates in a variety of settings

Type of communication behaviors demonstrated with recommended device

☐ Response to questions only ☐ Initiates occasionally ☐ Spontaneously initiates in a variety of settings

Describe device requested, components, and vendor (include model and price)

SECTION V: TREATMENT PLAN AND FOLLOW UP TRAINING IN USE OF THE DEVICE

Communication Goals (may attach additional)	Therapist/Facility/ Agency	Time Line

Note: It is expected that the treating SLP will be involved with the development of this treatment plan.
It is the evaluating SLP's responsibility to develop, in coordination with the client, caregivers, and treating SLP (e.g., school, day program, LTC) a basic vocabulary to be provided to the vendor (Provider type 87) for initial setup of the device.

Anticipated Frequency and Duration:

☐ **Yes** ☐ **No*** The patient/family/caregivers have been provided a copy of the above treatment plan, agree with the choice of the recommended device and to their participation in following and supporting the above treatment plan.

Explain:

BENEFICIARY MONITORING
PRIMARY PROVIDER REFERRAL NOTIFICATION / REQUEST

Michigan Department of Community Health
Medical Services Administration

- ***Read ALL instructions on the reverse side***
- ***See PA 431 and Non-discrimination information on the reverse side***

The beneficiary named below requires medical services in addition to those that I provide. I am referring this beneficiary to you as discussed with you and the beneficiary.

SECTION 1 – Beneficiary Information:

Beneficiary Name (Last, First, Middle)			Medical Assistance ID Number
Street Address			Home Telephone Number
City	State	ZIP Code	Work or Other Telephone Number

SECTION 2 – Primary Care Provider Information:

Name of Provider			Primary Care Provider ID Number
Business Address			Telephone Number
City	State	ZIP Code	

SECTION 3 – Referred Provider and Appointment Information:

Name of Provider			Date of First Appointment	Time of First Appointment : ☐ AM ☐ PM
Business Address / Location of Appointment			Telephone Number	
City	State	ZIP Code	Referred Provider Medical Provider ID Number`	

SECTION 4 – Reason for Referral and Authorization:

Primary Care Provider Authorizing Signature	Date of Authorization

MSA-1302 (Rev. 9-00) (W) Previous Editions are Obsolete

Copy Distribution: **WHITE** - Mail to MSA, Beneficiary Monitoring Program
YELLOW - Primary Provider File Copy
PINK - Referred Medical Provider File Copy

Instructions for form MSA-1302
Beneficiary Monitoring Primary Provider Referral Notification / Request

REFERRING PROVIDER INSTRUCTIONS:

- This form should be used ONLY for those beneficiaries that are restricted to a primary provider in the Beneficiary Monitoring Unit.
- Please type or clearly print all applicable information.
- **COPY DISTRIBUTION:**

  WHITE - Mail to MSA, Beneficiary Monitoring Unit

  YELLOW - Primary Provider File Copy

  PINK - Referred Medical Provider File Copy

- The primary provider must mail the original copy of this form to:

  BENEFICIARY MONITORING UNIT
  MEDICAL SERVICES ADMINISTRATION
  PO BOX 30479
  LANSING MI 48909-7979

BENEFICIARY INSTRUCTIONS:

- You are being referred to another medical provider.
- The name and address of that provider is shown in Section 3 on the front side of this form.
- Your appointment DATE and TIME are also shown in Section 3.
- You must keep this appointment or call this provider to make another appointment.

AUTHORITY: Title XIX of the Social Security Act

COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

CERTIFICATION FOR INDUCED ABORTION

Michigan Department of Community Health
Medical Services Administration

Medicaid Payments for abortion services are limited to cases in which the life of the mother would be endangered if the pregnancy were continued and cases in which the pregnancy was the result of rape or incest. To receive payment for abortion services, a physician must determine and certify that the abortion is necessary to save the life of the mother or is to terminate a pregnancy that resulted from rape or incest.

INSTRUCTIONS:

- Please TYPE or PRINT ALL Information below.
- The Physician completing this form is responsible for providing a copy of the completed form to any other provider assisting in this procedure, e.g., hospital, anesthesiologist, laboratory for billing purposes.

Patient Name	Patient Medicaid ID No.	Date of Service	
Patient Address (no. & street, etc.)	City	State	ZIP Code

One of these boxes **must** be checked for payment to be made.

By signing below, I certify that:

☐ the life of the mother would be endangered if the pregnancy were continued

Please list the medical condition(s) that exist

_____

_____

_____

_____

OR

☐ the pregnancy terminated through this procedure was the result of rape or incest. Information included in the medical record supports this claim.

In cases of rape or incest, was a police report filed? (If **NO**, please explain why not)

☐ **YES** ☐ **NO** (why not?):

If appropriate, was a report filed with the local FIA office? (If **NO**, please explain why not)

☐ **YES** ☐ **NO** (why not?):

NOTE: **Payment for service is not dependent upon a report being filed with the police or the local FIA office.**

Physician Name (typed or printed)			Handwritten Signature of Physician	
Address				
City	State	ZIP Code	Date Signed	Medicaid Provider ID No.

Authority: Title XIX of the Social Security Act **Completion:** Is Voluntary, but is required if payment from the Medicaid program is sought.	The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

Michigan Department of Community Health

Nurse Aide Training and Competency Evaluation Program

Certified Nurse Assistant Training Reimbursement

PURPOSE: The Certified Nurse Assistant (CNA) must present this information to his/her Medicaid and/or Medicare certified nursing facility employer to apply for reimbursement of eligible CNA training and testing costs. Reimbursement is not available to CNAs working in other residential or patient care settings.

CNA:

Last Name	First Name	Middle Initial
Social Security Number	Birthdate	Driver License/Identification

I incurred the following expenses to become a CNA (Certified Nurse Assistant).

TRAINING: *(Attach receipts)*

Approved Program Name: _____ Amount $ _____

Location _____ Date of Payment: _____

Completion Date of Training: _____

COMPETENCY EVALUATION: *(Attach receipts)*

Clinical Skills Test

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Knowledge Test

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Rescheduling Fee (No-Show) Date: _____ Amount: $ _____

Date: _____ Amount: $ _____

Date: _____ Amount: $ _____

Initial Registration Fee Date: _____ Amount: $ _____

Registration Document Renewal Date: _____ Amount: $ _____

Check appropriate box, sign and date*:*

☐ **I have not received any payment for any of these expenses from another source, such as another nursing home, a vocational training program, etc.**

☐ **I have received payment from another source for the listed expenses:**

Amount: $_____ Date: _____ Source: _____

Amount: $_____ Date: _____ Source: _____

Amount: $_____ Date: _____ Source: _____

I understand that the information I have provided may be audited.

CNA Signature: _____ Date: _____

NURSING FACILITY: (Retain this information for documentation of NATCEP costs.)

Facility Name: _____

Provider I.D. Number: _____ MDCH License Number: _____

DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST

Michigan Department of Community Health

☐ Medicaid ☐ CSHCS

Note: Approval refers to service only and does not authorize fees or patient eligibility, including age.

For MDCH Consultant Use Only

1. Prior Authorization No.

2	3	4	5	6	7	8	9

10. Provider Name (Last, First, Middle Initial)

11. Provider Street Address | 12. Provider County

13. City | State | ZIP Code

14. Prov. Type | 15. Provider ID No. | 16. Provider Phone No.

17. Recipient Name (Last, First, Middle Initial)

18. Recipient Street Address | 19. Birth Date

20. City | State | ZIP Code

21. Sex ☐ M ☐ F | 22. Recipient ID No. | 23. Recip. Phone No.

24. Does Patient Live in a Nursing or AIS Home? ☐ No ☐ Yes ➢ | If Yes, Facility Name | Facility Phone No.

25. Is Patient Covered by Any Other Dental Plan? ☐ No ☐ Yes ➢ | If Yes, Plan Name

26. Indicate Missing Teeth with an "X".

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J

T S R Q P O N M L K

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

27. Are X-Rays Enclosed? ☐ No ☐ Yes ➢ | If Yes, Number of X-Rays

28. Is Treatment for Orthodontics? ☐ No ☐ Yes

29. How Long Has Patient NOT Worn a Prosthesis?

30. How Long Has Patient Been Edentulous?

31. Other Pertinent Dental or Medical History:

EXAMINATION AND TREATMENT RECORD

LINE	32. Tooth	33. Surface: M D O L I F	34. Procedure Code	35. Consultant Use Only	36. Description of Service
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					

37. Status of Current Prosthesis:

	Part	Full	Date Inserted	Can Be Worn Yes	Can Be Worn No	Can Be Repaired Yes	Can Be Repaired No	Used Now Yes	Used Now No
Max									
Mand									

38. Reason for Denture Replacement:

39. PROVIDER CERTIFICATION: The patient named above (parent, if minor, or authorized representative) understands the necessity to request prior approval for the services indicated above. I understand the services requested herein require prior approval and if submitted on the proper invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal and State Law.

Provider's Signature Date:

For MDCH Consultant Use Only

40. Consultant Remarks:

41. Request Approved As:

1	5	Presented	4	8	Disapproved
2	6	Amended			No Action

42. Consultant Signature Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought

The Department of Community Health is an equal opportunity employer, services and programs provider.

MSA-1680-B (Rev. 05/03) Previous Edition May Be Used

For the Medicaid Program & Children's Special Health Care Services Mail to:

Michigan Department of Community Health
Prior Authorization – Dental
P.O. Box 30154
Lansing, MI 48909

Completion of MSA-1680-B Form

The instructions pertain to the completion of the Dental Prior Approval Authorization Request. MDCH requests that all PA forms be typewritten to facilitate processing the forms.

1	**Prior Authorization (PA)**	If the procedure is authorized, the consultant enters a PA Number in this box. The dentist must enter this number on the ADA 2000 Dental Invoice (Box 2) when submitting the charges for payment.
2-9	**Consultant Use Only**	These boxes are to be completed by staff upon review of the authorization request.
10-16	**Provider Information**	The dentist's name, provider type code, and seven-digit ID number must be entered as they appear on the DCH Provider Confirmation Form. The dentist's telephone number (including area code), mailing address, and county must be entered in the appropriate boxes.
17-23	**Beneficiary Information**	The beneficiary's last name, first name, middle initial, and eight-digit beneficiary ID number must be entered exactly as they appear on the beneficiary's **mihealth** card or the Children's Special Health Care Services (CSHCS) letter. A beneficiary receiving CSHCS and Medicaid benefits has the same ID number for both programs. The beneficiary's mailing address, birth date, phone number, and sex must be entered in the appropriate box.
24	**Does Patient Live in a Nursing Facility?**	If the beneficiary resides in a nursing facility, the dentist must check "YES" and enter the name of the facility.
25	**Is Patient Covered by Another Dental Plan?**	If the beneficiary has other dental coverage, the dentist must check "YES" and enter the name of the insurance carrier, the policy number, etc.
26	**Tooth Chart**	The dentist must indicate the status of the beneficiary's teeth at the time of examination prior to treatment by indicating missing teeth with an "X."
27	**Are X-Rays Enclosed?**	"YES" or "NO" should be checked to indicate if x-rays are enclosed. If "YES", the dentist should indicate how many.
28	**Is Treatment for Orthodontic Purposes?**	Answer "YES" or "NO" in boxes provided.
29-30	**Prosthesis Questions**	Provide information for denture requests.
31	**Other Pertinent Dental or Medical History**	Provide additional documentation or information necessary for MDCH staff to make a decision for the procedure requested.
32	**Tooth Number or Letter**	If a procedure submitted for authorization involves treatment of a single tooth, the dentist must enter the appropriate tooth number or letter as indicated on the Tooth Chart.
33	**Surface**	The appropriate tooth surface code(s) for each procedure submitted for authorization must be entered, as applicable. Restorative procedures must be identified by the specific tooth surface(s) involved. M = Mesial D = Distal O = Occlusal L = Lingual I = Incisal F = Facial B = Buccal
34	**Procedure Code**	The appropriate code, as indicated in the Procedure Codes Appendix, must be entered for each procedure submitted for authorization.

35	**Consultant Use Only**	The dentist should not write or mark in this column. The Dental Consultant may enter a procedure code in this area. If the Consultant has entered a procedure code, this is the code the dentist must use for billing purposes.
36	**Description of Service**	Using current dental terminology, the dentist must enter the description of the procedure, treatment, or service submitted for authorization. The description for each procedure code must be limited to one line. Appropriate abbreviations may be used if necessary.
37	**Prosthesis Status**	This box must be completed for all beneficiaries who have worn partial or full dentures at any time. The dentist must complete this box even if denture services are not included in the present request. The possession of maxillary and/or mandibular prosthesis must be indicated by: • Checking “PARTIAL” or “FULL”; • Entering the date of insertion; • Checking “YES” or “NO” to indicate if prosthesis is usable or repairable; • “YES” or “NO” must be checked to indicate if the beneficiary is wearing maxillary and/or mandibular prosthesis; and • Where applicable, the dentist must indicate how long the beneficiary has not worn or been without either or both prostheses.
38	**Reason for Denture Replacement**	The dentist must indicate the reason why the prosthesis is requested; provide an oral health assessment along with a five-year prognosis for the prosthesis.
39	**Provider Certification**	The dentist must sign and date this certification to validate the Dental Prior Approval Authorization Request. All unsigned requests are returned to the dentist for signature.
40-41	**Consultant Use Only**	These boxes are to be completed by the Dental Consultant upon review of the treatment plan. The Consultant indicates: • The plan is approved as presented; • Approved as amended; • Disapproved; or • Returned with no action taken. If the plan is authorized, a PA Number is entered in Box 1. The dentist must enter this number on the ADA 2000 Dental Invoice (Box 2) when submitting the charges for payment. If the plan is disapproved, the dentist may submit a new, revised treatment request for authorization. If the request is returned with no action, the dentist may resubmit the same form and any materials originally accompanying it, addressing the Consultant’s requests for additional information or treatment coverage concerns.

Mailing Address

Mail completed PA requests to MDCH Prior Authorization Section– Dental. (Refer to the Directory Appendix for contact information.)

Reordering PA Request Forms

The Dental Prior Approval Request Authorization (MSA-1680-B) form is available on the MDCH website, or may be requested from the MDCH. (See the Directory Appendix for website and forms ordering information.) Please allow at least four to six weeks for processing a forms order.

All requests for forms must include the following information:

- Provider name
- Provider ID number
- Billing address
- Name of contact person
- Telephone number

Documentation of Medical Necessity for the Provision of Contact Lenses

(This form is to be completed and attached to DCH-0893 when requesting prior authorization for the provision of contact lenses. Prior authorization is NOT required for beneficiaries with congenital or surgical aphakia who are under six years of age.).

Beneficiary's Name _____ **Medicaid ID Number** _____

Indicate the diagnosis(es) which best describes the beneficiary's condition:

- ☐ Aphakia (congenital or surgical)
- ☐ Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses)
- ☐ Anisometropia or antimetropia (of 2 diopters or greater that results in aniseikonia)
- ☐ Congenital cataracts (up to six years of age)
- ☐ Other conditions with no alternative treatment (Explain)

_____

_____

Diagnosis(es) (ICD-9-CM): _____

Current spectacle correction:				**Best spectacle correction:**			
R	_____	**VA**	_____	**R**	_____	**VA**	_____
L	_____	**VA**	_____	**L**	_____	**VA**	_____
ADD	_____			**ADD**	_____		

Has the beneficiary previously worn contact lenses? ☐ YES ☐ NO
If yes, explain:

_____

_____

Is the beneficiary currently wearing contact lenses? ☐ YES ☐ NO
If yes, indicate reason for new lenses:

_____

_____

Keratometry (diopters)

R _____ @ _____ ; _____ @ _____

L _____ @ _____ ; _____ @ _____

Type of contact lens requested:

A. Hydrogels

	R	L
Power		
Series (Brand Name)		
Additional Specifications		
Manufacturer		
Manufacturer's wholesale cost		

B. Rigid Gas Permeable

	R	L
Base Curve		
Power		
Diameter		
Additional Specifications		
Manufacturer		
Brand Name		
Manufacturer's wholesale cost		

Expected obtainable visual acuity with contact lenses at distance:

R _____ **L** _____

Approximate wearing time per day (specify number of hours): _____

Are eyeglasses to be worn simultaneously, as an over-correction, with the contact lenses? ☐ Yes ☐ No

Provide your assessment of beneficiary's ability to insert, remove, maintain, and wear contact lenses:

_____

_____

_____

_____ _____

Provider's Signature **Provider's Name (Print)**

Date: _____

Michigan Department of Community Health

FACILITY ADMISSION NOTICE (MSA-2565-C)

INSTRUCTIONS

GENERAL INSTRUCTIONS/DISTRIBUTION:

- The MSA-2565-C serves as notice of admission of a beneficiary (or potential beneficiary). It must be completed for potentially eligible Medicaid beneficiaries of all ages.

- The facility must retain **THE ORIGINAL** of the Facility Admission Notice in the beneficiary's file. A copy **MUST** be sent to the Local FIA Office.

- A copy of the MSA-2565-C will be returned to the facility, noting the eligibility status and patient pay amount of the resident.

Authority: P.A. 280 of 1939 and Federal 42 CFR of 435
Title XIX of the Social Security Act
Completion: Is Voluntary
Penalty: None, but a medical eligibility determination would be delayed

Michigan Department of Community Health

FACILITY ADMISSION NOTICE

1. Patient Name *(Last, First, Middle)*	2.Gender ☐ M ☐ F	3. Birth Date / /	4. Social Security No. - -
5. Home Address *(No. & Street including apartment number)*	City	State	Zip Code
6. Name of Person Responsible for Patient *(Last, First, Middle)*	7. Phone No. ( ) -	8. Relationship to Patient	
9. Home Address *(No. & Street including apartment number)*	City	State	Zip Code

10. Name of Provider		12. Provider ID No.	
11. Provider Address *(No. & Street)*		13. Attending Physician Name	
City	State / Zip Code	14. Hospital Case No. *(If Applicable)*	

15. Type of Facility *(Check ONE)*

☐ Hospital ☐ Long Term Care (in Hospital) ☐ Nursing Facility ☐ ICF/MR Care (in AIS Facility)
☐ Special MR Nursing Facility ☐ ICF/MR Care (in DCH Facility) ☐ Medical Care Facility ☐ Psychiatric Care (in DCH Facility)
☐ Other (Explain) _____

16. Date of Admission / /	17. If LTC Facility, Specify Private Rate $ _____ per diem amount	18. Is this Admission Likely to be 30 days or Longer? ☐ NO ☐ YES (If YES, Estimate Total Length of Stay) _____

19. Present Status of Patient *(Check ONE)*

☐ Still a Patient ☐ Discharged (Date): / / ☐ Deceased (Date): / /

20. Primary Diagnosis	21. Secondary Diagnosis

22. Patient Admitted to Facility From: *(Check ONE)*

☐ Home ☐ Long Term Care Facility/Unit ☐ AFC/ Home for the Aged ☐ Other (Specify) _____
☐ Hospital (Enter applicable dates) Admission Date / / Discharge Date / /

23. Indicate Medicare or Private Health Insurance coverage available to patient and complete the following as applicable

☐ Medicare ☐ No Other Insurance Coverage Available
☐ Private Health Insurance (Complete Items 24 thru 29 below) ☐ Private LTC Coverage (Complete Items 30 thru 35 below)

24. Name of Policyholder (Private Health Ins.)	25. Policyholder's SS No. - -	30. Name of Policyholder (Private LTC Ins.)	31. Policyholder's SS No. - -
26. Name of Insurance Company		32. Name of Insurance Company	
27. Location (City) / State / Zip Code		33. Location (City) / State / Zip Code	
28. Group / Policy Number	29. Cert. / Contract No.	34. Group / Policy Number	35. Cert. / Contract No.

PATIENT CERTIFICATION

I certify that the information furnished by me in applying for skilled nursing facility, other long term care, or hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in section **10** above, the name(s) and address (es) of all parties liable or who may be liable in whole or in part for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible in whole or in part for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

36. Signature of Patient or Patient's Representative Date Signed / /	37. Signature of Person Completing This Form Date Signed / /

STATEMENT OF ELIGIBILITY (To be completed by MDCH / FIA for MA eligibility)

Eligibility is:

☐ **DENIED** (Contact Patient or Patient's Representative for Explanation) ☐ **APPROVED** (See the Billing Information Below)

Eligible Person's Name / Program		Grantee Name				
Recipient ID No. / MA Eligibility Effective Date		Grantee Client ID No.				FIA Case No.
Patient Pay Amount $ / Patient Pay Amt. Effective Date		County	District	Section	Unit	Worker Name
Insurance, Medicare, Third Party Name		Signature of Worker				

MSA-2565-C (01-05) Previous editions may be used.

M - #######

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

GUARANTEE OF PAYMENT FOR PREGNANCY-RELATED SERVICES

NOTICE TO PRENATAL CARE PROVIDERS
PHARMACY, LABORATORY AND DIAGNOSTIC SERVICES AGENCIES

Today's Date	Expected Date of Confinement / **Due Date**
Beneficiary's Name	Beneficiary's Date of Birth
Address (Number and Street) Apt. No.	Medicaid Case Number (if available)
City, State, ZIP Code	Medicaid Beneficiary ID Number (if available)

IMPORTANT: All of the above information MUST be completed.

The Department of Community Health (DCH) **GUARANTEES PAYMENT,** of the pregnancy-related services listed below, for 45 days from the date listed above. This document should be considered as proof of coverage until the beneficiary receives a **mihealth card or a beneficiary ID number**. Michigan Medicaid-covered maternity services and fee screens apply.

Subsequent to the 45 days, DCH will continue to provide medical coverage for eligible women, through the Maternal Outpatient Medical Services (MOMS) Program or the Michigan Medicaid Program for prenatal care, delivery, and other pregnancy-related services for the duration of the pregnancy. Medically necessary ambulatory postpartum care will be covered for 60 days after the pregnancy ends. Inpatient hospital coverage is limited to delivery-related services only.

Pregnancy-related covered services during the eligibility period include:

1. Prenatal care
2. Pharmaceuticals and prescription vitamins
3. Laboratory
4. Labor and Delivery – will cover both professional fees and inpatient hospitalization
5. Postpartum Care through 60 days after the pregnancy ends
6. Radiology and Ultrasound
7. Maternal Support Services (MSS) until delivery
8. Outpatient hospital care
9. Childbirth education
10. Other pregnancy-related care with prior authorization

If you have questions regarding billing or you are providing a medical service that is not listed above, please refer to the back of this letter for instructions on billing and prior authorization procedures.

If you require this document for your files, please make a copy and return the original to the beneficiary.
Guarantee of payment applies only for providers enrolled in the Michigan Medicaid Program.

Name of Contact Person	Signature	Date
Phone Number ( )		
Name of Issuing Agency		
Agency's Mailing Address (Number and Street) (Suite)	City	**MI** ZIP Code

Paul Reinhart

Paul Reinhart, Director
Medical Services Administration

DISTRIBUTION:
WHITE: Beneficiary
YELLOW: Send to: **MDCH – MOMS**
PO Box 30479
Lansing, MI 48909-7979
PINK: Issuing Agency File Copy

DCH-1164 (05-04) (W)

PROVIDER BILLING INSTRUCTIONS

ELIGIBILITY:

MOMS' eligibility may be obtained through the Department of Community Health's Eligibility Verification System (EVS). The Department will issue a beneficiary ID number to be used when billing for services. If the beneficiary receives full Medicaid and enrolls in a Medicaid Health Plan, the health plan's policies and procedures will apply. If you are not a participating provider with the health plan, the beneficiary should be referred to the health plan before services are rendered.

BILLING INSTRUCTIONS:

- Electronic submission of claims is the preferred method for quick and accurate claim reimbursement.
- All services must be billed within one year of the date of service. Pharmacy services should be billed within six months of the date of service.
- Claims must be completed following standard Medicaid billing and reimbursement guidelines contained in Billing and Reimbursement Chapter of the Medicaid Provider Manual. Claims must be submitted to the same location where you submit your Medicaid Claims.
- Private insurance must be billed first, if applicable.
- This Guarantee of Payment insures the department will provide coverage for pregnancy related services. You must hold your claim for services provided until the beneficiary receives her MIHealth card or a beneficiary ID number can be identified on the EVS system. You must provide the beneficiary ID, which is available on the EVS, number on the claim to receive payment. You can no longer use the "M" number, which appears in the upper right hand corner of the Guarantee of Payment letter.
- MOMS claim adjudication information will be included in the weekly Remittance Advice, merged alphabetically with Medicaid and other MDCH-administered programs. The remittance advice is your claim status. If a claim doesn't appear on a remittance advice within 45 days, the account should be resubmitted for processing. Should you have other questions about your claim, you may contact the Medicaid Provider Inquiry line at 1-800-292-2550 or by e-mail at providersupport@michigan.gov.

All MOMS covered services are subject to the published policies and procedures applicable under the Medicaid program as they relate to health care and claim submission requirements.

PRIOR AUTHORIZATION:

If your service does not meet the definition of pregnancy-related services listed on the front of this letter or if the service normally requires prior authorization by the Medicaid program, please submit your request for authorization, by mail or by fax. Please see the Directory Appendix in the Medicaid Provider Manual for contact information.

PHARMACY SERVICES:

Pharmacy services provided to MOMS beneficiaries must be billed to the Pharmacy Benefit Manager. Refer to the Michigan Pharmaceutical Product List to identify products that may require prior authorization. To obtain prior authorization, you may write, call or fax your request to the Pharmacy Benefit Manager. Please see the Directory Appendix in the Medicaid Provider Manual for contact information.

Pharmacies, who provide MOMS services, when presented with this Guarantee of Payment letter, have the option of billing the Pharmacy Benefit Manager in one of two ways:

A. Hold the claim until the beneficiary ID number is available on the Department's EVS and then bill the Pharmacy Benefit Manager via the on-line system.
B. Submit the appropriate HIPAA compliant National Council for Prescription Drug Programs (NCPDP) electronic claim or submit a Universal Claim Form, along with a copy of the Letter, to the Pharmacy Benefit Manager per the instructions in Appendix B of their manual.
C. In the cases where a beneficiary ID is not available, because the MOMS eligibility has not yet been entered on the EVS, pharmacies should obtain a copy of the Letter as proof of coverage and fill the prescription(s). Pharmacies will need to hold the electronic claim until an ID number can be obtained through the EVS.

AUTHORITY:	Title XIX of the Social Security Act	The Department of Community Health is an equal opportunity employer, services and programs provider.
COMPLETION:	Is Voluntary, but is required if Medical Assistance program payment is desired.	

HOSPICE MEMBERSHIP NOTICE

Michigan Department of Community Health

Fax to: (517) 373-1437

☐ **ENROLLMENT APPLICATION** ➔	1. Effective Date		
☐ **ENROLLMENT UPDATE** ➔	2. Effective Date		
☐ **DISENROLLMENT NOTICE** ➔	3. Effective Date	4. Reason Code	

SECTION I- PROVIDER INFORMATION:

5. Provider Name			6. Provider ID Number	7. Control Number
8. Attending Physician Name			10. Hospice Phone Number ( ) –	11. Hospice Fax Number ( ) –
9. Physician Address (Number & Street, Suite Number)			12. Physician Provider ID Number	13. Provider Type
City	State	ZIP Code	14. Is this Beneficiary a Waiver Participant? ☐ **YES** ☐ **NO**	

SECTION II- FACILITY INFORMATION:

Is beneficiary currently in Nursing Facility, Hospice Owned Nursing Facility or Hospital?

☐ **YES** (If Yes, complete this section.) ☐ **NO** (If No, proceed to Section III.)

15. Facility Name	16. Facility. Medicaid ID Number	17. Date Admitted to Facility	
18. Facility Address (Number & Street)	City	State	ZIP Code

SECTION III- BENEFICIARY INFORMATION:

19. Beneficiary Name (Last, First, Middle Initial)			21. Beneficiary ID Number	
20. Beneficiary Address (Street Address and Apt. No.)			22. Social Security Number	23. Birth Date
City	State	ZIP Code	24. Gender ☐ **Male** ☐ **Female**	25. Home Phone Number ( ) –
26. CSHCS Beneficiary? ☐ **YES** ☐ **NO**	27. Beneficiary LOC		28. Previous Hospice Enrollee? ☐ **YES** ☐ **NO**	29. Estimated Remaining Life Span Months
30. Legal Parent or Guardian Name (Last, First, Middle Initial)			31. Diagnosis Code(s)	

REMARKS:

32.

☐ By placing an "X" or a "✓" in this box, I certify that I have read (or they have been read to me) and understand the Conditions of Enrollment and Certification provisions on Page 2 of this form. Any questions I had about these provisions or my hospice care were answered by a hospice representative.

For ENROLLMENT Only		***For DISENROLLMENT Only***	
33. Beneficiary (or authorized representative) Signature	Date	35. Beneficiary (or authorized representative) Signature	Date
34. Witness Signature	Date	36. Witness Signature	Date

AUTHORITY: Title XIX of the Social Security Act **COMPLETION:** Is Voluntary, but is required if Medical Assistance program payment is desired.	The Department of Community Health is an equal opportunity employer, services and programs provider.

See Page 2

CONDITIONS OF ENROLLMENT:

Hospice services are an option of medical care that you may choose while you are in the terminal stages of your illness. Palliative at-home care is the basis for hospice care. If you do not have a family member or friend to care for you in your home, hospice care may be provided while you are a resident of an approved nursing facility (NF), home for the aged (HFA), adult foster care facility (AFC), licensed hospice long term care unit, boarding home, or hospice owned nursing facility. All Medicaid and any approved Children's Special Health Care Services (CSHCS) covered services for the terminal illness will be provided by the hospice. You must use your **mihealth card**, health plan card, or CSHCS Eligibility Letter to obtain care from your private physician or health plan for services not related to the terminal illness. You may elect to disenroll from the hospice at any time by signing the disenrollment form.

CERTIFICATION:

By signing this form, I certify that I voluntarily apply for hospice enrollment for myself or the person indicated in item number 19. The enrollment is effective on the date entered on item number 1 and will continue as long as the hospice continues operation and eligibility continues under the Medicaid Program or CSHCS approval. If the Medicaid Eligibility Verification System indicates a patient-pay amount, I understand that I must pay that amount, **each month**, to the hospice for my care. Any applicable patient-pay amount, insurance payment, and Medicaid reimbursement represents payment-in-full to the hospice. I understand and accept the conditions of enrollment stated above. I authorize any physician or hospital to release medical information to the hospice. I authorize the hospice to release medical information to the Michigan Department of Community Health.

DCH-1074 (11-03) Obsoletes previous editions.

Hospice Membership Notice (DCH-1074) Completion Instructions

The Hospice Membership Notice form (DCH-1074) is used for enrollment, update and disenrollment of the Medicaid eligible beneficiary. The hospice indicates which function the form is serving by checking the appropriate box at the top right hand side of the form and including an effective date. The enrollment update function is to inform the MDCH when a hospice beneficiary has moved from their home to a NF for their routine hospice care. This information is critical to payment of room and board for those hospice beneficiaries.

The entries on the form should be typed. The beneficiary information must be taken directly from the **mihealth** card or the MDCH eligibility verification system. If the beneficiary information is incorrect on the **mihealth** card, advise the beneficiary or legal advocate to contact the local FIA worker to have correct information submitted.

The addition of the specific nursing home information for hospice beneficiaries who reside in or are admitted to a nursing home changed the order of the numbered boxes in the previous form. Please use the directions below.

Membership Notice as an Enrollment Application

The hospice must complete the Hospice Membership Notice as an enrollment application according to the instructions below. The hospice must read the conditions of enrollment on the form to the beneficiary, and answer any questions raised.

Provider Information

Item 1: The effective date of enrollment is a mutually agreed upon date by the hospice and the beneficiary. If the beneficiary is currently in a hospital, the effective date of hospice enrollment must be after the date of hospital discharge.

Item 2: The enrollment update box is checked to indicate that the beneficiary has been admitted from their home to a nursing facility for their routine hospice care. By checking this box and providing the required nursing facility information in items 15 thru 18, the hospice can receive payment for nursing facility room and board for the beneficiary.

Items 3 and 4: For enrollment, these items remain blank.

Item 5: The name of the hospice (provider name) must be entered. The hospice may use the abbreviation that is recognized by the Provider Enrollment section of the MDCH.

Item 6: The hospice's Medical Assistance provider identification number must be entered exactly as it appears on the hospice's Provider Enrollment Turn-Around DCH Provider Confirmation Form form.

Item 7: This control number is for hospice internal patient identifier and is for hospice use only.

Items 8 and 9: The attending physician's name and his/her address must be entered.

Items 10 and 11: The area code and telephone number for the hospice. The area code and FAX number for the hospice.

Items 12 and 13: Enter the attending physician's Medicaid provider identification number and provider type.

Item 14: Indicate whether the beneficiary is receiving services from the MI Choice Waiver program in addition to services from the hospice.

Nursing Facility Information

Items 15 thru 18: The name of the nursing facility in which the beneficiary resides (if applicable) or has been admitted to for routine hospice care. The Medicaid nursing facility provider identification number, nursing facility address, and the date the beneficiary was admitted to the nursing facility.

Beneficiary Information

Items 19 thru 21: The beneficiary's name and complete Medicaid identification number must be entered as they appear on the **mihealh** card.

Item 22: The beneficiary's nine-digit social security number must be entered. Do not use hyphens in the social security number.

Item 23: The beneficiary's date of birth with 4-digit birth year must be entered

Item 24: The beneficiary's gender must be appropriately indicated.

Item 25: The beneficiary's home telephone number, including area code, must be entered, if applicable.

Item 26: If the beneficiary is NOT enrolled in the Children's Special Health Care Services, an "X" must be placed in the NO area.

If the beneficiary is enrolled in the Children's Special Health Care Services, an "X" must be placed in the YES area.

Item 27: The beneficiary's previous level of care, if any (from the MDCH eligibility verification system) must be indicated here.

Item 28: Indicate whether the beneficiary previously received hospice services.

Item 29: The beneficiary's estimated remaining life span (in months) must be entered here.

Item 30: If appropriate, the name of the beneficiary's parent or legal guardian, who is authorizing hospice enrollment by signing Item 39 on the form, must be entered

Item 31: The beneficiary's terminal diagnosis must be entered using the appropriate alphanumeric diagnosis code(s). Common terminology cannot be substituted for the diagnosis code. Diagnosis codes are listed in the International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM). The enrollment cannot be processed without the appropriate alphanumeric ICD-9-CM code. A primary diagnosis code is required for hospice enrollment. If available, the hospice may enter the secondary and tertiary codes applicable to the hospice admission.

Other Health Insurance

Items 32 thru 37: The hospice must enter any resources the beneficiary has other than Medicaid. The information may be found on the beneficiary's Medicaid ID Card. The hospice must ask the beneficiary if he/she has other health insurance. If the beneficiary has other insurance, but it is not indicated on the MDCH eligibility verification system, the hospice should advise the beneficiary to contact his/her local FIA worker to correct the information. The hospice may notify the worker of the beneficiary's other insurance coverage also.

Remarks

Item 38: Enter information in the REMARKS section only when specifically directed to do so.

For Disenrollment Only

Items 41 and 42: For enrollment, these items remain blank. They are used for disenrollment only.

Enrollment Application: Fee For Service Beneficiaries

The DCH 1074, Hospice Membership Notice, is used to enroll the beneficiary and update MDCH's computerized eligibility system.Submit the completed form to the MDCH Enrollment Services Section. (Refer to the Directory Appendix for contact information.) Timely notification is necessary in order to ensure that the beneficiary's eligibility file contains the appropriate level of care code.

The MDCH hospice enrollment coordinator will review the Hospice Membership Notice for completeness, Medicaid eligibility, and appropriate effective date. If the enrollment form is accepted, a level of care code 16 will be entered on the computerized eligibility system. If changes are required (e.g., the effective date is incorrect), the hospice enrollment coordinator will return the membership notice to the hospice for correction and resubmission.

Hospice Membership Notice as a Disenrollment Notice

The hospice completes the disenrollment notice according to the following instructions. Only the items listed in the disenrollment instructions must be completed if the hospice uses the previously completed membership notice. If the hospice does not use the previously completed membership notice, all information contained on that previous document must be entered. The information must be either from that document or according to the completion instructions for the Hospice Membership Notice, as well as following the completion instructions for disenrollment.

Item 3: The hospice enters the appropriate disenrollment effective date as explained in the Disenrollment Process section of the Medicaid Hospice Manual.

Item 4: The hospice must enter the appropriate code to indicate the reason for the disenrollment.

2 = Deceased

3 = Beneficiary elected to disenroll

9 = Other (requires brief explanation in REMARKS; Item 38*)

*When reason code 9 is used, the reason for disenrollment must be briefly stated in the REMARKS Section (Item 38).

(Refer to the Beneficiary Enrollment Section of the Hospice Chapter of this manual, hospice elects to terminate the beneficiary enrollment, for disenrollment examples.)

Items 41 and 42: The beneficiary or the beneficiary's representative must sign and date the disenrollment notice only if the beneficiary or the beneficiary's representative is initiating the disenrollment. When a beneficiary representative (other than the parent or legal guardian) signs the form, that person's name and his/her relationship to the beneficiary must be entered in the Remarks section. Another person must witness the signature and sign the disenrollment notice in the space provided.

INFANT SUPPORT SERVICES (ISS)
DISCHARGE SUMMARY

Infant's Name:_____ **Date of Birth:**_____
Mother's Name:_____
Caregiver's Name:_____
Referral Source (Agency/Program/Medical Care Provider):_____
Reason for Referral (High Risk Criteria):_____
Date of Initial Assessment: _____
Sent to Medical Care Provider ☐**Yes** ☐**No**
Total Number of Visits By: ___**RN** ___**SW** ___**RD**

Summary of ISS Plan of Care Problems/Issues Addressed:

HEALTH INFORMATION

INFANT

- ☐ Premature birth
- ☐ Low birth weight
- ☐ Difficulties with access to medical care provider
- ☐ Well child visits
- ☐ Hospital admissions
- ☐ Special needs
- ☐ Unsatisfied with health care
- ☐ Unmet needs _____
  _____

MOTHER

- ☐ Lack of prenatal care
- ☐ No postpartum visits
- ☐ Problems with previous pregnancies
- ☐ Lack of family planning
- ☐ Lack of dental care
- ☐ Unmet needs _____
  _____

SMOKING

- ☐ Smoked during pregnancy
- ☐ Continues to smoke
- ☐ Unmet needs _____
  _____

IMMUNIZATION

- ☐ Infant: Up to date
- ☐ Preschooler(s): Up to date
- ☐ Exposure to _____
- ☐ Unmet needs _____
  _____

INFANT'S NUTRITION

- ☐ Insufficient weight gain
- ☐ Difficulties with breast-feeding
- ☐ Difficulties with bottle feeding
- ☐ Inappropriate eating patterns
- ☐ Digestive problems
- ☐ Inadequate baby formula/food
- ☐ Unmet needs _____
  _____

MOTHER'S/CAREGIVER'S NUTRITION

- ☐ Inappropriate eating patterns
- ☐ Inadequate food supply
- ☐ Unmet needs _____
  _____

Infant's Name: _____

INFANT SUPPORT SERVICES (ISS)
DISCHARGE SUMMARY

EMOTIONAL/MENTAL HEALTH INFORMATION

- ☐ Lack of knowledge about infant care
- ☐ Lack of acceptance of this pregnancy
- ☐ Lack of father involvement
- ☐ Lack of social supports
- ☐ Lack of child care
- ☐ Children's Protective Services involvement
- ☐ Unusual stressors
- ☐ Unmet needs _____
  _____
- ☐ Lack of coping skills
- ☐ Symptoms of depression
- ☐ Diagnosis of mental illness
- ☐ Indicators of domestic violence
- ☐ Ineffective parent-child interaction
- ☐ Lag in developmental milestones

ENVIRONMENTAL INFORMATION

- ☐ Unsafe or inadequate housing
- ☐ Exposure to toxic substance such as:
  ☐ lead ☐ asbestos ☐ pesticides ☐ cleaners ☐ other _____
- ☐ Exposure to allergens
- ☐ No smoke detector
- ☐ Second-hand smoke
- ☐ Presence of weapon(s)
- ☐ Frequent moves
- ☐ Problems with money management
- ☐ Lack of proper car seat
- ☐ Unsafe sleeping arrangements
- ☐ Inadequate baby supplies
- ☐ Unmet needs _____
  _____

PARENTING EDUCATION

- ☐ Lack of parenting education
- ☐ Unmet needs _____
  _____

TRANSPORTATION

- ☐ Lack of transportation
- ☐ Unmet needs _____
  _____

OTHER: _____
_____
_____

REFERRALS MADE: _____
_____
_____

Signature of ISS Care Coordinator: _____ **Date:** _____

Infant's Medicaid ID #: _____
Mother's Medicaid ID #: _____ Date of Assessment:_____
Type: Open Card or Fee For Service_____ Managed Care (MHP):_____
Non-Medicaid: Location: ☐ Home Visit ☐ Other Visit
☐ Application in process. Explain_____ ☐ Office Visit
☐ Not yet applied. Explain _____

Has the consent form been signed? ☐YES ☐NO

Infant Support Services
INITIAL ASSESSMENT

GENERAL INFORMATION

Infant's First Name _____ Last Name _____ Date of Birth ____/_____/____ Race/Ethnicity _____
Mother's First Name _____ Last Name _____ Date of Birth ____/_____/____ Race/Ethnicity _____
Primary Caregiver's First Name _____ Last Name _____ Date of Birth ____/_____/____

Phone Number _____(hm) _____(wk) Best time to reach caregiver _____
Is there another phone number where you can be reached?_____
Current Address _____
Street Address City Zip County
Directions
_____
_____

Are you?
☐ Single ☐ Married
☐ Divorced ☐ Widowed
☐ Separated ☐ Cohabiting

Circle one: Mother or Primary Caregiver
Employment Status: ☐ Full Time (FT) ☐ Part Time (PT) ☐ Work First ☐ Not Working ☐ Student
Last Grade Completed _____ Race/Ethnicity _____
What language do you prefer to speak? _____
What language do you prefer to use for reading?_____

Name of Father of Baby (FOB)_____Date of Birth ____/_____/____ Race/Ethnicity_____
Employment Status: ☐ Full Time (FT) ☐ Part Time (PT) ☐ Not Working ☐ Student
Relationship with Mother: ☐ Involved ☐ Not Involved

Household Roster (List names of all members)*	Relationship to Infant	Sex	Race/Ethnicity	Age

*Include husband/partner if different than above; Mother of Baby (MOB) parents/FOB parents; MOB siblings/FOB siblings; MOB other children.

Infant's Name: _____

HEALTH INFORMATION

INFANT HEALTH

1. Gestational Age at Birth _____ Birth Weight _____ Birth Height _____ Head Circumference _____
2. Do you have a medical care provider that accepts Medicaid? ☐ YES ☐ NO
   If no, what kind of problem have you had in selecting a provider?_____
   _____
3. Have you had a well child visit with a medical care provider? ☐ YES ☐ NO
   a. Name of medical care provider_____
   b. Address/Location_____
   c. Infant's age of first appointment _____ Date of next appointment _____
4. Has your baby been admitted to the hospital since delivery? ☐ NO ☐ YES
   a. Intensive care ☐ NO ☐ YES
   b. Emergency room ☐ NO ☐ YES
   c. Pediatric Unit ☐ NO ☐ YES
   d. Name of Hospital _____
   e. Reason for admittance _____
5. Has your baby been diagnosed with special needs? ☐ NO ☐ YES
   a. Were there any positive test results from newborn screening? ☐ NO ☐ YES
   b. Is your baby enrolled in Children's Special Health Care Services? ☐ NO ☐ YES
6. Are you satisfied with the medical care your baby is receiving? ☐ YES ☐ NO
   If no, check all the items below that you are not satisfied with:
   - ☐ amount of time you had to wait to see the provider
   - ☐ amount of time the doctor or nurse spent with you during your visit
   - ☐ advice you received on how to take care of your baby
   - ☐ hours the office or clinic was open
   - ☐ understanding and respect the staff showed towards you as a person

MOTHER'S HEALTH *(Complete questions which have not been answered for Maternal Support Services Program)*

1. What month did you start prenatal care with this pregnancy? _____
2. How many prenatal visits were you able to keep for this pregnancy? _____
3. Have you had your six-week check-up (postpartum) after this pregnancy? ☐ YES ☐ NO
4. Previous Pregnancy:
   a. How many pregnancies have you had before this one?_____ How many living children?_____
   b. How many stillbirths (fetal deaths)?_____ miscarriages?_____ abortions?_____
   c. Have any of your children had a birth defect? ☐ NO ☐ YES
      If yes, please explain_____
      _____
   d. Did you have any complications with any previous pregnancy? ☐ NO ☐ YES
      If yes, please explain_____
      _____
5. Family Planning:
   a. Were you using birth control when you became pregnant with this child? ☐ YES ☐ NO
   b. What are you currently using for birth control?_____
   c. Do you need additional information on birth control methods? ☐ YES ☐ NO
6. Dental Health:
   a. Do you currently have a dentist? ☐ YES ☐ NO
   b. When was the last time you saw a dentist? _____
   c. Do you currently have any dental problems? ☐ NO ☐ YES
   d. Do your children have any dental problems? ☐ NO ☐ YES

SMOKING *(Complete questions which have not been answered for Maternal Support Services Program)*

1. Do you currently smoke cigarettes? ☐ NO ☐ YES
   a. How many cigarettes do you smoke a day? _____
   b. Have you cut down? ☐ YES ☐ NO
   c. Have you/are you seriously considering quitting? ☐ YES ☐ NO
2. Have you ever smoked? ☐ NO ☐ YES
   a. When did you stop smoking? _____
3. Do you plan to stay a non-smoker after this pregnancy ☐ YES ☐ NO
4. Has your smoking pattern changed since having the baby? ☐ NO ☐ YES
   If yes, please explain_____

Infant's Name: _____

IMMUNIZATIONS

1. Have you been immunized against any of the following infections?
   ☐ Chicken Pox ☐ Hepatitis B ☐ Measles ☐ Meningitis ☐ Mumps ☐ Rubella ☐ Don't Know
2. Have you ever been around anyone with these infections in the last month? ☐ NO ☐ YES
3. Are the immunization records on all preschool children in the household available? ☐ YES ☐ NO
4. What immunizations has your new baby received? _____
5. What questions do you have about immunizations? _____

INFANT'S NUTRITION

1. Infant current weight or at last doctor visit? _____ Current height/length? _____
2. Are you breastfeeding? ☐ YES ☐ NO
   If yes, what concerns do have about breast-feeding?_____
3. Are you bottle feeding? ☐ YES ☐ NO
   If yes, describe how you mix your formula?_____
   If yes, describe how you warm the bottle?_____
4. Do you put cereal in the bottle? ☐ NO ☐ YES
   If yes, how much? _____
   If yes, how often? _____
5. Is your baby eating solid food? ☐ YES ☐ NO
6. Describe a typical day's feeding: _____
   _____
7. How many of the following does your baby have per day?
   a. Bowel movement _____
   b. Wet diapers _____
8. How many times a day does your baby spit up? _____ When and how much?_____
9. What concerns do you have about the way your baby eats? _____
10. Do you have enough formula/food for a whole day? _____

MOTHER'S/ CAREGIVER'S NUTRITION

1. What changes, if any, have you made in your eating habits since the baby was born? _____
   _____
2. Have you ever had an eating disorder? ☐ NO ☐ YES
   If yes, please describe _____
3. Do you have enough food for yourself? ☐ YES ☐ NO
   a. For others in the household? ☐ YES ☐ NO
   b. Are you currently enrolled in WIC? ☐ YES ☐ NO
   c. Do you receive food stamps? ☐ YES ☐ NO
   d. What other resources do you have for food?_____

EMOTIONAL/ MENTAL HEALTH INFORMATION

EMOTIONAL/ MENTAL STRESS

1. Are you a first-time parent? ☐ NO ☐ YES
   If yes, have you taken care of a baby before? ☐ NO ☐ YES
   If no, what are your concerns about being a parent? _____
2. How did you feel when you found out you were pregnant? _____
3. How does your partner feel about this baby? _____
4. Is your partner the father of the baby? ☐ YES ☐ NO
   a. If no, what is your current relationship with the father of the baby? _____
   _____
5. Who can you depend on when you need help or someone to talk to? _____
   a. Will you be relying on them for assistance with child care? ☐ NO ☐ YES
   b. What agencies are helping you with the care of your baby? _____
6. Have you or a family member been involved with Children's Protective Services (CPS)? ☐ NO ☐ YES
7. Are you feeling particularly stressed right now? ☐ NO ☐ YES
   If yes, please describe. _____
8. How do you normally cope with stress? _____

Infant's Name: _____

9. What are you family strengths right now? _____
_____

10. Depression
    a. Have you had any of these feelings since your baby was born?
    ☐ Depressed mood ☐ Loss of interest in usually pleasurable activities ☐ Difficulty concentrating or making decisions
    ☐ Fatigue ☐ Changes in appetite or sleep ☐ Recurrent thoughts of suicide ☐ Feelings of worthlessness or guilt
    ☐ Excessive anxiety
    b. Have you ever been diagnosed with a mental illness by a health professional? ☐ NO ☐ YES
    If yes, are you currently taking medications for this illness? ☐ NO ☐ YES
    If yes, are you currently seeing a mental health counselor? ☐ NO ☐ YES

11. Domestic Violence – Since the baby was born:
    a. Has your partner pushed, hit, slapped, kicked, choked or physically hurt you in any way? ☐ NO ☐ YES
    b. Has anyone else physically hurt you in any way? ☐ NO ☐ YES
    c. Are you fearful of your safety at this time? ☐ NO ☐ YES

12. Parenting –
    a. Child Interaction Assessment (Complete this information from observation)
    ☐ Baby is easy to console
    ☐ Speaks endearingly to baby
    ☐ Has pleasurable time with feeding
    ☐ Seems confident about care giving
    ☐ Touches baby frequently
    ☐ Has eye contact with baby while holding
    ☐ Smiles at baby frequently
    ☐ Responds to baby's needs (in tune with baby)
    ☐ Prepared at home for baby
    ☐ Have realistic expectations of baby
    b. When your baby is upset, what do you do to quiet him or her? _____
    c. What questions do you have about taking care of your baby? _____

13. Growth and Development
    a. Which of these developmental milestones have you seen in your baby?
    ☐ Follows your face and eyes
    ☐ Sleeps for 3-4 hours at a time
    ☐ Good head control
    ☐ Rolls over
    ☐ Crawls
    ☐ Picks up with two fingers
    ☐ Recognizes your voice
    ☐ Coos or vocalizes
    ☐ Raises body on hands
    ☐ Shakes an object
    ☐ Walks
    ☐ Holds cup
    ☐ Lifts head when on stomach
    ☐ Smiles
    ☐ Sits with support
    ☐ Pulls to stand
    ☐ Plays peek-a-boo
    ☐ Feeds self

ENVIRONMENTAL INFORMATION

1. What is your current housing situation? (Select all that apply.)
    ☐ House-own ☐ Apartment ☐ Live with FOB ☐ Shelter ☐ Friend
    ☐ House-rent ☐ Live with SO (not fob) ☐ Migrant Housing ☐ Relative ☐ Rent
    ☐ Live with parents ☐ Homeless ☐ Other
2. Is your current housing?
    ☐ Built before 1950 ☐ Remodeled/renovated in the last year ☐ Near an industrial plant, dump site
3. Does your house (or frequently visited home) have peeling or chipping paint? ☐ NO ☐ YES
4. Does your house (or frequently visited home) have a lot of dust and mold? ☐ NO ☐ YES
5. Was asbestos insulation used on pipes or hot water tank or for insulation in attic/walls? ☐ NO ☐ YES
6. Does anyone in your household work around lead (pottery, automobile repair, plumbing)? ☐ NO ☐ YES

Infant's Name: _____

7. Do you regularly (at least weekly) use cleaners for glass, oven, floors, glues, solvents, paint strippers? ☐ NO ☐ YES
8. Do you currently use pesticides (bug or weed killer, flea or tick spray) in the home? ☐ NO ☐ YES
9. What is the source of your drinking water? ☐ well ☐ city ☐ store bought
10. Are the following in good working order? ☐ furnace ☐ plumbing ☐ refrigerator ☐ stove
11. Do you have a working smoke detector? ☐ YES ☐ NO
    Last time checked?_____
12. Does anyone in your household:
    a. Smoke? ☐ NO ☐ YES
    b. Use a wood stove? ☐ NO ☐ YES
13. Do you have guns and/or weapons in your home? ☐ NO ☐ YES
14. How many times have you moved in the past year? _____ Why? _____
15. Are you having any housing problems at this time? ☐ NO ☐ YES
    If yes, please describe _____
16. Are you having problems paying bills at this time? ☐ NO ☐ YES
    If yes, ☐ rent/mortgage ☐ gas ☐ electric ☐ phone
    More description _____
17. Do your child/children have a car seat? ☐ YES ☐ NO
    If yes, is the car seat ☐ new ☐ used
    a. Have you been shown how to install the seat in your vehicle? ☐ YES ☐ NO
18. Where does your new baby usually sleep?_____
    a. How do you most often lay your baby down to sleep? ☐ Back ☐ Side ☐ Stomach
    b. How often does your new baby sleep in the same bed with you or anyone else? _____
    c. Do you have a crib for your baby? ☐ YES ☐ NO
19. Do you need help getting baby items? ☐ YES ☐ NO

PARENTING EDUCATION CLASSES

1. Have you ever attended a group parenting class? ☐ NO ☐ YES
2. Would like to attend a group parenting class? ☐ YES ☐ NO
3. Will there be a problem getting to the class? ☐ NO ☐ YES

KEEPING MEDICAL APPOINTMENTS (TRANSPORTATION)

1. How do you usually get to healthcare appointments (e.g., doctor's office, WIC, lab, pharmacy, etc.)? _____
2. Do you drive? ☐ YES ☐ NO
3. Do you have access to a reliable vehicle? ☐ YES ☐ NO
4. Do you have any concerns with keeping your baby's medical appointments? _____
5. If you know, what is the maximum distance you will have to travel to keep your appointments? _____
6. If you are in a Medicaid Health Plan, have they ever helped you to get to the doctor's office? ☐ YES ☐ NO

SUMMARY

CAREGIVER'S SUMMARY

1. Do you understand what the ISS program is about? ☐ YES ☐ NO
2. What do you want the ISS team to work with you on? _____
   _____
3. Do you foresee any problems keeping appointments with the ISS team? ☐ NO ☐ YES
   What kind? _____
   _____

Infant's Name: _____

CLINICIAN ASSESSMENT SUMMARY

Strengths:

Weaknesses:

Referrals Made:

I have provided a copy of the following ISS program information:

- ☐ Caregiver grievance policy/procedure
- ☐ Medical and non-medical emergency options

ISS assessment form completed by:

Signature	Discipline	Date

INFANT SUPPORT SERVICES PLAN OF CARE

Infant Name:	Date of Birth	Birth Weight	Birth Ht/Length	Gestational Age	Medical Care Provider:
Caregiver Name:					
Care Coordinator:					Discipline

PROBLEMS/NEEDS	GOALS/OBJECTIVES	INTERVENTIONS
Health:		
Family Planning:	Assist family to achieve their goal of spacing and composition of family through use of birth control method of their choice.	
Smoking: ☐Caregiver Amount ____ ☐Quit Smoking When ____ ☐Environmental Smoke Who ____ ☐Smoke-Free Environment	Infant will have a smoke-free environment.	
Immunization Status of Caregiver (Based on Immunization Record/MCP) ☐Up To Date ☐Not Up To Date Status of Preschool Child(ren) (Based on MICR/Immunization Record/MCP) ☐Up To Date ☐Not Up To Date	Infant will remain current with immunizations.	
Nutrition:		

Infant Name: _____

INFANT SUPPORT SERVICES PLAN OF CARE

PROBLEMS/NEEDS	GOALS/OBJECTIVES	INTERVENTIONS
Emotional/Mental Health		
Environmental:		
Parenting Class:	Caregiver will receive the benefits of a group setting.	
Transportation:	Infant will not miss any appointments due to a lack of transportation	
Other:		

We the undersigned have reviewed the initial assessment and have participated in the above described plan. We concur with the number of visits to implement the interventions.
Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature	Date	SW Signature	Date	RD Signature	Date

Care Plan Update

We the undersigned have reviewed the care plan update and agreed to the changes in the above described plan. We concur with the number of visits to achieve the specific objectives.
Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature	Date	SW Signature	Date	RD Signature	Date

INFANT SUPPORT SERVICES
RISK SCREENING TOOL

Infant Referred For ISS
❑ **Yes** ❑ **No**

Infant Name: _____ **D.O.B.:** _____
Last First Middle

Medicaid ID #: _____ **County:** _____

Address: _____ **Telephone:** _____

Mother/Caregiver: _____ **Alternate Telephone:** _____

Additional Contact Person: _____ **Telephone Number:** _____

Medical Care Provider

Name: _____ **Telephone Number:** _____

Address: _____

Medicaid Health Plan Name: _____

---

1. Need for assistance to care for your infant
Are you good at following directions/instructions? ☐Yes ☐ No
Barriers: ☐ language ☐ literacy* Education level _____
Physical limitations _____

Describe where you live:
☐ Rent ☐ Own your home ☐ With relatives
☐ Shelter* ☐ Motel* ☐ Car*

2. Failure to thrive
How often do you feed your baby in a day? _____
Do you: ☐ Breast feed ☐Bottle feed
Supplement with _____
Is your baby losing weight? ☐Yes* ☐No
Does your baby have any other health problems that concern you?

Explain: _____
_____

3. Mother with cognitive, emotional or mental needs
How are you coping with taking care of your baby?
☐ Good ☐ Bad* ☐ O.K.
Do you feel stressed? ☐Yes* ☐No
Do you have a history of postpartum depression?
☐Yes* ☐No
Do you have any concerns about your mental or emotional health?
☐Yes* ☐No

4. Low Birth Weight
What was the birth weight of your baby? _____
☐ >2500 grams or ☐ <2500 grams
What week of the pregnancy was your baby born? _____

5. Family support
Are you under 18 years old? ☐Yes* ☐No
Who do you currently live with? _____
Who supported you during pregnancy? _____
Who can you count on for support from?
the baby's father? ☐Yes ☐No*
a parent? ☐Yes ☐No*
a friend? ☐Yes ☐No*
Anyone else? _____

6. Homeless/dangerous living situation
Do you worry about anyone mistreating your child/children?
☐Yes* ☐No
Do you/baby feel safe in your home? ☐Yes ☐No*
Are you planning on moving from current location?
☐ Yes ☐ No ☐ Don't Know

7. Family history of mother's abuse/neglect
Have you ever been abused? ☐Yes* ☐No
Have you ever been neglected? ☐Yes* ☐No

8. Abuse of alcohol, street drugs or tobacco products
Do you smoke? ☐Yes* ☐No
Do you drink alcohol (beer, wine, liquor) when you are pregnant?
☐Yes* ☐No
Do you use drugs not prescribed by your doctor?
☐Yes* ☐No
Does someone in your household use drugs?
☐Yes* ☐No

9. Any other condition that may place the infant at risk for death, illness, or significant impairment?

Explain

_____
_____
_____

Completed by: _____ **Date:** _____

Note: A yes or check to an asterisk (*) question indicates a referral of ISS. Provider judgment must be used in making appropriate referrals.

Infant's Name: _____

INFANT SUPPORT SERVICES
RISK SCREENING TOOL

INSTRUCTIONS:

1. If the responses to Items 2-10 indicate no other high-risk situation, and responses to questions in Item 1 indicate no experience or knowledge of dealing with pregnancy/baby, the beneficiary needs only Parenting Education. Enrollment in ISS is not required.
2. Based on the responses to questions for Item 2, assess the need for transportation and, as appropriate, make arrangements to transport beneficiary for appointments.
3. A check/yes response to an asterisk (*) question indicates an automatic referral for ISS. Non-asterisk items should be referred based on provider judgment.

CAREGIVER:

I understand I may qualify to receive ISS, but I do not want these services**.**

Signature: _____ **Date:** _____

MEDICAL or ISS CARE PROVIDER

Signature: _____ Date: _____

Print Name: _____

Note: A yes or check to an asterisk (*) question indicates a referral of ISS. Provider judgment must be used in making appropriate referrals.

INFORMED CONSENT TO STERILIZATION

Michigan Department of Community Health

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

_____. When I first asked for the
(Doctor or Clinic)

information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on_____
(Month / Day / Year)

I, _____
(Name of Individual Being Sterilized)

hereby consent of my own free will to be sterilized by

_____
(Name of Doctor and Professional Degree)

by a method called _____ .

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services OR Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

_____ Date: _____
(Signature of Person Giving Consent) *(Month / Day / Year)*

You are requested to supply the following information, but it is not required: *Ethnicity and race designation (please check)*

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ Date: _____
(Interpreter's Signature) *(Month / Day / Year)*

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
(Name of Individual)
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ _____
(Signature of person obtaining consent) *(Date)*

_____
(Facility)

_____
(Facility Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ **on** _____
(Name of individual to be sterilized) *(Date of sterilization)*

I explained to him/her the nature of the sterilization operation _____, the fact that it is intended
(specify type of operation)
to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery: _____
  (describe circumstances)

_____

_____ Date: _____
(Signature of Physician and Professional Degree) *(Month / Day / Year)*

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

INSTRUCTIONS TO COMPLETE INFORMED CONSENT TO STERILIZATION FORM

1. Name of the physician or clinic giving information to the beneficiary. The "M.D." or "D.O." designation must be included.
2. Name of the sterilization procedure to be performed (e.g., Tubal Ligation or Vasectomy).
3. Beneficiary's complete birth date (month, day, and year). The beneficiary must be 21 years of age at the time they sign the form.
4. Beneficiary's full name. If a name change is indicated on the Medicaid card by the time surgery is performed, both names must be indicated.
5. Name of physician performing the sterilization. If the physician is unknown, "doctor on call" may be indicated.
6. Name of surgery to be performed (e.g., Tubal Ligation or Vasectomy).
7. Beneficiary's handwritten signature. A beneficiary who cannot write should sign with an "X." The "X" signature must be witnessed. The witness' handwritten signature must appear below item 7.
8. Date the consent form was signed (month, day and year). This date must be more than 30 days and less than 180 days before the date the sterilization is performed. If it is less than 30 days, see instructions for "alternative final paragraphs."
9. Race and ethnicity designation is optional.
10. Interpreter's Statement. This information is only required if the beneficiary is unable to understand English. The language used for interpretation must be specified (e.g., Spanish). The interpreter's handwritten signature and date must appear. The date must be the same date the beneficiary signed the form.
11. Name of beneficiary.
12. Name of sterilization procedure (e.g., Tubal Ligation or Vasectomy).
13. The handwritten signature of the person obtaining consent.
14. Date consent is taken (month, day and year). This date must be before the date sterilization is performed (#18).
15. Name of provider or clinic (e.g., office of John Doe, M.D., doctor's office, ABC Clinic, XYZ Hospital).
16. Street address, city, state, and zip code. No P.O. boxes allowed.
17. Beneficiary's full name.
18. Date of sterilization (month, day, and year). The surgery date must be the same as indicated on the claim.
19. Name of sterilization procedure (e.g., Tubal Ligation, Vasectomy).
20. Instructions for use of alternative final paragraphs.
21. If at least 30 days have passed since the date the beneficiary signed the consent form and the date of sterilization, paragraph "1" applies and paragraph "2" should be crossed out.
22. If the date the sterilization was performed is less than 30 days and more than 72 hours of the beneficiary signing the consent form, paragraph "2" applies and paragraph "1" should be crossed out. The applicable box should be checked.
23. For premature delivery, the expected date of delivery must be given.
24. Physician's signature. This can be a stamped signature if counter initialed.
25. Date physician signed the consent form. This date must be on or after the date of surgery. This can be typed or stamped.

If abdominal surgery was performed, the circumstances must be explained and operative notes submitted with the claim.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

MATERNAL AND INFANT SUPPORT SERVICES PROGRAM

Authorization and Consent to Release Protected Health Information

The Maternal Support Services (MSS) and Infant Support Services (ISS) Programs are designed to provide you with information and referrals to agencies that may help you stay healthy and care for you and your infant. To do this, **we would like you to answer some questions to help us understand your** daily living habits and to identify potential health risks to you and your infant.

The answers that you give to the following questions are protected health information and will be kept confidential unless we are permitted or required by law to release them. In order to plan and provide the best possible care for you and your infant, we may need to share the answers that you give with various health and social services professionals in the Michigan Department of Community Health (MDCH) and the local Family Independence Agency (FIA). To assure that program services are coordinated with your primary health care, we may also need to provide information regarding services you receive, or need to receive, with your physician and other community agencies.

If you qualify for program services, your participation will be completely voluntary. You may refuse to answer any questions that you do not wish to answer. You are free to end the interview at any time. If you decide not to answer some of the questions or if you decide to end the interview, it will not affect your Medicaid eligibility or your ability to receive MSS or ISS for you or your infant.

I have read the above or have had it read/explained to me. I understand that I may qualify to receive MSS or ISS.

☐ I **do not** wish to participate in the MSS or ISS assessment and do not want to receive MSS or ISS for myself or my infant.

☐ I **do** wish to participate in the MSS or ISS assessment and want to receive MSS or ISS for myself or my infant. I also authorize the release of information to other community agencies to assist in my care.

Print Beneficiary's Name

_____

_____

Beneficiary's Signature Date

_____

Name of Interviewer Date

MATERNAL AND INFANT SUPPORT SERVICES PROGRAM
PROFESSIONAL VISIT PROGRESS NOTE

Beneficiary ID #: _____

Beneficiary Information

Name: _____
Parent/ Guardian: _____
Type of Visit: ☐ MSS ☐ ISS
Location of Visit: ☐ Home ☐ Office ☐ Other
Date of Visit: _____

Insurance Information

Medicaid Number: _____
Any Changes in Medicaid? ☐ YES ☐ NO
Managed Care: ☐ YES ☐ NO
If yes, Name and ID#: _____

Purpose of visit (per care plan)

#1 Problem/Needs Addressed:

Interventions Provided:

#2 Problem/Needs Addressed

Interventions Provided

Beneficiary's Name: _____

MATERNAL AND INFANT SUPPORT SERVICES PROGRAM
PROFESSIONAL VISIT PROGRESS NOTE

Follow-Up Plan Next Steps

Family Planning Issues: _____

Immunization Issues: _____

CBE/PE Issues: _____

Last Medical Care Provider Visit: _____

Next Medical Care Provider Visit: _____

Date of Next Visit by MSS/ISS Provider: _____

Referrals Needed:
Referrals Made:
Care Plan Update Needed ☐ Yes ☐ No

Signature Date

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

MATERNAL INFANT HEALTH PROGRAM

PRENATAL PLAN OF CARE

Beneficiary Name	Care Coordinator	Discipline

PROBLEMS / NEEDS	OBJECTIVES/OUTCOMES	INTERVENTIONS
Demographics and Health History Risk ___ Client needs information on resources available and how to access health care providers for _____ .		
Prenatal Care/Nutrition ___ Client needs information on resources available and how to access prenatal care providers to assist her to get to her appointments. ___ Client needs information on prenatal nutrition due to: _____		
Smoking ___ Client needs information on effects of tobacco on her baby. ___ Client needs information on how to decrease tobacco use.	Client will have information to recognize risk of substances to self and fetus and wil: ☐ Have a smoke free environment ☐ Quit smoking by (date): _____ ☐ Decrease cigarette use to (number): ____ per day by (date) _____ ☐ Identify a support for smoking cessation	
Alcohol/Drug Use ___ Client needs information on effects of substances on her baby. ___ Client needs information on resources available to assist her to decrease or discontinue her substance use.		

Beneficiary's Name: _____

PRENATAL PLAN OF CARE

PROBLEMS / NEEDS	OBJECTIVES/OUTCOMES	INTERVENTIONS
Stress ___ Client needs information on how to deal with stress.	Client will verbalize her stress has decreased.	
Depression and Mental Health ___ Client needs information on perinatal depression.		
Social Support ___ Client needs assistance with finding a good support system.	Client will identify a support system and will describe who will support her during her pregnancy and after delivery of the baby.	
Abuse/Violence		
Basic Needs ___ Client needs information on (circle appropriate responses): housing; financial resources; food supply; transportation; Other _____ _____		

Beneficiary's Name: _____

PRENATAL PLAN OF CARE

PROBLEMS / NEEDS	OBJECTIVES/OUTCOMES	INTERVENTIONS
Breastfeeding ___ Client needs information on the benefits of breastfeeding. ___ Client needs information on breastfeeding techniques and supportive community resources.	.	
Family Planning ___ Client needs information on contraceptive options available. ___ Client needs information on how to access reproductive health care after Medicaid coverage ends.	Client will verbalize future reproductive plans, including: ☐ Contraceptive Choice: _____ ☐ Reproductive Health Care Provider: _____ ☐ Method of Payment for Care: _____ ☐ Spacing of Children	
Other		

We, the undersigned, have reviewed the initial assessment and have participated in the above described plan. We concur with the number of visits to implement the interventions. Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature	Date	SW Signature	Date	RD Signature	Date

Care Plan Update

We, the undersigned, have reviewed the care plan update and agreed to the changes in the above described plan. We concur with the number of visits to achieve the specific objectives. Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature	Date	SW Signature	Date	RD Signature	Date

Michigan Department of Community Health

Maternal Infant Health Program
Prenatal Risk Factor Eligibility Screening Form

1 BASICS/DEMOGRAPHICS

0 SCREENING DATE

MM DD YY

1.0 IDENTIFICATION

1.0A NAME

FIRST

MI

LAST

1.0B MEDICAID ID #

1.0C SOCIAL SECURITY #

- -

1.1 What is your date of birth?

MM DD YY

☐ REFUSED

1.2 What do you identify as your race/ethnic background? (Check all that apply, question is optional)

☐ Asian
☐ American Indian or Alaska Native
☐ Black or African American
☐ Hispanic/Latino
☐ Native Hawaiian or other Pacific Islander
☐ White/Caucasian
☐ REFUSED

→ 1.3

1.3 How many grades of school have you completed?

☐☐ grades completed

Junior high/middle school = 8
High school diploma/GED = 12
Associate's degree = 14
Bachelor's degree = 16

☐ REFUSED

1.4A Do you currently work outside the home?

☐ Yes
☐ No ⇩ 1.5

1.4B How many hours do you work in a typical week?

☐☐ Hours

1.5 Are you currently attending school?

☐ Yes
☐ No

1.6 Are you currently married or unmarried?

☐ Married
☐ Unmarried → 2.1A
☐ REFUSED

2 HEALTH HISTORY/RISKS

2.1A When was your last menstrual period?

MM DD YY ⇩2.2A

☐ DON'T KNOW

☐ REFUSED

2.1B When is your baby due?

MM DD YY

☐ DON'T KNOW

☐ REFUSED

2.2A How do you feel about becoming pregnant? Did you:

☐ Want to be pregnant sooner ⇩2.3

☐ *Want to be pregnant later

☐ Want to be pregnant now ⇩2.3

☐ *Not want to be pregnant now or at any time in the future

☐ DON'T KNOW ⇩2.3

☐ REFUSED

2.2B At the time you became pregnant, were you using any birth control method?

☐ Yes

☐ No

☐ DON'T KNOW

☐ REFUSED

2.3 What was your weight just before you became pregnant this time?

☐☐☐ Pounds

☐ DON'T KNOW

☐ REFUSED

2.4 What is your height without shoes?

☐ Feet ☐ Inches ➡2.5A

☐ REFUSED

2.5A Including this pregnancy, how many times have you been pregnant? (Count any abortions, miscarriages or stillbirths)

☐ 1 TIME (FIRST PREGNANCY) ⇨2.7

☐ TIMES

☐ REFUSED ⇨2.7

2.5B When did your last pregnancy end? (date of last delivery, abortion, miscarriage or stillbirth)

☐☐ ☐☐ (Approximate if necessary)

MM YY

☐ REFUSED

2.6 Did any of your previous pregnancies result in:	YES	PG #	NO
2.6A *Miscarriage in the 4th month of pregnancy or later?	☐	☐	☐
2.6B *Stillbirth?	☐	☐	☐
2.6C *Baby weighing less than 5.5 pounds at birth?	☐	☐	☐
2.6D *Baby born more than 3 weeks early (or did anyone tell you that your baby was premature/preterm?)	☐	☐	☐
2.6E *Baby that stayed in the hospital after you went home?	☐	☐	☐

☐ REFUSED ➡

2.7	**Have you ever been treated for or told that you have:**

2.7A	**High blood pressure (hypertension)?**	
	No	⇩2.7B
	Yes	➡

2.7A.1	**When did you last see a health care provider about this problem?**			
	MONTH:		YEAR:	⬇
2.7A.2	**Do you have another visit scheduled?**			
	Yes	⬇		
	No			
2.7A.3	**Have you been in the hospital or ER for this problem in the last six months?**			
	Yes	⬅2.7B		
	No			

2.7B	**Anemia or sickle cell disease?**	
	No	⇩2.7C
	Yes	➡

2.7B.1	**Have you ever had a blood transfusion for this problem?**		
	Yes	LAST DATE: /	⬇
	No		
2.7B.2	**When did you last see a health care provider about this problem?**		
	MONTH:	YEAR:	⬇
2.7B.3	**Do you have another visit scheduled?**		
	Yes	⬇	
	*No		
2.7B.4	**Have you been in the hospital or ER for this problem in the last six months?**		
	Yes	⬅2.7C	
	No		

2.7C	**Diabetes or high blood sugar?**	
	No	⇨2.7D
	*Yes	➡

2.7C.1	**Is it Insulin dependent?**	
	Yes	⬇
	No	
2.7C.2	**When did you last see a health care provider about this problem?**	
	MONTH:	YEAR: ⬇
2.7C.3	**Do you have another visit scheduled?**	
	Yes	⬇
	No	
2.7C.4	**Have you been in the hospital or ER for this problem in the last six months?**	
	Yes	➡2.7D
	No	

2.7D	**Asthma?**	
	No	⇩2.7E
	Yes	➡

2.7D.1	**When did you last see a health care provider about this problem?**			
MONTH:		YEAR:		⬇
2.7D.2	**Do you have another visit scheduled?**			
	Yes			⬇
	No			
2.7D.3	**Have you been in the hospital or ER for this problem in the last six months?**			
	Yes			⬅2.7E
	No			

2.7E	**Problems with your heart, kidneys, or lungs?**	
	No	⇩2.7F
	Yes	➡

2.7E.1	**When did you last see a health care provider about this problem?**			
MONTH:		YEAR:		⬇
2.7E.2	**Do you have another visit scheduled?**			
	Yes			⬇
	No			
2.7E.3	**Have you been in the hospital or ER for this problem in the last six months?**			
	Yes			⬅2.7F
	No			

2.7F	**Problems with bleeding?**	
	No	⇩2.7G
	Yes	➡

2.7F.1	**When did you last see a health care provider about this problem?**			
MONTH:		YEAR:		⬇
2.7F.2	**Do you have another visit scheduled?**			
	Yes			⬇
	No			
2.7F.3	**Have you been in the hospital or ER for this problem in the last six months?**			
	Yes			⬅2.7G
	No			

2.7G	**Recurring vaginal infections?**	
	No	⇨2.7H
	Yes	➡

2.7G.1	**When did you last see a health care provider about this problem?**			
MONTH:		YEAR:		⬇
2.7G.2	**Do you have another visit scheduled?**			
	Yes			⬇
	No			
2.7G.3	**Have you been in the hospital or ER for this problem in the last six months?**			
	Yes			➡2.7H
	No			

2.7H	A sexually transmitted infection?	
	No	⇩2.7I
	Yes	➡

2.7H.1	When did you last see a health care provider about this problem?			
MONTH:		YEAR:		⬇
2.7H.2	Do you have another visit scheduled?			
	Yes			⬇
	No			
2.7H.3	Have you been in the hospital or ER for this problem in the last six months?			
	Yes			⬅2.7I
	No			

2.7I	Other problem(s) that you see a doctor for?	
	No	⇩2.8
	Yes	➡

2.7I.1	When did you last see a health care provider about this problem?			
MONTH:		YEAR:		⬇
2.7I.2	Do you have another visit scheduled?			
	Yes			⬇
	No			
2.7I.3	Have you been in the hospital or ER for this problem in the last six months?			
	Yes			
	No			⬅2.8A
	REFUSED			

2.8A	Are you now taking any prescription drugs?	
	Yes	➡
	No	⇩2.9A
	REFUSED	

2.8B	Which prescription drugs are you taking?	
		⬅2.9A

2.9A	How long has it been since you had a dental exam and cleaning?	
	Within the past year	⇨3.1
	Within the past 2 years	
	Within the past 5 years	
	More than 5 years ago	➡2.9B
	Don't know/not sure	
	Never	
	REFUSED	

2.9B	In the past year, have you noticed any problems with your teeth or gums such as bad breath that won't go away, loose or sensitive teeth, or gums that are red, swollen, tender, or bleeding?	
	Yes	➡3.1
	No	

3 PRENATAL CARE

3.1 When you have a health issue or problem, where do you usually go for care?

- ☐ Doctor's office
- ☐ Public health clinic
- ☐ Readicare facility
- ☐ Hospital
- ☐ Emergency room
- ☐ Other _____
- ☐ Nowhere
- ☐ REFUSED

3.2 How many months' pregnant were you when you had your first visit for prenatal care? Do not count a visit that was only for a pregnancy test or only for WIC.

- ☐☐ Months
- ☐ I haven't gone for prenatal care
- ☐ REFUSED

3.3 Have you had any trouble getting the prenatal care you want or need?

- ☐ * Yes
- ☐ No → 3.4
- ☐ REFUSED

3.4 Here is a list of problems some women can have getting prenatal care. For each item, please let us know if it has been true for you at any time during this pregnancy [READ LIST]

- ☐ I couldn't get an appointment when I wanted one
- ☐ I couldn't find a doctor or clinic that accepted Medicaid
- ☐ It is hard to communicate with the doctor or clinic staff
- ☐ It is hard to understand the information the doctor or clinic give to me
- ☐ I haven't had enough money or insurance to pay for my visits
- ☐ I haven't had my Medicaid card or Guarantee of Payment letter
- ☐ *I've had no way to get to the clinic or doctor's office
- ☐ I couldn't take time off from work
- ☐ I've had no one to take care of my children
- ☐ I have had too many other things going on in my life
- ☐ *I didn't want anyone to know I was pregnant
- ☐ Other. Please tell us: _____
- ☐ REFUSED

→ 4.1

4 SMOKING

4.1 Which of the following statements would you say best describes your cigarette smoking? Would you say:

	*I smoke regularly now – about the same amount as before finding out I was pregnant	
	*I smoke regularly now, but I've cut down since I found out I was pregnant	⇩
	*I smoke every once in a while	
	I have quit smoking since finding out I was pregnant	
	I wasn't smoking around the time I found out I was pregnant, and I don't currently smoke cigarettes.	⇨5.1
	REFUSED	⇩

4.2 How many cigarettes do you smoke on an average day now/or did before quitting?

	1-1/2 or more packs	
	1 to 1-1/2 packs	➡
	1/2 to 1 pack	
	6 to 10 cigarettes	
	1 to 5 cigarettes	⇨ 4.4A If smoking
	Less than 1 cigarette	
	REFUSED	➡

4.3A How soon after you wake up do you smoke your first cigarette?

	Within 5 minutes	⇩
	6-30 minutes	
	31 or more minutes	

4.3B Do you find it difficult to stop smoking in non-smoking areas?

	No	⇩
	Yes	

4.3C Which cigarette would you MOST hate to give up?

	The first cigarette in the morning	⇩
	All others	

4.3D Do you smoke MORE FREQUENTLY in the first hours after waking than the rest of the day?

	No	⇩
	Yes	

4.3E Do you smoke if you are so ill that you are in bed most of the day?

	No	⇩
	Yes	

If still smoking:

4.4A Have you seriously thought about quitting smoking during this pregnancy?

	Yes	⇩
	No	⇨5.1

4.4B Have you tried to quit smoking in the last 30 days?

	Yes	⇩
	No	⇨5.1

4.4C Have you made any changes or gotten any supports to make it easier for you to not smoke?

	Yes	➡5.1
	No	

5 ALCOHOL

5.1 Which of the following statements would you say best describes your alcohol consumption, INCLUDING beer and wine coolers? Would you say:

- ☐ *I drink alcohol regularly now – about the same amount as before finding out I was pregnant
- ☐ *I drink alcohol regularly now, but I've cut down since I found out I was pregnant
- ☐ *I drink alcohol every once in a while
- ☐ I have quit drinking alcohol since finding out I was pregnant → 5.3A
- ☐ I wasn't drinking alcohol around the time I found out I was pregnant, and I don't currently drink. → 6.1
- ☐ REFUSED

5.2 Approximately how many alcoholic drinks do you have in an average week/or did when drinking?

- ☐ 14 drinks or more a week
- ☐ 7 to 13 drinks a week
- ☐ 4 to 6 drinks a week
- ☐ 1 to 3 drinks a week
- ☐ Less than 1 drink a week
- ☐ REFUSED

5.3A How many drinks does it/did it take to make you feel high?

- ☐ 1
- ☐ 2
- ☐ 3 or more

5.3B Have people annoyed you by criticizing your drinking?

- ☐ Yes
- ☐ No

5.3C Have you ever felt you ought to cut down on your drinking?

- ☐ Yes
- ☐ No

5.3D Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

- ☐ Yes
- ☐ No

If still drinking alcohol:

5.4A Have you seriously thought about quitting all alcohol during this pregnancy?

- ☐ Yes
- ☐ No → 6.1

5.4B Have you tried to quit drinking alcohol in the last 30 days?

- ☐ Yes
- ☐ No → 6.1

5.4C Have you made any changes or gotten any supports to make it easier for you to not drink alcohol?

- ☐ Yes
- ☐ No → 6.1

6 DRUG USE

6.1	Does your partner or anyone in your household use street drugs?	
	*Yes	⬇
	No	
	REFUSED	

6.2A	In the month before you knew you were pregnant, did you use any street drugs, diet pills, or drugs not prescribed by a physician?	
	*Yes	⬇ 6.2B
	No	⇨ 7.1
	REFUSED	

6.2B	What did you use? (check all that apply) [OPEN ENDED, PROMPT FOR OTHERS]	
	Marijuana	
	PCP	
	Crack	
	Cocaine	
	Heroin	
	Uppers/Crank/Meth/Speed	⬇
	Downers	
	LSD	
	Diet Pills	
	Prescription drugs not prescribed for you	
	Other:	

6.2C	What drugs have you used since becoming pregnant? (check all that apply) [OPEN ENDED, PROMPT FOR OTHERS]	
	Marijuana	
	PCP	
	Crack	
	Cocaine	
	Heroin	
	Uppers/Crank/Meth/Speed	⬇
	Downers	
	LSD	
	Diet Pills	
	Prescription drugs not prescribed for you	
	Other:	
	None	

If still using drugs:		
6.3A	Have you seriously thought about quitting all drugs during this pregnancy?	
	Yes	
	No	
6.3B	Have you tried to quit using drugs in the last 30 days?	
	Yes	
	No	
6.3C	Have you made any changes or gotten any supports to make it easier for you to not use drugs?	
	Yes	
	No	

7 STRESS

7.1 In the last month, how often have you felt nervous and stressed?

- ☐ Never → 8.1
- ☐ Almost Never
- ☐ *Sometimes
- ☐ *Fairly Often
- ☐ *Very Often
- ☐ REFUSED
- ☐ SNAG

7.2 During pregnancy, pressures and hassles of everyday life can become even harder to cope with. In the last month, have you felt like you were struggling to cope with:

	YES	NO
Problems with money?	*	
Problems with a personal relationship?	*	
Demands of family or children?	*	
Demands of work or school?	*	

→

7.3A In the last month, how often have you felt that you were unable to control the important things in your life?

- ☐ Never
- ☐ Almost never
- ☐ *Sometimes
- ☐ *Fairly often
- ☐ *Very often

↓

7.3B In the last month, how often have you felt confident about your ability to handle your personal problems?

- ☐ *Never
- ☐ *Almost never
- ☐ *Sometimes
- ☐ Fairly often
- ☐ Very often

↓

7.3C In the last month, how often have you felt that things were going your way?

- ☐ *Never
- ☐ *Almost never
- ☐ *Sometimes
- ☐ Fairly often
- ☐ Very often

↓

7.3D In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

- ☐ Never
- ☐ Almost never
- ☐ *Sometimes
- ☐ *Fairly often
- ☐ *Very often

→ 8.1

8 DEPRESSION AND MENTAL HEALTH

8.1 Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

- ☐ Not at all
- ☐ *Several days
- ☐ *More than half the days
- ☐ *Nearly every day
- ☐ REFUSED

8.2 Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?

- ☐ Not at all
- ☐ *Several days
- ☐ *More than half the days
- ☐ *Nearly every day
- ☐ REFUSED

8.3 Over the past 2 weeks, how often have you had 'nerves' or felt angry, blue, or out of sorts?

- ☐ Not at all
- ☐ *Several days
- ☐ *More than half the days → 8.4
- ☐ *Nearly every day
- ☐ REFUSED

8.4A Have you ever had the "baby blues"?

- ☐ *Yes
- ☐ No
- ☐ REFUSED

8.4B Have you ever been treated for or told that you have depression, bipolar disorder, or schizophrenia?

- ☐ No ⇩ BELOW
- ☐ *Yes → 8.4B.1

8.4B.1 When did you last see a health care provider about this problem?

MONTH: ☐☐ YEAR: ☐☐☐☐

8.4B.2 Do you have another visit scheduled?

- ☐ Yes
- ☐ No

8.4B.3 Have you been in the hospital or ER for this condition in the last six months?

- ☐ Yes → BELOW
- ☐ No

IF ONE OR MORE ANSWERS TO 8.1 – 8.3 ARE MARKED ★, CONTINUE TO 8.5.

OTHERWISE, SKIP TO 9.1

QUESTIONS 8.5 – 8.14: DEPRESSION FOLLOW UP SCREENING

I'd like to ask you some follow up questions about how you're feeling.
I'm going to read you some statements and responses. For each statement, please let me know which response is closest to how you've been in the past 7 days.

8.5	**I have been able to laugh and see the funny side of things**
	As much as I always could
	Not quite so much now
	Definitely not so much now
	Not at all

8.6	**I have looked forward with enjoyment to things**
	As much as I ever did
	Rather less than I used to
	Definitely less than I used to
	Hardly at all

8.7	**I have blamed myself unnecessarily when things went wrong**
	Yes, most of the time
	Yes, some of the time
	Not very often
	No, never

8.8	**I have been anxious or worried for no good reason**
	No, not at all
	Hardly ever
	Yes, sometimes
	Yes, very often

8.9	**I have felt scared or panicky for no very good reason**
	Yes, quite a lot
	Yes, sometimes
	No, not much
	No, not at all

8.10	**Things have been getting the best of me**
	Yes, most of the time I haven't been able to cope at all
	Yes, sometimes I haven't been coping as well as usual
	No, most of the time I have coped quite well
	No, I have been coping as well as ever

8.11	**I have been so unhappy that I have had difficulty sleeping**
	Yes, most of the time
	Yes, sometimes
	Not very often
	No, not at all

8.12	**I have felt sad or miserable**
	Yes, most of the time
	Yes, quite often
	Not very often
	No, not at all

8.13	**I have been so unhappy that I have been crying**
	Yes, most of the time
	Yes, quite often
	Only occasionally
	No, never

8.14	**The thought of harming myself has occurred to me**
	Yes, quite often
	Sometimes
	Hardly ever
	Never

9 SOCIAL SUPPORT

9.1	Would you describe the father of this baby as:	
	Involved in my pregnancy and supportive of me	
	Involved but not supportive of me	
	*Aware that I'm pregnant but not involved	⬇
	Not aware that I'm pregnant	
	REFUSED	

9.2A	Is there someone in your life who you can count on to help you during this pregnancy and with your new baby?	
	Yes	➡
	*No	⇨10.1

9.2B	Who do you count on for support? (check all that apply)	
	Partner and/or the baby's father	
	Parent(s)	
	Other child or children	
	Other relative(s)	➡10.1
	Friend(s)/Neighbor(s)	
	Clergy and/or people at my place of worship	
	Other:_____	

10 ABUSE/VIOLENCE

10.1 Do you feel safe in your present relationship?

- ☐ I am not in a relationship right now
- ☐ Yes
- ☐ *No

10.2A Within the last year, have you been hit, kicked, slapped, or otherwise physically hurt by someone?

- ☐ *Yes
- ☐ No ⇨ 10.4

10.2B By whom? (Check all that apply)

- ☐ Current partner
- ☐ Ex-partner
- ☐ Stranger
- ☐ Others
- ☐ Specify_____

10.2C How many times has this happened?

- ☐ times

10.3A Since you have been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?

- ☐ *Yes
- ☐ No ⇨ 10.4

10.3B By whom? (Check all that apply)

- ☐ Current partner
- ☐ Ex-partner
- ☐ Stranger
- ☐ Others
- ☐ Specify:

10.3C How many times has this happened?

- ☐ times

10.3D What part or parts of your body were hurt?

- ☐ Limbs
- ☐ Torso
- ☐ Head

➡ 10.3E

10.3E How did this person hurt you? (Score the most severe incident to the following scale)**:**

- ☐ Threats of abuse, including use of a weapon
- ☐ Slapping, pushing; no injuries and/or lasting pain
- ☐ Punching, kicking, bruises, cuts and/or continuing pain
- ☐ Beaten up, severe contusions, burns, broken bones
- ☐ Head, internal, and/or permanent injury
- ☐ Use of weapon, wound from weapon

10.4 Has your partner or someone else now in your life:

- ☐ *Called you names, humiliated you, or made you feel that you don't count?
- ☐ *Kept you from seeing or talking to your family, friends, or other people?
- ☐ *Thrown away or destroyed your belongings, threatened pets, or done other things to bully or scare you?
- ☐ *Controlled your use of money, your access to money or your ability to work?

10.5A Within the past year, has anyone forced you to have sexual activities?

- ☐ *Yes
- ☐ No ⇩ 10.6

10.5B Who was it?

- ☐ Current partner
- ☐ Ex-partner
- ☐ Stranger
- ☐ Others
- ☐ Specify:

10.5C How many times has this happened?

- ☐ times

10.6 Have you *ever* been emotionally or physically abused by your partner or someone important to you?

- ☐ *Yes
- ☐ No

10.7 Are you afraid of your partner or anyone you listed above?

- ☐ *Yes
- ☐ No

➡ 11.1A

11 BASIC NEEDS

11.1A	**In the last 12 months, did you (or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?**	
	Yes	⇩
	No	⇩ 11.2
11.1B	**How often did this happen?**	
	Almost every month	⇩
	Some months but not every month	
	In only 1 or 2 months	
11.2	**How many times have you moved in the past 12 months?**	
	0	⇩
	1	
	2	
	3	
	4 or more	
11.3A	**Do you currently have any concerns or worries about your housing situation?**	
	*Yes	⇩
	No	⇨ 11.4

11.3B	**What are your concerns or worries about housing? (check all that apply)** [OPEN ENDED]	
	Instability	⇨ 11.4
	No place to live, no regular nighttime residence, or live in a shelter.	
	Eviction or being forced to move out.	
	Affordability of current house or apartment	
	Strained relations with others in household	
	Adequacy	
	House or apartment is too crowded.	
	Lack of continuous functioning basic utility service (e.g., heat, electricity)	
	Safety	
	Safety of house/apartment	
	Safety of neighborhood	

11.4	**How often do you have access to a telephone to make and receive calls where you live?**	
	Always	⇩ 12.1
	Sometimes	
	Never	

12 BREASTFEEDING

12.1	**Which of the following best describes your thoughts on breastfeeding your new baby?**	
	I know I will breastfeed	
	I think I might breastfeed	
	I know I will not breastfeed	
	I don't know what to do about breastfeeding	
	REFUSED	

END

Throughout this risk-screening form an asterisk (*) was placed next to the responses that if checked by the beneficiary would indicate they have a risk. If a beneficiary checks, at a minimum, one box where the corresponding response has an asterisk, they are automatically eligible for Maternal Infant Health Program (MIHP). In the event none of the beneficiary's answers on this form are marked by an asterisk, they may still be assessed based on the MIHP provider's judgment.

MIHP Prenatal Risk Factor Eligibility Screening Form completed by:

Signature Discipline Date

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

MATERNAL INFANT HEALTH PROGRAM
PRENATAL SERVICES ASSESSMENT

Medicaid ID #: _____ Date of Assessment: _____
Provider Name: _____
Type (Check one): ☐ Fee For Service ☐ Medicaid Health Plan (MHP), MHP Name: _____
Non-Medicaid: Visit Location: ☐ Home Visit ☐ Other Visit
☐ Application in process. Explain _____ ☐ Office Visit
☐ Not yet applied. Explain _____

Has the consent form been signed? ☐YES ☐NO

GENERAL INFORMATION

Beneficiary's First Name _____ Last Name _____ Date of Birth ____/_____/____
Phone Number _____ (hm) _____(wk) Best time to reach Beneficiary _____
Is there another phone number where you can be reached?_____
Current Address _____
Street Address City Zip County
Travel Directions_____
_____
What language do you prefer to speak? _____ What language do you prefer to use for reading? _____

Name of Father of Baby (FOB)_____Date of Birth ____/_____/____ Race/Ethnicity _____
Employment Status: ☐ Full Time (FT) ☐ Part Time (PT) ☐ Not Working ☐ Student
Relationship with Mother: ☐ Involved ☐ Not Involved

Household members other than mother or FOB	Relationship to Beneficiary	Sex	Race/Ethnicity	DOB or Age*

*List DOB for preschool children - may list age for others living in the household.

IMMUNIZATIONS

1. Have you been immunized against any of the following infections?
   ☐ Chicken Pox ☐ Hepatitis B ☐ MMR ☐ Meningitis ☐ Polio ☐ Flu ☐ Don't Know
2. Have you been around anyone with these infections in the last month?..... ☐ NO ☐ YES
3. Are the immunization records on all preschool children in the household available?..... ☐ YES ☐ NO

COGNITION

1. Do you have trouble reading materials given to you by WIC or your doctor? ☐ Always ☐ Sometimes ☐ Never
2. Did you or do you attend special education classes in school? ..... ☐ YES ☐ NO
3. How do you like to receive educational materials? ☐ Written ☐ Verbally ☐ Audio ☐ Video

NUTRITION

1. How much weight would you like to gain with this pregnancy? _____
2. Have you had any of the following problems?

   ☐ change in appetite ☐ constipation ☐ diarrhea ☐ food allergies ☐ heartburn ☐ nausea ☐ vomiting
3. What changes have you made in eating since you found out you are pregnant? _____

   a. Are you on a special diet? ..... ☐ NO ☐ YES

      If yes, please describe _____

   b. Are you able to drink milk and/or eat milk products? ..... ☐ YES ☐ NO

   c. Do you feel the need to eat any non-food, such as ice, clay, starch, etc.? ..... ☐ YES ☐ NO

      If yes, what _____

   d. Have you ever had an eating disorder, such as bulimia or anorexia nervosa? ..... ☐ NO ☐ YES

      If yes, please explain _____

   e. How often do you eat fast foods in a week? _____

   f. How many pops/Kool-aid do you drink in a day? _____

   g. How many caffeinated drinks (i.e., coffee, tea, pop, etc.) do you drink in a day? _____

   h. How many glasses of water do you drink in a day? _____

   l. Describe a typical day's meals: _____

      _____
4. Are you taking a prenatal vitamin daily? ..... ☐ YES ☐ NO

   a. Are you taking herbal supplements? ..... ☐ NO ☐ YES
5. Breast-Feeding:

   a. Are you planning to breast-feed this baby? ..... ☐ YES ☐ NO

   b. What concerns do you have about breast-feeding? _____

      _____
6. Family Planning:

   What do you want to use for birth control after your baby is born? _____

SEXUALLY TRANSMITTED INFECTIONS

1. Have you had a test for HIV during this pregnancy? ..... ☐ YES ☐ NO
2. Would you like more information on HIV? ..... ☐ YES ☐ NO

ENVIRONMENTAL INFORMATION

1. What is your current housing situation? (Check all that apply.)
   ☐ House-own ☐ Apartment Live With: ☐ FOB ☐ Friend
   ☐ House-rent ☐ Shelter ☐ Parents ☐ Relative
   ☐ Migrant Housing ☐ Homeless/other ☐ SO (not FOB)
2. Is your current housing: (Check all that apply.)
   ☐ built before 1978 ☐ remodeled/renovated in the last year ☐ near an industrial plant, dump site
3. Does your house (or frequently visited home) have peeling or chipping paint? ..... ☐ NO ☐ YES
4. Does your house (or frequently visited home) have a lot of dust and mold? ..... ☐ NO ☐ YES
5. Was asbestos insulation used on pipes or hot water tank or for insulation in attic/walls? ..... ☐ NO ☐ YES
6. Does anyone in your household work around lead (pottery, automobile repair, plumbing)? ..... ☐ NO ☐ YES
7. Do you regularly (at least weekly) use cleaners for glass, oven, floors, or use glues, solvents, paint strippers? .. ☐ NO ☐ YES
8. Do you currently use pesticides (bug or weed killer, flea or tick spray) in the home? ..... ☐ NO ☐ YES
9. What is the source of your drinking water? ☐ well ☐ city ☐ store bought
10. Are the following in good working order? ☐ furnace ☐ plumbing ☐ refrigerator ☐ stove
11. Do you have a working smoke detector(s)? ..... ☐ YES ☐ NO
    Last time checked: _____
12. Do you use a wood stove?..... ☐ NO ☐ YES
13. Do you have guns and/or weapons in your home? ..... ☐ NO ☐ YES
14. Are you having problems paying bills at this time? ..... ☐ NO ☐ YES
    If yes, check all that apply. ☐ rent/mortgage ☐ gas ☐ electric ☐ phone
    Please describe: _____
15. Does your child/children have a car seat? ..... ☐ YES ☐ NO
    If yes, is the car seat: ☐ new ☐ used
    a. Have you been shown how to install the seat in your vehicle? ..... ☐ YES ☐ NO
16. Do you have a crib for your new baby? ..... ☐ YES ☐ NO
17. Do you need help getting baby items? ..... ☐ NO ☐ YES

CHILDBIRTH EDUCATION CLASSES (CBE)

1. Are you nervous about going through the labor and delivery process? ..... ☐ NO ☐ YES
   Please describe: _____
2. Who will be taking you to the hospital when you are in labor? _____
3. Who will be your coach/with you during delivery? _____
4. Have you ever taken a CBE class? ..... ☐ YES ☐ NO
5. Do you plan to take a CBE class? ..... ☐ YES ☐ NO
6. Will there be a problem getting to the class? ..... ☐ NO ☐ YES

SUMMARY

BENEFICIARY SUMMARY

1. Do you have any questions about the MIHP program? ..... ☐ YES ☐ NO
2. What do you want the MIHP team to work with you on? _____
   _____
3. Do you foresee any problems keeping appointments with the MIHP team? ..... ☐ NO ☐ YES
   What kind? _____
   _____

CLINICIAN ASSESSMENT SUMMARY

Strengths:

Problems:

Referrals Made:

I have provided a copy of the following Maternal Infant Health Program (MIHP) information:

- ☐ Beneficiary grievance policy/procedure
- ☐ Medical and non-medical emergency options

MIHP Prenatal Services Assessment form completed by:

Signature | Discipline | Date

MATERNAL SUPPORT SERVICES (MSS)
DISCHARGE SUMMARY

Beneficiary's Name:_____ **Date of Birth:**_____
Current Address:_____
Referral Source (Agency/Program/Prenatal Care Provider):_____
Reason for Referral (High-Risk Criteria):_____
Date of Initial Assessment: _____
Sent to Medical Care Provider ☐**Yes** ☐**No**
Total Number of Visits By: ___**RN** ___**SW** ___**RD**

Summary of MSS Plan of Care Problems/Issues Addressed:

HEALTH INFORMATION

MATERNAL HEALTH

- ☐ Lack of prenatal care
- ☐ Difficulties with access to prenatal care provider
- ☐ Unsatisfied with health care
- ☐ Current health problem(s)_____
- ☐ Problems with previous pregnancies
- ☐ Lack of family planning
- ☐ Lack of dental care
- ☐ Unmet needs _____
  _____

SMOKING

- ☐ Smoked during pregnancy
- ☐ Continues to smoke
- ☐ Unmet needs _____
  _____

IMMUNIZATION

- ☐ Mom: Not up to date
- ☐ Preschooler(s): Not up to date
- ☐ Exposure to _____
- ☐ Unmet needs _____
  _____

NUTRITION

- ☐ Pre-pregnancy overweight/obesity
- ☐ Inappropriate weight gain
- ☐ Gastrointestinal problems
- ☐ Inappropriate eating patterns
- ☐ Inadequate food supply
- ☐ Lack of prenatal vitamins
- ☐ Difficulty with breast-feeding
- ☐ Unmet needs _____
  _____

SEXUALLY TRANSMITTED INFECTIONS

- ☐ At risk for sexually transmitted infection(s)
- ☐ Positive test for sexually transmitted infection(s) during this pregnancy
- ☐ Unmet needs _____
  _____

Beneficiary's Name: _____

MATERNAL SUPPORT SERVICES (MSS)
DISCHARGE SUMMARY

EMOTIONAL/MENTAL HEALTH INFORMATION

EMOTIONAL/MENTAL STRESSOR

- ☐ Lack of knowledge about pregnancy
- ☐ Lack of acceptance
- ☐ Lack of father involvement
- ☐ Lack of social support
- ☐ Unusual stressors
- ☐ Inadequate coping skills
- ☐ Symptoms of depression
- ☐ Diagnosis of mental illness
- ☐ Children's Protective Services involvement
- ☐ Indicator(s) of domestic violence
- ☐ Unmet needs _____
  _____

ALCOHOL/DRUG USE

- ☐ Alcohol use during pregnancy
- ☐ Prescription drug use
- ☐ Street drug use
- ☐ Arrested during pregnancy
- ☐ Unmet needs _____
  _____

ENVIRONMENTAL INFORMATION

- ☐ Unsafe or inadequate housing
- ☐ Exposure to toxic substance such as:
  ☐ lead ☐ asbestos ☐ pesticides ☐ cleaners ☐ other _____
- ☐ Exposure to allergens
- ☐ No smoke detectors
- ☐ Second-hand smoke
- ☐ Presence of weapons
- ☐ Frequent moves
- ☐ Problems with money management
- ☐ Lack of proper car seat
- ☐ Unsafe sleeping arrangements
- ☐ Inadequate baby supplies
- ☐ Unmet needs _____
  _____

CHILDBIRTH EDUCATION

- ☐ Lack of childbirth education
- ☐ Unmet needs _____
  _____

TRANSPORTATION

- ☐ Lack of transportation
- ☐ Unmet needs _____
  _____

OTHER: _____
_____
_____

REFERRALS MADE: _____
_____
_____

Signature of MSS Care Coordinator: _____ **Date:** _____

MATERNAL SUPPORT SERVICES
RISK SCREENING TOOL

Beneficiary Referred For MSS
❑ **Yes** ❑ **No**

Beneficiary Name: _____ **D.O.B.:** _____
Last First Middle
E.D.C.: _____
Medicaid ID #: _____ **County:** _____
Address: _____ **Telephone:** _____
Beneficiary's Parent/ Guardian/Spouse: _____ **Alternate Telephone:** _____
Additional Contact Person: _____ **Telephone Number:** _____

Health Care (Obstetrical) Provider
Name: _____ **Telephone Number:** _____
Address: _____
Medicaid Health Plan Name: _____

---

1. Need for childbirth education
Do you know what to expect at different stages of your pregnancy? ☐ Yes ☐ No
Would you like to learn more about delivery? ☐ Yes ☐ No
Do you have experience in caring for a baby? ☐ Yes ☐ No
Would you like to learn more about how to take care of your baby? ☐ Yes ☐ No

2. Need for transportation to keep medical appointments
How do you get around? ☐ By car ☐ Public transport
How do you plan to get to medical appointments?
_____

3. Need for assistance to care for your infant
Are you good at following directions/instructions? ☐Yes ☐ No
Barriers: ☐ language ☐ literacy* Education level _____
Physical limitations _____

Describe where you live:
☐ Rent ☐ Own your home ☐ With relatives
☐ Shelter* ☐ Motel* ☐ Car*

4. Nutrition/Health problems
Describe your eating habits
No. of meals eaten per day _____ ☐ Skip meals*
☐ Cook at home ☐ Fast food
Which beverages do you drink often?
☐ Pop ☐ Juice ☐ Water ☐ Milk
Do have any food cravings, e.g. PICA? ☐Yes* ☐ No
Is your blood low in iron (anemia)? ☐Yes* ☐ No
Do you have high blood pressure? ☐Yes* ☐ No
Do you have diabetes now or during other pregnancies? ☐Yes* ☐ No
Have you had problems with weight gain/loss during your pregnancy? ☐Yes* ☐ No
Do you have any other health problems that concern you?
Explain _____

5. Family support
Are you under 18 years old? ☐Yes* ☐No
Who do you currently live with? _____
Who supported you during pregnancy? _____
Who can you count on for support from?
The baby's father? ☐Yes ☐No*
A parent? ☐Yes ☐No*
A friend? ☐Yes ☐No*
Anyone else? _____

6. Feelings about current pregnancy
Have you been pregnant before?_____
What are your feelings about this pregnancy?
☐ Happy ☐ Unhappy* ☐ Don't Know
Did your last pregnancy result in fetal (womb) or neonatal (within 30 days of birth) death?
☐ N/A ☐ Yes* ☐ No
Have you experienced death of a prior child before age one?
☐ N/A ☐ Yes* ☐ No

7. Mother with cognitive, emotional or mental needs
How are you coping with taking care of your baby?
☐ Good ☐ Bad* ☐ O.K.
Do you feel stressed? ☐Yes* ☐No
Do you have a history of postpartum depression? ☐Yes* ☐No
Do you have any concerns about your mental or emotional health? ☐Yes* ☐No

8. Social situation
Do you worry about somebody mistreating you? ☐Yes* ☐No
Do you worry about anyone mistreating your child/children? ☐Yes* ☐No
Are you planning on moving during your pregnancy?
☐ Yes ☐ No ☐ Don't Know

9. Use of alcohol, drugs or tobacco products
Do you smoke? ☐Yes* ☐No
Do you drink alcohol (beer, wine, liquor) now that you are pregnant? ☐Yes* ☐No
Do you use street drugs? ☐Yes* ☐No
Does someone in your household use street drugs? ☐Yes* ☐No

A Check/Yes response to any asterisk (*) question indicates automatic referral for MSS.

Beneficiary's Name: _____

MATERNAL SUPPORT SERVICES
RISK SCREENING TOOL

10. Other (explain): _____

_____

_____

_____

_____

_____

_____

Completed by: _____ **Date:** _____

INSTRUCTIONS:

1. If the responses to Items 2-10 indicate no other high-risk situation, and responses to questions in Item 1 indicate no experience or knowledge of dealing with pregnancy/baby, the beneficiary needs only Childbirth Education. Enrollment in MSS is not required.
2. Based on the responses to questions for Item 2, assess the need for transportation and, as appropriate, make arrangements to transport beneficiary for appointments.
3. A check/yes response to an asterisk (*) question indicates an automatic referral for MSS. Non-asterisk items should be referred based on provider judgment.

BENEFICIARY:

I understand I may qualify to receive MSS, but I do not want these services.

Signature: _____ **Date:** _____

MEDICAL or MSS CARE PROVIDER

Signature: _____ Date: _____

Print Name: _____

A Check/Yes response to any asterisk (*) question indicates automatic referral for MSS.

Michigan Department of Community Health

MEDICAID VENTILATOR DEPENDENT CARE ASSESSMENT

Instructions:

- All fields must be typewritten
- Fax completed form to:

  Program Review Division
  (517) 241-7813

Beneficiary's Name:	Date of Birth: / /
Prospective Ventilator Unit:	Sex: ☐ Female ☐ Male
Address of Unit: (Street, Suite Number, City, State, Zip)	
Administrator:	
Admissions Coordinator:	

INSURANCE/RESOURCE SOURCE:

Medicaid ID #: Active: ☐ Yes ☐ No	Medicaid Health Plan: (Name)	Disenrollment Date / /
Medicare ID #:	Blue Cross/Blue Shield ID #:	Other Insurance: (Name)
Date Benefits Exhausted: / /	Date Benefits Exhausted: / /	Date Benefits Exhausted: / /

DISCHARGE INFORMATION:

☐ Hospital ☐ Nursing Facility	Facility Name:	Admission Date: / /

Primary Diagnosis: Secondary Diagnosis:

Medical History:

Surgeries and Dates:

RESPIRATORY STATUS:

Date Placed on Ventilator: / /	Suctioning Frequency:
Number of Hours on Vent (Out of 24 hrs.):	Secretion Description:
Weaning Potential:	Prognosis:
Weaning Attempts:	

02 Usage: Level: Frequency: Route:

NOTE: Medicaid does not reimburse for C-PAP/BI-PAP only.

Blood Gases: Labs:

Medications:

ADDITIONAL DATA:

Mental Status:	Sensory/Communication Status:
Diet Type: ☐ Tube Feeding Status:	Caloric Intake: Supplements:

Incontinence:				Treatment /Therapies: (Check as applicable.)
	Bowel	☐ Yes	☐ No	☐ OT ☐ PT ☐ ST
	Bladder	☐ Yes	☐ No	
	Catheter	☐ Yes	☐ No	

Wounds:

Comments:

Submitted by: Date:

Telephone Number: ( ) - Fax #: ( ) - Pager: ( ) -

MSA-1634 (03-06) Previous editions may be used.

Michigan Department Of Community Health

MEDICAID VENTILATOR DEPENDENT CARE AUTHORIZATION

Complete this request with diagnosis information.

FAX TO: MDCH-Program Review Division at **(517) 241-7813**

Hospital Name

Beneficiary Name	**Facility Name**		
Beneficiary ID Number	**Facility Street Address**		
Admission Date	**Facility City**	**State**	**Zip**
Anticipated Date of Discharge to Long-Term Care	**Provider Contact Name**		
Provider ID Number	**Provider Contact Phone Number** ( ) -		
Diagnosis			
Physician's Signature	**Date**		

MDCH USE ONLY:

Prior Authorization Number

APPROVED	**DENIED**
☐ As Presented ☐ As Amended	☐

Start Date	**End Date**	**Number of Days**	**Total Daily Vent Rate**
			$

MDCH Signature Date

Authority: Title XIX of Social Security Act

MSA-1635 (03-06) Previous edition may be used.

The MichiganDepartment of Community Health is an equal opportunity employer, services and programs provider.

Instructions for Form MSA-4114
CSHCS MEDICAL ELIGIBILITY REPORT

Michigan Department of Community Health

Children's Special Health Care Services (CSHCS) Plan Division

Purpose:

This form is used to determine if someone is medically eligible for the Children's Special Health Care Services program.

This form should be completed for the following persons:

- Anyone, **UNDER 21** years of age with a Potentially Eligible Condition.
- Anyone, regardless of age, who has CYSTIC FIBROSIS.
- Anyone, regardless of age, who has certain Blood Clotting Disorders.

Completion Instructions:

- Read this (YELLOW) instruction page thoroughly and then separate it from the form set underneath.
- Please **TYPE** or **PRINT** clearly in INK.
- The **Physician's Signature** (or the Attending Physician if a Hospital) and the **Date Signed** are **REQUIRED**.
- When complete, file the **PINK** copy in the child's file until the request result is returned to you.
- **Mail** the remaining **WHITE** copy in the enclosed postage paid envelope, or addressed to:
  CSHCS PLAN DIVISION
  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  PO BOX 30734
  LANSING MI 48909-8234

Other Information:

- If this request is approved, the person is medically eligible for the CSHCS program.
- For actual program coverage, the child's family or applicant MUST apply to join the CSHCS program by completing form **MSA-0737**, APPLICATION FOR CHILDREN'S SPECIAL HEALTH CARE SERVICES
- If the family does NOT receive an application after notification of approval, please call **1-800-359-3722**.

AUTHORITY:	Title V of the Social Security Act	The Department of Community Health is an equal opportunity employer, services and programs provider.
COMPLETION:	Completion is Voluntary, but is required if coverage under the Crippled Children's Program is desired.	

MSA-4114 Cover Sheet (05-03) Previous versions may be used.

Read, the Separate this YELLOW instruction sheet from the form set.

CSHCS MEDICAL ELIGIBILITY REPORT

Michigan Department of Community Health
Children's Special Health Care Services (CSHCS) Plan Division

1. CHILD'S Name			3. Date of Birth	4. Sex ☐ **MALE** ☐ **FEMALE**
2. CHILD'S Address (number and street)			5. HOME Phone Number ( ) –	6. WORK Phone Number ( ) –
City	State	ZIP Code	7. County	
8. PARENT or GUARDIAN'S Name			9. HOME Phone Number ( ) –	10. WORK Phone Number ( ) –
11. Parent or Guardian Street Address (if different from child's)			12. Does Child have other Health Insurance? ☐ **NO** ☐ **YES** (Co. Name):	
City	State	ZIP Code	13. Is Child enrolled in Medicaid? ☐ **NO** ☐ **YES** (Medicaid ID No.):	
14. DIAGNOSIS: *(If Newborn, give birth weight)* **Primary:**			**Other:**	
15. Severity / Complications / Chronicity:				
16. HISTORY:				
17. TREATMENT PLAN: (Include names of specialists involved, and any special needs such as; surgery, medications, supplies, therapies, equipment)				
18. What Care will this Child need: ☐ **HOSPITAL** ☐ **HOME CARE** ☐ **Other** (explain)				19. Requested Coverage Begin Date
20. PROGNOSIS:				
21. HOSPITAL Name			22. Hospital Case Record Number	
23 Hospital Contact Person Name and Title			24. Hospital Phone Number ( ) –	
25. PHYSICIAN'S Name			26. Physician's Phone Number ( ) –	
27. Physician's Address (Number and Street)			28. Physician's Signature ***(REQUIRED)***	29. Date Signed
City	State	ZIP Code		
30. **MAIL RESPONSE TO:** (Name, Address, City, State, ZIP Code)				

For CSHCS Use Only

☐ **APPROVED** - This person **IS** medically eligible for the CSHCS Program, but must now apply to join the CSHCS Program for Coverage

☐ **DISAPPROVED** - This person is **NOT** medically eligible for the CSHCS Program. Reason:

☐ Eligible for Diagnostic Evaluation at:

☐ PENDING / OTHER:

CSHCS Signature Date

MSA-4114 (05-03) Previous versions may be used.

MENTAL ILLNESS / DEVELOPMENTAL DISABILITY EXEMPTION CRITERIA CERTIFICATION
(For Use in Claiming Exemption Only)

INSTRUCTIONS: Michigan Department of Community Health

- This form must be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant or physician and signed by a physician.
- The patient being screened shall require a comprehensive LEVEL II screening UNLESS either of the exemption criteria below is met and certified by a physician. **Indicate which one applies.**

Patient Name		Date of Birth	
Name of Referring Agency		Referring Agency Telephone No. ( ) –	
Referring Agency Address (Number, Street, Building, Suite No., etc.)	City	State	ZIP Code

Exemption Criteria:

☐ **COMA:** **YES**, I certify the patient under consideration is in a coma/persistent vegetative state.

☐ **DEMENTIA:** **YES**, I certify the patient under consideration has a dementia as established by clinical examination and evidence of meeting ALL five criteria below and does **NOT** have a developmental disability or another primary psychiatric diagnosis of mental illness.

Specific Diagnosis: _____

1. Has demonstrable evidence of impairment in short-term or long-term memory as indicated by the inability to learn new information or remember three objects after five minutes, and the inability to remember past personal information or facts of common knowledge.
2. Exhibits at least one of the following:
   - Impairment of abstract thinking as indicated by the inability to find similarities and differences between related words; has difficulty defining words, concepts and similar tasks.
   - Impaired judgment as indicated by inability to make reasonable plans to deal with interpersonal, family and job related issues.
   - Other disturbances of higher cortical function, i.e., aphasia, apraxia and constructional difficulty.
   - Personality change: altered or accentuated premorbid traits.
3. Disturbances in items 1 or 2 above significantly interfere with work, usual activities or relationships with others.
4. The disturbance has NOT occurred exclusively during the course of delirium.
5. **EITHER:**
   a) Medical history, physical exam and/or lab tests show evidence of a specific organic factor judged to be etiologically related to the disturbance **OR**
   b) An etiologic organic factor is presumed in the absence of such evidence if the disturbance cannot be accounted for by any non-organic mental disorder.

☐ **EXEMPTED HOSPITAL DISCHARGE:**

YES, I certify that the patient under consideration is:

1) being admitted after a hospital stay, **AND**
2) requires nursing facility services for the condition for which she/he received hospital care, **AND**
3) is likely to require less than 30 days of nursing services.

Physician Signature	Date Signed	Name (Typed or Printed)
		Telephone Number ( ) –

AUTHORITY: Title XIX of the Social Security Act **COMPLETION:** Is Voluntary, but if NOT completed, Medicaid will not reimburse the nursing facility.	The Department of Community Health is an equal opportunity employer, services, and programs provider.

COPY DISTRIBUTION:
ORIGINAL - Nursing Facility retains in Patient File
COPY - Attach to form DCH-3877 and send to Local CMHSP.
COPY - Patient Copy or Authorized Representative

DCH-3878 (06/03) Replaces form MSA-3878, which is Obsolete

Instructions for Completing Form DCH-3878
MENTAL ILLNESS / DEVELOPMENTAL DISABILITY EXEMPTION CRITERIA CERTIFICATION
(For Use in Claiming Exemption Only)

- The **DCH-3878** is to be used ONLY when a person identified on a **DCH-3877** as needing a LEVEL II screening meets one of the specified exemptions from LEVEL II screening. If the individual under consideration meets one of the following exemptions, she/he may be admitted (under preadmission screening) or retained (under annual resident review) at a nursing facility without additional screening. However, a completed copy of the **DCH-3878** must be attached to the **DCH-3877** and sent to the local Community Mental Health Services Program (CMHSP).

- The nursing facility must retain the facility copy in the patient file and see that the patient copy goes to the patient or authorized patient representative.

- This form may be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or physician, but must be certified and signed by a physician.

- Complete the following information to match the **DCH-3877**: Patient Name, DOB, and Referring Agency (including agency address and telephone number).

- Use an "**X**" to indicate which exemption applies to the individual under consideration.

DEMENTIA:

- Review the five criteria listed under the dementia exemption category. Do NOT check this exemption **unless** the individual meets all five criteria. Any individual who meets some, but not all five, criteria will be subject to a LEVEL II screening. If the person under consideration meets this exemption category, please specify the type of dementia.

Dementia diagnoses include the following:

1. Dementia of the Alzheimer's Type,
2. Vascular Dementia,
3. Dementia due to Other General Medical Conditions,
4. Substance - Induced Persisting Dementia, **or**
5. Dementia Not Otherwise Specified.

COPY DISTRIBUTION:

Original	-	Nursing Facility retains in Patient File
Photocopy	-	Attach to form DCH-3877 and send to Local CMHSP
Photocopy	-	Patient Copy or Authorized Representative

NURSE AID TRAINING AND TESTING PROGRAM INTERIM REIMBURSEMENT REQUEST

Michigan Department of Community Health

INSTRUCTIONS:

Please send completed request to:

LTC REIMBURSEMENT AND RATE SETTING SECTION
MEDICAL SERVICES ADMINISTRATION
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30479
LANSING MI 48909-7979.

Interim reimbursement request data is used to establish the amount of per diem add-on reimbursement to be included in the Medicaid Program per diem payment rate. The total amount of add-on reimbursement for nurse aide training and testing programduring the fiscal year will be adjusted through the annual settlement determination of the training and testing costs apportioned to Medicaid patients utilizing inpatient day activity.

Information included in this request may reflect estimated costs and projections for the time period indicated.

1. Provider Cost Period:From: **From:** **To:**	3. Name of Training Contractor (if used)		
2. Training Conducted By: (check one) ❑ **In-House Staff** ❑ **Outside Contractor** (complete items 3, 4 & 5)	4. Contractor Address		
	5. City	State	ZIP Code

6. Was the facility designated by the Michigan Department of Public Health as a "LOCKOUT FACILITY" any time during the cost reporting period?

❑ **NO** ❑ **YES** (complete # 7 below)

7. If YES, what time period:

From: **To:**

8. Estimated Nursing Aide Training Program Costs for the Period. (from Page 2, Line 11) . . . . . _____

9. Estimated Total Inpatient Days for the Period . . . . . _____

10. Estimated Nurse Aide Training Program Cost Per Day (line 8 divided by line 9) . . . . . _____

CERTIFICATION STATEMENT: To be Signed by Provider Representative

I certify that this claim for adjustment is true, accurate, and prepared with my knowledge and consent, and does not contain untrue, misleading or deceptive information. In the event the actual allowable costs do not support the increased rate, the provider will reimburse the State for excess amounts received. I further agree that retrospective cost settlements will be made in accordance with the State Plan, as applicable.

11. Signature of Provider Representative Date	14. Name of Facility		
	15. Street Address		16. County No.
12. Typed Name	17. City	State	ZIP Code
13. Phone Number	18. Provider ID No.	19. Provider License No.	

Authority: Completion:	Title XIX of the Social Security Act Is Voluntary, but is required if Medical Assistance program payment is desired.	The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

MSA-1324 (04-05)

ESTIMATED NURSE AIDE TRAINING AND TESTING COSTS

Michigan Department of Community Health

1	**Facility Training Staff:**		
	a. Salaries and Wages		
	b. Fringe Benefits		
	c. Payroll Taxes		
	d. Total Training Staff Personnel (1a + 1b + 1c)	**1**	0
2	**Nurse Aide Training Consultants**	**2**	
3	**Nurse Aide Student Staff:**		
	a. Wages		
	b. Fringe Benefits		
	c. Payroll taxes		
	d. Total Student Staff Personnel (3a + 3b + 3c)	**3**	0
4	**Training Program Supplies**	**4**	
5	**Training Program Transportation:**		
	a. Training Staff		
	b. Student Staff		
	c. Total Transportation (5a + 5b)	**5**	0
6	**Outside Contracted Approved Nurse Aide Training:**		
	a. Paid Directly By Facility		
	b. Reimbursed To Employee Staff		
	c. Total Outside Training (6a+6b)	**6**	0
7	**Nurse Aide Testing Fees:**		
	a. Paid Directly By Facility		
	b. Reimbursed To Employee Staff		
	c. Total Testing Fees Paid (7a + 7b)	**7**	0
8	**Other Training Program Costs (Specify):**		
	a.	**8a**	
	b.	**8b**	
9	**Total Training Program Cost Before Equipment Allowance** (Sum of Lines 1 thru 8b)	**9**	0
10	**Training Program Equipment Use Allowance:** (equipment specific to training program)		
	a. Number of months in reporting period		
	b. Reporting period training program use allowance. Line 10.a. 0 divided by **12**, times **15%** =		**0.00%**
	c. Equipment purchased in Current Year (CY) and Prior 6 years:		
	CY minus 6 years $ times Line 10.b.% =		0
	CY minus 5 years $ times Line 10.b.% =		0
	CY minus 4 years $ times Line 10.b.% =		0
	CY minus 3 years $ times Line 10.b.% =		0
	CY minus 2 years $ times Line 10.b.% =		0
	CY minus 1 year $ times Line 10.b.% =		0
	Current Year $ times Line 10.b.% =		0
	d. Total equipment use allowance (Sum of 10.c. line amounts)	**10d**	0
11	**Estimated Total Nurse Aide Training Program Costs** (Sum of Line 9 and Line 10d.)	**11**	0

NURSE AIDE TRAINING AND TESTING PROGRAM
FACILITY INTERIM REIMBURSMENT (MSA-1324) PAGE 1 - INSTRUCTIONS

The purpose of this form is for the provider to access Medicaid Program reimbursement outside the routine nursing care rate per diem for OBRA nurse aide training and testing programs. The form must be completed in order to receive interim reimbursement for those providers that have been determined to be a lockout facility, or for those facilities incurring costs in excess of interim reimbursement. Costs will be retrospectively settled to reflect the Medicaid Program's appropriate share of actual allowable training and testing costs.

Training and testing program costs claimed for services and supplies furnished to or purchased by the facility from organizations related to the provider by common ownership or control must adhere to the related party allowable cost principles. Expenses for such transactions should not exceed expenses for like items or services in an arms-length transaction with other non-related organizations, or the cost to the related organization, whichever is lower.

Administrative overhead costs and space costs in nursing facilities conducting in-house training are not considered training and testing program costs. The costs reported must be specifically incurred in conducting the approved nurse aide training and testing program.

Supporting accounting records such as class attendance rosters or training participation logs, purchase orders, vendor invoices, contracts, documentation verifying amounts reimbursed to employees for approved training program expense incurred by the employee prior to employment at the facility (canceled check, training program receipt), etc. must be maintained for audit purposes. Supporting materials should be readily identifiable as training related cost documentation and must indicate the type of training involved.

If the facility maintains separate cost center reporting for the training program, enter the appropriate costs as identified.

o Training Program Approval Requirement

Only costs incurred relative to a Bureau of Health Systems approved Nurse Aide Training Program may be claimed on this schedule. An approved program may be conducted by the provider facility or by a separate entity from the provider. The provider **must not report and make claim** for Medicaid Program reimbursement on this schedule for any costs incurred and associated with providing training **by the lockout facility** during the lockout time period. Nurse aide training program costs during the lockout time period are limited to the costs incurred in obtaining training and testing outside the facility from an approved nurse aide training program.

o Enter the following data in the yellow shaded cells:

1. Cost Reporting Period:
   Enter the fiscal period coinciding with the provider's cost reporting period.
2. Mode of Training
   It is possible that providers may utilize both in-house staff and outside contractors. If a chain organization or group home ownership uses an approved central training program, indicate the training as "in-house" with the notation "centralized training". If multiple outside contractors are used, indicate each of them and the time periods utilized.
6. Lockout Facility
   A facility identified by the Bureau of Health Systems as a "lockout facility" cannot conduct an approved training and testing program, cannot be a training/clinical practice site for another approved program and cannot conduct clinical skills testing. The facility is notified of the lockout determination action by the Bureau of Health Systems. Answer question as applicable.
9. Estimated Inpatient Days for the Period
   Indicate the appropriate number of total inpatient days of care estimated to be rendered during the time period reported on this form.
14. Name of Facility
    Enter the provider name under which Medicaid payments are issued to the provider.
16. County No.
    Enter the two digit county number.
17. Provider Location
    Enter the city, village, etc., state, and zip code in which the facility is physically located.
18. Medicaid Provider ID Type and Number
    Enter the nursing facility's Medicaid Program payment number. This includes the two digit provider type and seven digit individual facility number.
19. License No.
    Enter the three digit license number.

NURSE AIDE TRAINING AND TESTING PROGRAM
FACILITY INTERIM REIMBURSMENT (MSA-1324) PAGE 2 - INSTRUCTIONS

1. Facility Training Staff
   Payroll related costs for facility employees, incurred for the approved program direct training time or nurse aide training program preparation time.
2. Nurse Aide Training Consultants **-** Costs incurred for non-facility staff engaged to provide instruction or consultation for the facility's approved nurse aide training program.
3. Student Staff
   Payroll costs for facility employees incurred while the student is actually engaged in the approved training program or traveling to and from the off-site approved training location, or engaged in off-site testing or traveling to and from the off-site testing location.
4. Training Program Supplies
   Cost incurred for supplies and materials used in conducting an approved training program.
5. Training Program Transportation
   Travel or transportation cost incurred by facility staff in conducting approved training program activity and testing, or for off-site nurse aide training and testing. Identify costs separately for training and student staff.
6. Outside Contracted Approved Nurse Aide Training Program
   - o Paid Directly By Facility - Costs incurred to obtain nurse aide training through an outside entity approved training program. Payment for subject training is made directly from the nursing facility to the training entity and the nurse aide trainees are employed by the nursing facility.
   - o Reimbursed To Employee Staff - Costs incurred to reimburse a facility employee who had personally paid for approved nurse aide training program participation prior to becoming an employee at the facility. Reasonable and necessary expenses incurred by the prospective employee through participation and completion of an Bureau of Health Systems approved training program, for which the aide has made payment, are eligible for remuneration. Only cost of tuition and books are reimbursed. The aide must be hired by a facility within 12 months after incurring this expense. The facility must obtain receipts and retain documentation from the employee to verify the expense.
7. Nurse Aide Testing Fees
   - o Paid Directly By Facility - Cost incurred for State-run testing. Payment for subject testing fees is made directly from the nursing facility to the testing authority for aides employed at the facility.
   - o Reimbursed To Employee Staff - Cost incurred to reimburse a facility employee who had personally paid for State-run testing prior to becoming an employee at the facility. The aide must be hired by a facility within 12 months after paying the testing fee. The facility must obtain receipt and retain documentation from the employee to verify the expense.
8. Other Training Program Costs
   Cost incurred that are not classified in the identified cost categories 1-7 explained above requires the completion of this section.

   Rental costs for space located off-site of the facility are reimbursable under training and testing only if the space is used solely for the training and testing program. Space costs not meeting this requirement are reimbursable within the plant cost component of Michigan's prospective reimbursement system. Reasonable rental expense for training equipment necessary to the approved training program is an eligible cost.

   Enter the detail description and cost of these individual expenses, in the yellow shaded cells. The total of these items will be automatically calculated by use of the F9 key.
9. Total Training Program Cost Before Equipment Allowance
   Subtotal of Lines 1 through 8b costs. This total will be automatically calculated by use of the F9 key.
10. Training Program Equipment Use Allowance
    An annual cost allowance is made for equipment purchased specifically for the Bureau of Health Systems approved nurse aide training program. Such equipment purchases are not included in the plant asset costs of the facility for routine nursing care. An annual allowance of 15% of the equipment purchase price is reported as a cost of the training program, for as long as the equipment is used in the program, but not to exceed seven years.

    The use allowance is an annual percentage, therefore an adjustment is made to the 15% amount if the cost report period differs from 12 months. Line 10.a. and Line 10.b. will automatically be calculated.
    Enter line 10.c. equipment purchase cost as required in the yellow shaded cells.

OCCUPATIONAL/PHYSICAL THERAPY – SPEECH PATHOLOGY
PRIOR APPROVAL – REQUEST/AUTHORIZATION

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

1. CONTROL NUMBER

NOTE: FOR INITIAL AND REVISED REPORT S ONLY, YOU **MUST** ATTACH A COPY OF THE INITIAL EVALUATION AND TREATMENT PLAN.

CONSULTANT USE ONLY

2. | 3. | 4.

5. PRIOR AUTHORIZATION NUMBER

6. TREATMENT SITE	7. TYPE	8. I.D. NUMBER	9. PROVIDER'S USE ONLY

10. ADDRESS (NUMBER, STREET, CITY STATE, ZIP)	11. PHONE NUMBER

12. RECIPIENT NAME (LAST, FIRST, MIDDLE INITIAL)	13. SEX	14. I.D. NUMBER	15. BIRTH DATE	16. ADM. DATE

17. DIAGNOSIS TO BE TREATED/EVALUATED	18. ONSET DATE

19. THERAPIST / PATHOLOGIST NAME (LAST, FIRST, MIDDLE INITIAL)	20. OFFICE PHONE NUMBER	21. LICENSE / CERTIFICATION NUMBER

22. TREATMENT AUTHORIZATION REQUEST	23. SERVICE GIVEN BY	24. TREATMENT MO..	25. DATE STARTED	26. LAST AUTH.	27. NO. SESSIONS
☐ INITIAL ☐ CONTINUING ☐ REVISED	☐ THERAPIST/ ☐ PATHOLOGIST ☐ ASST ☐ AIDE				

28. REHABILITATION POTENTIAL	29. LINE NO.	30. NUMBER PER MONTH	31. PROCEDURE CODE	32. CONSULTANT USE ONLY
33. GOALS	01			
	02			
ESTIMATED TIME	03			
34. PROGRESS NOTES/ DISCHARGE PLAN	04			
	05			
	06			

35. COMPLICATIONS CAUSING EXTENSION OF TREATMENT

36. PHYSICIAN CERTIFICATION

I certify, ☐ re-certify ☐ that I have examined the above named patient and have determined that therapy is necessary; that service will be furnished on an in/out-patient basis while the patient is under my care; that I approve the above treatment plan or evaluation and will review it every 30 days or more often if the patient's condition requires.

PHYSICIAN NAME (TYPE OR PRINT) | PHYSICIAN SIGNATURE | DATE

37 PROVIDER CERTIFICATION

The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and if approved, and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements, documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

PROVDIER SIGNATURE | DATE

CONSULTANT USE ONLY

38. CONSULTANT REMARKS

39. APPROVED AS	40. DISAPPROVED	41. CONSULTANT SIGNATURE	42. DATE	43. MONTH
PRESENTED ☐ **AMENDED** ☐	☐			

MSA-115 (02-03) AUTHORITY: Title XIX of the Social Security Act. COMPLETION: Is voluntary, but is required if payment from applicable programs is sought. The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

Completion Instructions for MSA-115
Occupational/Physical Therapy/Speech-Language Pathology
Prior Approval Request Authorization

General Instructions

MSA-115 is used by outpatient hospitals, nursing facilities and home health agencies to request PA for therapy services. MDCH requests that all PA forms be typewritten to facilitate processing. Fill-in enabled electronic copies of this form can be downloaded from the MDCH website (Refer to the Directory Appendix for website information). The request for PA must be complete and of adequate clarity to permit a determination of the appropriateness of the service without examination of the beneficiary.

PA may be authorized for a period not to exceed three months for outpatient hospitals or two months for home health agencies and nursing facilities. If continued treatment is necessary, a subsequent request for PA must be submitted. The provider should retain a copy of the PA form until the approval or disapproval is returned.

For complete information on covered services and PA requirements, refer to the Hospital, Nursing Facilities or Home Health Chapters.

Attachments/Additional Documentation

Any additional documentation submitted with the request must contain the beneficiary name and Medicaid identification (ID) number, provider name and address and the provider's Medicaid ID number.

When requesting the initial PA, the provider must attach a copy of the initial evaluation and written treatment plan to the PA request.

Form Completion

The following fields must be completed on the MSA-115 unless stated otherwise:

Box 1	A control number will be entered by MDCH for identification purposes. Do not fill in this item.
Box 2-4	These items are not to be completed by the provider. These items are for the consultant's use only and will be completed by MDCH upon review of the request.
Box 5	This is the prior authorization number issued by MDCH if all parts of the service are authorized. The provider must enter this number on the claim when submitting the charges for payment. If the service is not approved, no number will be assigned on the request.
Box 6-8	The provider's name, provider type code, and seven-digit identification number are used to identify the provider. The information should be taken directly from the Medical Assistance Enrollment Turn-Around Form, page 2.
Box 9	This item may be used by the provider to help identify the claim. The provider may enter its own reference number or the beneficiary's name, not to exceed 10 alpha or numeric characters, to correspond with their individual filing system.
Box 10-11	This is the provider's mailing address and telephone number (including area code) and must correspond with the treatment site.
Box 12-15	The beneficiary's name (last, first, and middle initial), sex (M or F), Medicaid ID number, and birth date (in the six-digit format: month, day, year) identifies the beneficiary. The information should be taken directly from the mihealth card and should be verified through the Michigan Eligibility Verification Systems.
Box 16	This is the date the beneficiary was most recently admitted to the hospital or facility.
Box 17	This is the diagnosis for which the beneficiary requires the requested service.
Box 18	The date of onset must be entered. The approximate date of exacerbation must be cited if the beneficiary has a chronic disease (e.g., arthritis) and recently suffered such exacerbation.

Box 19-21	This is the therapist's name, office telephone number (including area code), address, and certificate number.
Box 22	**Initial:** The treatment authorization request is the initial prior authorization request for this beneficiary under this treatment plan. **Continuing:** The treatment authorization request is to continue treatment for additional calendar month(s) of service under this treatment plan. **Revised:** The treatment authorization request is a revision of a previously authorized treatment plan.
Box 23	This is to indicate if the treatment is to be rendered by a therapist, therapy assistant, or therapy aide.
Box 24	The calendar months in which treatment is to be rendered, in a two-digit format (e.g., April should be shown as 04, April-May should be shown as 04, 05)
Box 25	If treatment has been initiated previously, this is the date treatment was started for the given diagnosis.
Box 26	This is the date MDCH signed the last approved prior authorization request for the given diagnosis.
Box 27	This is the total number of sessions rendered since the development of this treatment plan.
Box 28	This is the brief assessment of the beneficiary's rehabilitative potential and factors, which contribute to this determination (e.g., "good potential, patient's attitude is positive and persistent, progress depends upon the reduction of pain").
Box 29	Complete a separate line for each month of service requested even when the service is identified by the same HCPCS code each month.
Box 30	This is the number of times per month the service is to be provided.
Box 31	The Hospital, Nursing Facilities or Home Health Databases on the MDCH website list the HCPCS/Revenue Codes that describe covered services. (Refer to the Directory Appendix for website information.)
Box 32	The provider is not to complete this item. MDCH will use this area to indicate any amendments to approved services. The provider should always review this area to see if any changes are necessary for delivery of services and accurate billing.
Box 33	Goals must be measurable. In functional terms, this is the provider's expectation for the beneficiary's ultimate achievement and the length of time it will take (e.g., ambulation unassisted for 20 feet; able to dress self within 15 minutes; oral expression using 4-5 word phrases to express daily needs).
Box 34	This will include documentation of the beneficiary's progress from the prior month to the current time in reference to the measurable and functional goals stated in the treatment plan. Documentation of the beneficiary nursing and family education may be included. The final month of anticipated treatment should include the discharge plan for the carry-over of achieved goals to supportive personnel.
Box 35	This item must include any conditions, which might require an extension of services (e.g., decubitus ulcers, urological complications, or fractures).
Box 36	The attending physician must indicate if this is an initial certification or a recertification and sign the prior authorization form. The attending physician's signature is required each time a request is made unless a signed treatment plan is included with the request.
Box 37	The provider's certification is the signature of an authorized representative. The business office of a hospital may designate the director of the department providing the service as its representative. All unsigned requests will be returned for signature.

Box 38-43	These items are for the consultant's use only upon review of the request. The service will be approved by MDCH as presented, approved and amended, or disapproved. If all or part of the plan is authorized, a Prior Authorization Number will be assigned in Box 5.

Form Submission

PA request forms for all eligible Medicaid beneficiaries must be sent or faxed to the MDCH Prior Authorization Division. To check the status of a PA request, contact the MDCH Prior Authorization Division via telephone. (Refer to the Directory Appendix for contact information.)

PREADMISSION SCREENING (PAS) / ANNUAL RESIDENT REVIEW (ARR)

(Mental Illness / Developmental Disability Identification)

Michigan Department of Community Health

☐ **PAS**
☐ **ARR**
☐ **Significant Changes**

SECTION I – Patient, Guardian, and Agency Information:

Patient Name (First, MI, Last)			Date of Birth (M,D,Y)	Gender ☐ **Male** ☐ **Female**
Address (Number and Street)			County of Residence	Social Security Number
City	State	ZIP Code	MEDICAID Beneficiary ID Number	MEDICARE ID Number
Does this patient have a court-appointed guardian or other legal representative? ☐ **NO** ☐ **YES** ▶			If YES, Give Name of Guardian or Legal Representative	
County in which the Guardian was Appointed			Address (Number, Street, Apt. Number or Suite Number)	
Guardian or Legal Representative Telephone Number ( ) –			City	State / ZIP Code
Referring Agency Name			Telephone Number ( ) –	Admission Date (Actual or Proposed)
Nursing Facility Name (Proposed or Actual)			County Name	
Facility Address (Number and Street)			City	State / ZIP Code

INSTRUCTIONS:

- Sections II & III of this form must be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or a physician.
- Answer **ALL SIX (6)** items below.
- The person screened shall be determined to require a comprehensive **Level II OBRA** screening if any of the items 1 thru 6 are answered "YES" **UNLESS** a physician certifies on form DCH-3878 that the person meets at least one of the exemption criteria.
- If you check "YES" to items 1 and/or 2 in **Section II** below, circle the word "**mental illness**" or "**dementia**".

SECTION II – Screening Criteria: *(See the copy distribution in the Instructions.)*

1. ☐ NO ☐ YES ..... The person has a current diagnosis of MENTAL ILLNESS or DEMENTIA. ***(Circle One)***
2. ☐ NO ☐ YES ..... The person has received treatment for MENTAL ILLNESS or DEMENTIA within the past 24 months. ***(Circle One).***
3. ☐ NO ☐ YES ..... The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days.
4. ☐ NO ☐ YES ..... There is presenting evidence of mental illness or dementia including significant disturbances in thought, conduct, emotions, or judgment.
5. ☐ NO ☐ YES ..... The person has a diagnosis of a developmental disability including, but not limited to, mental retardation, epilepsy, autism, or cerebral palsy.
6. ☐ NO ☐ YES ..... There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have mental retardation or a related condition.

Explain any "YES"

SECTION III – CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate.

Clinician Signature Date			Name (Typed or Printed)	
			Degree / License	
Address (Number, Street, Apt. Number or Suite Number)				
City	State	ZIP Code	Telephone Number ( ) –	

DCH-3877 (06/03) Replaces form MSA-3877, which is obsolete.

Instructions for completing form DCH-3877
Mental Illness / Developmental Disability Identification Criteria

LEVEL I SCREENING: Completing the DCH-3877

The DCH-3877 is used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or developmental disability and who may be in need of mental health services. This form must be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or physician.

Preadmission Screening: The DCH-3877 must be completed by hospitals as part of the discharge planning process or by physicians seeking to admit an individual to a nursing facility from other than an acute care setting. **Check the PAS box.**

Annual resident review: The DCH-3877 must be completed by the nursing facility. **Check the ARR box.**

1. **Mental Illness:** A current primary diagnosis of a mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV).
   Current Diagnosis means that a physician has established a diagnosis of a mental disorder within the past 24 months. Do NOT mark "YES" for an individual cited as having a diagnosis "by history" only.
2. **Receipt of treatment for mental illness or dementia within the past 24 months** means any of the following: inpatient psychiatric hospitalization; outpatient services such as psychotherapy, day program, or mental health case management; or referral for psychiatric consultation, evaluation, or prescription of psychopharmacological medications.
3. **Antidepressant and antipsychotic medications** mean any currently prescribed medication classified as an antidepressant or antipsychotic, plus Lithium Carbonate and Lithium Citrate.
4. **Presenting evidence** means the individual currently manifests symptoms of mental illness or dementia, which suggest the need for further evaluation to establish causal factors, diagnosis and treatment recommendations.
5. **Developmental Disability:** An individual is considered to have a severe, chronic disability that meets **ALL** four of the following conditions:
   a) It is manifested before the person reaches **age 22**.
   b) It is likely to continue indefinitely.
   c) It results in substantial functional limitations in **three or more** of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.
   d) It is attributable to:
      - mental retardation such that the person has significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period;
      - cerebral palsy, epilepsy, autism; or
      - any condition other than mental illness found to be closely related to mental retardation because this condition results in impairment in general intellectual functioning OR adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons.

6. **Presenting evidence** means the individual manifests deficits in intellectual functioning or adaptive behavior, which suggests the need for further evaluation to determine presence of a developmental disability, causal factors, and treatment recommendations.

NOTE: When there are one or more "YES" answers to questions 1 – 6 under SECTION II, a DCH-3878 must be completed only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or exempted hospital discharge.

AUTHORITY:	P.A. 280 of 1939	The Department of Community Health is an equal opportunity employer, services, and programs provider.
COMPLETION:	Is Voluntary, but is required if Medical Assistance program payment is desired.	

DISTRIBUTION:

If any answer to questions 1 – 6 in SECTION II is "YES," do the following:

- Send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested.
- The nursing facility must retain the original in the patient record and see that a copy goes to the patient or authorized patient representative.

PRIOR AUTHORIZATION FOR PRIVATE DUTY NURSING (PDN)

CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)

Instructions for MSA-0732

The Medicaid Program has developed the Prior Authorization for Private Duty Nursing (PDN) form (MSA-0732). This form is to be used for persons with CSHCS or Medicaid coverage, except those beneficiaries enrolled in, or receiving case management services from, the Children's Waiver, Habilitation Supports Waiver, or MI Choice Waiver.

The MSA-0732 may be completed by community-based medical personnel (e.g., hospital discharge planner, private duty nursing provider, etc.).

Providers are not to submit form CMS 485 with the authorization form.

If services are approved, the provider will receive an authorization letter. For continued authorization, the provider must submit the MSA-0732 and required documentation within 15 days prior to the end date of the current authorization. The required documentation includes medical reports that support the need for private duty nursing as identified on the authorization form; a proposed 24-hour nursing plan of care at the end of the initial 30 days and for each 90-day interval. For each re-authorization, two recent seven-day periods of nursing notes must be submitted that demonstrate the beneficiary's current clinical need for private duty nursing.

Physician and Parent/Guardian signatures on the MSA-0732 are required on an annual basis and when the plan of care is updated as needed based on the beneficiary's needs.

If there are no changes to items on pages 2 and 3, note "No Changes" in the applicable item. The MSA-0732 must be completed in its entirety annually and when changes occur.

Note: The purpose of the PDN benefit is to assist the beneficiary with medical care, enabling the beneficiary to remain in their home. The benefit is not intended to supplant the care giving responsibility of parents, guardians, or other responsible parties (e.g., foster parents). There must be a primary care giver (i.e., parent, guardian, significant other adult) who resides with a beneficiary under the age of 18 and the care giver must provide a monthly average of a minimum of eight hours of care during a typical 24-hour period.

Providers may download the form off the MDCH website at www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Medicaid Provider Forms and Other Resources. .

The completed MSA-0732 may be mailed or faxed to:

Michigan Department of Community Health
Program Review Division
P.O. Box 30170
Lansing, MI 48909

Fax: (517) 241-7813

Questions should be directed to 1-800-622-0276.

PRIOR AUTHORIZATION FOR PRIVATE DUTY NURSING (PDN)

CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)

BENEFICIARY INFORMATION:

1. LAST NAME	2. FIRST NAME			3. M.I.	4. MEDICAID I.D. #
5. STREET ADDRESS (APT., ETC.)				6. SEX	7. DATE OF BIRTH
8. CITY	9. STATE MI	10. ZIP -	11. COUNTY		12. PHONE NUMBER ( ) -

MEDICAL CARE/TREATMENT AND CLINICAL INFORMATION RELEVANT FOR MEDICAID COVERED PDN:

13. Medical documentation must be attached or documented below (14.) to support the intensity of care required, as well as to provide additional clinical information to support the need for coverage of PDN. The referring physician or appropriate subspecialist must complete the following information:

Name of Physician Ordering PDN: _____

Address of Physician: _____

I certify that this information, with attachments, clearly identifies the current treatment and service needs of the beneficiary. The plan submitted indicates that PDN is medically necessary, as defined in Medicaid policy. I will manage the PDN for the beneficiary, including annual review of the home care plan, or delegate the responsibility to:

Name of Physician: _____

14. IF NOT ATTACHING DOCUMENTS, EXPLAIN BELOW WHY THE BENEFICIARY REQUIRES CARE BY A LICENSED NURSE:

15. Physician Signature:	16. Phone: ( ) -	17. DATE:

Note: Physician signature required annually and when the plan of care is updated based on the beneficiary's needs.

18. WHAT ARE THE SKILLED NURSING CARE NEEDS OF THE BENEFICIARY? LIST ALL ASSESSMENTS, JUDGMENTS AND INTERVENTIONS REQUIRED, WITH A STATEMENT OF EXPECTED FREQUENCY OF NEED. ATTACH PROPOSED 24-HOUR NURSING PLAN OF CARE TO BE RENDERED IN THE HOME AND TWO RECENT SEVEN-DAY PERIODS OF NURSING NOTES.

BENEFICIARY'S LAST NAME	FIRST NAME	MEDICAID ID #

HOME ENVIRONMENT:

19. NUMBER OF SIBLINGS: _____

20. NUMBER OF OTHER INDIVIDUALS IN THE HOME: _____

21. NUMBER OF CARE GIVERS: _____

22. NUMBER OF CARE GIVERS WHO WORK OR ATTEND SCHOOL OUTSIDE OF THE HOME: _____

23. CARE GIVER'S NAME: _____ NO. OF HRS/DAYS WORKING: _____

CARE GIVER'S NAME: _____ NO. OF HRS/DAYS WORKING: _____

24. CAN PDN BE SAFELY PROVIDED IN A HOME SETTING? YES ☐ NO ☐

25. PERSON/AGENCY MANAGING THE PDN PLAN: _____

SCHOOL:

26. IS BENEFICIARY CURRENTLY IN SCHOOL? YES ☐ NO ☐ IF YES, HOW MANY HOURS? _____ PER DAY _____ PER WEEK (INCLUDING TRAVEL TIME)

HOSPITALIZATION:

27. IS BENEFICIARY CURRENTLY HOSPITALIZED? YES ☐ NO ☐

IF YES, ANTICIPATED DISCHARGE DATE: __/__/____

NAME OF HOSPITAL: _____

NAME OF DISCHARGE COORDINATOR: _____

28. HOSPITAL TO BE USED IN THE FUTURE: _____

29. PHYSICIAN'S NAME COORDINATING BENEFICIARY'S DISCHARGE: _____

PHYSICIAN'S TELEPHONE:

PHYSICIAN'S ☐ PAGER OR ☐ CELL OR ☐ FAX:

PHYSICIAN'S E-MAIL ADDRESS:

30. PHYSICIAN'S NAME COORDINATING CARE IN THE COMMUNITY: _____

PHYSICIAN'S TELEPHONE:

PHYSICIAN'S ☐ PAGER OR ☐ CELL OR ☐ FAX:

PHYSICIAN'S E-MAIL ADDRESS:

HEALTH INSURANCE/OTHER PUBLICLY FUNDED PROGRAMS:

31. NAME OF PRIVATE HEALTH INSURANCE: _____

PRIVATE HEALTH INSURANCE POLICY NUMBER: _____

32. NAME OF OTHER PUBLICLY FUNDED PROGRAMS THAT THE BENEFICIARY IS BEING SERVED UNDER: _____

PARENT/GUARDIAN REQUEST AND AGREEMENT:

33. NUMBER OF PDN HOURS PER DAY REQUESTED BY FAMILY: _____

34. I AM APPLYING FOR PRIVATE DUTY NURSING FOR _____.

I agree to the release of information from this PDN application and supporting proof in order to evaluate and verify PDN eligibility. I agree that the Department of Community Health (DCH) or Department of Human Services (DHS) may use or disclose necessary medical information about me or my children, including any mental health, substance abuse, HIV, ARC, or AIDS information, to determine eligibility for a specific program or for treatment, payment, health care operations, or other administrative purposes. I understand that these agencies will maintain confidentiality according to the Health Insurance Portability and Accountability Act, 45 CFR 164.102 – 164.534, and any other applicable federal and state laws and regulations. This consent is valid for 3 years from the date this application is signed. I understand that I am obligated to participate in the daily provisions of care and that my child must maintain Medicaid eligibility for this benefit.

Parent/Guardian Signature: _____ Date: _____

Note: Parent/Guardian signature is required annually and when substantive changes are made to the plan of care.

BENEFICIARY'S LAST NAME	FIRST NAME	MEDICAID ID #

PROVIDER INFORMATION: (NAME OF MEDICAID ENROLLED PRIVATE DUTY NURSING AGENCY, R.N., OR SUPERVISING R.N. FOR THE MEDICAID ENROLLED LPN WHO WILL PROVIDE SERVICE.)

35. PROVIDER #1: START OF SERVICE DATE: ___/___/_____

Provider Name: _____

Street Address: _____

_____

City: _____ State: __ Zip _____ - ____

Medicaid Provider ID Number: _____ Provider Phone Number: (___)____-____

PDN Provider Signature: _____

36. PROVIDER #2: START OF SERVICE DATE: ___/___/_____

Provider Name: _____

Street Address: _____

_____

City: _____ State: __ Zip _____ - ____

Medicaid Provider ID Number: _____ Provider Phone Number: (___)____-____

PDN Provider Signature: _____

37. Medical Supplier/DME Name: _____

Provider Phone Number: (___)____-____

MDCH CONSULTANT USE ONLY

☐ APPROVED ☐ AMENDED ☐ DENIED ☐ PENDED

Comment:_____ _____

For Number of Hours Per Day: _____ From: ___/___/_____ To: ___/___/_____

MDCH AUTHORIZED SIGNATURE:

_____ DATE: _____

_____ DATE: _____

Provision of Low Vision Services and Aids
Support Documentation

To facilitate processing of your request for low vision services and aids, this form must be completed. Failure to provide complete documentation will result in automatic disapproval of your request. Do not use abbreviations as their use may result in misinterpretation and possible disapproval. A Version Services/Order form (DCH-0893) must accompany this documentation. (Exception: High add bifocals do not require prior approval; hence, a completed DCH-0893 should be sent directly to the State's vision contractor.)

Beneficiary's Name _____ **Medicaid ID Number** _____

Based on the Low Vision Evaluation provide the following information:

A. HISTORY

1. History of onset of low vision (including, but not limited to, onset, duration, etiology, and any ocular surgery):

_____

_____

_____

_____

_____

2. Present spectacle correction:

R _____ **VA** _____ **ADD** _____ **VA** _____

L _____ **VA** _____ **ADD** _____ **VA** _____

3. Contact Lenses: (If worn)

Power R _____ **Type R** _____

Power L _____ **Type L** _____

4. Low vision aids presently in use:

Magnifiers: _____ Electronic Projection Magnifier: _____

Microscopics: _____

Telescopics: _____ Filers/typoscopes/visors: _____

Loupes: _____ Other: _____

5. Relevant Systemic Conditions:

_____

_____

_____

_____

_____

B. BENEFICIARY'S GOALS

_____

_____

_____

_____

_____

C. SUMMARY FINDINGS

1. Ocular Diagnosis(es):
   R _____ **L** _____

2. Vision Impairment Diagnosis:
   R _____ **L** _____

3. Nature and Extent of Visual Fields:

   _____

   _____

4. Specifications of best conventional spectacle correction:

At distance	**R**	_____	**VA**	_____
	L	_____	**VA**	_____
At near	**R**	_____	**VA**	_____
	L	_____	**VA**	_____

D. RECOMMENDED TREATMENT

1. No treatment at this time. Follow-up for monitoring (check one):

   ☐ 3 Months ☐ 6 Months ☐ 9 Months ☐ 12 Months

2. Referral for medical and/or surgical treatment:

   _____

   _____

3. Description of Recommended Low Vision Aids:

A. VA **R** _____ **L** _____ Description, manufacturer and catalog number _____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

B. VA **R** _____ **L** _____ Description, manufacturer and catalog number _____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

C. VA **R** _____ **L** _____ Description, manufacturer and catalog number _____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

E. OTHER RECOMMENDATIONS – DESCRIBE BENEFITS

_____

_____

_____

_____

_____

F. PROGNOSIS

_____

_____

_____

_____

Signature of Examiner _____

Examiner (Print)_____ **Date**_____

RECIPIENT VERIFICATION OF COVERAGE

Michigan Department of Community Health

Medical Services Administration

I understand that Medicaid only covers payment for elective abortions under limited circumstances.

These are:

- ☐ Elective abortion to terminate a pregnancy to save the life of the mother,
- ☐ Elective abortion to terminate a pregnancy that was the result of rape, or
- ☐ Elective abortion to terminate a pregnancy that was the result of incest.

I certify that I am eligible for Medicaid coverage for an elective abortion based upon the circumstance(s) that I have checked above. I understand that if I have given false information to obtain coverage for an elective abortion I can be prosecuted for fraud. I also understand that a copy of this verification will be sent to the local Family Independence Agency office or to a police agency when appropriate.

Recipient Name (typed or printed)			Signature of Recipient	
Recipient Address				
City	State	ZIP Code	Date Signed	Medicaid Recipient ID No.

WITNESSED BY:

Witness Name (printed)			Witness Signature
Witness Address			
City	State	ZIP Code	Date Signed

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Family Independence Agency office in your county.

Authority: Title XIX of the Social Security Act
Completion: Is Voluntary, but is required if payment from the Medicaid program is sought.

MSA-1550 (Rev. 5-97) Previous edition may be used

REQUEST FOR PRIOR AUTHORIZATION FOR A COMPLEX CARE
Memorandum Of Understanding
Nursing Facility
and
Michigan Department of Community Health

Complete this request with specific information. Include current documentation regarding the beneficiary's medical condition and any other information you feel will support this request for reimbursement.

FAX TO: MDCH-Program Review Division at **(517) 241-7813**

Client/Beneficiary Name	**Nursing Facility Name**
Beneficiary ID Number	**Nursing Facility Street Address**
Admission Date	**Nursing Facility City, State and Zip**
Effective Date of Current CCMOU	**Provider Contact Name**
Nursing Facility Provider ID Number	**Provider Contact Phone Number** ( ) -

List the average number of nursing hours and supplies, vent, etc. required for this beneficiary's care that EXCEED the standard level of care and the corresponding rate of pay. *Attach additional information if necessary.*

Excess Nursing Hours	Charges Per Hour/Day	Total
RN _____ Hours Per Day	$ _____ Per hour	$ _____
LPN _____ Hours Per Day	$ _____ Per hour	$ _____
Aide _____ Hours Per Day	$ _____ Per hour	$ _____
Excess Daily Supplies		
Medical Supplies (e.g., vent)	$ _____ Per day	$ _____
TOTAL		$ _____

Provider Certification

The patient named above understands the necessity of prior approval for the increase in reimbursement. I understand the increase in reimbursement for the above charges requires prior authorization and, if approved and submitted on the appropriate invoice, payment and satisfaction of the approved services will be from Federal and State funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable Federal or State laws. I understand the information provided is to be held in confidence and not divulged without consent of the beneficiary.

Provider Signature Fax Number Date

MDCH USE ONLY:

Prior Authorization Number

APPROVED	DENIED
☐ As Presented ☐ As Amended	☐

Start Date	End Date	Units – Number of Days	Total Daily MOU Rate
			$

MDCH Signature Date

Authority: Title XIX of Social Security Act

The Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.

MSA-1576 (03-06) - Previous editions may be used.

"SAMPLE"
NOTICE OF NON-COVERAGE

(Hospital Letterhead)

(Name of Patient) (Date of Notice)
(Address)
(City, State, Zip)

(Medical Record Number)
(Beneficiary Medicaid Number)
(Attending Physician's Name)
(Admission Date – *if applicable*)

Subject: NOTICE OF NON-COVERAGE FOR INPATIENT HOSPITAL ADMISSION

Dear (Name of Patient):

As a Medicaid beneficiary, it is important for you to understand that there are circumstances when Medicaid does not pay for hospital care or inpatient services provided in the hospital. Medicaid pays for hospital care when the services are medically necessary and delivered in the most appropriate setting.

NOTICE OF NON-COVERAGE

(Name of Hospital) Utilization Review (UR) Committee has reviewed your physician's request for your hospital admission. The request has been denied. The hospital's UR Committee has determined that your admission to (Name of Hospital) for treatment of (Specify services or condition) is either: 1) not medically necessary, or 2) that the medical services you may require for the treatment of your condition can be safely rendered in another less costly setting. You should discuss arrangements for any health care treatment you may require with your physician.

APPEAL RIGHTS

The Michigan Peer Review Organization (MPRO) is the review organization authorized by the Medicaid Program to review on behalf of the patient or his/her physician any hospital care denied to Medicaid patients in the State of Michigan.

If you disagree with this decision, you or your representative must request an immediate review by MPRO. You must request this review by calling:

Michigan Peer Review Organization
Attention: Medicaid PACER Program
22670 Haggerty Road, Suite 100
Farmington Hills, MI 48335-2611
Telephone: 1-800-727-7223

If MPRO confirms the hospital's initial decision, you will be notified in writing of its decision. If you decide to proceed with the admission to the hospital, you will be responsible for the payment of all services provided to you by the hospital beginning with the date of admission.
If MPRO overturns the hospital's decision, you will also be notified in writing of MPRO's decision. The hospital will contact your physician and make arrangements for your admission to the hospital. Medicaid will cover the cost of your hospital stay except for the payment of any deductible, coinsurance, or convenience services or items not covered by Medicaid.

SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION

Michigan Department of Community Health

1. CONTROL NUMBER

NOTE: APPROVAL REFERS TO SERVICE AND DOES NOT GUARANTEE RECIPIENT ELIGIBILITY.

CONSULTANT USE ONLY

2. 3. 4. 5. 6. 7. 8. 9. 10.

11. PRIOR AUTHORIZATION NO.

12. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIATL)	13. TYPE	14. ID NUMBER	15. PROVIDER USE ONLY
16. PROVIDER'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)			17. PHONE NUMBER
18. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIATL)	19. SEX	20. ID NUMBER	21. BIRTH DATE / 22. COUNTY
23. RECIPIENT'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)			24. DOES PATIENT RESIDE IN A NURSING CARE FACILITY? ☐ YES ☐ NO
25. REFERRING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL)	26. TYPE	27. ID NUMBER	28. PHONE NUMBER
29. REFERRING PHYSICIAN'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)			

30. LINE NO.	31. DESCRIPTION OF SERVICE (INCLUDE BRAND NAME AND MODEL NUMBER WHERE APPLICABLE)	32. PROCEDURE CODE	33. QUANTITY	34. CHARGE	35. MODIFIER
01					
02					
03					
04					
05					

36. PRIMARY DIAGNOSIS DESCRIPTION AND PRESCRIPTION (QUOTE PHYSICIAN ORDER)	37. REMARKS AND/ OR DOCUMENTATION OF MEDICAL NECESSITY

38. INDICATE ANY OTHER SERVICES PROVIDED TO THIS RECIPIENT DURING THE PAST YEAR

39. PROVIDER CERTIFICATION: The patient named above (parent if minor or authorized representative) understands the necessity to request prior approval for the services indicated in item 31. I understand the services requested herein require prior approval and if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State law.

PROVIDER SIGNATURE _____ DATE _____

CONSULTANT USE ONLY

40.	41.	42.
APPROVED AS:	DISAPPROVED ☐	
PRESENTED ☐	NO ACTION ☐	
AMENDED ☐	INSUFF. DATA ☐	CONSULTANT SIGNATURE _____ DATE _____

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

MSA-1653-B (04-03) PREVIOUS EDITION MAY BE USED

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

Prior Approval Request/Authorization Form Completion Instructions

The Special Services Prior Approval-Request/Authorization (MSA-1653B) is utilized by Medical Suppliers, DME Providers, Orthotists, Prosthetists, Hearing Aid Dealers and Hearing and Speech Centers. The form is generally self-explanatory. . Completion of boxes 12 through 39 is mandatory. For complete information on required modifiers, documentation, and appropriate quantity amounts, please refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters.
- Billing & Reimbursement for Professionals Chapter of this manual.
- Provider-specific Databases on the MDCH website.

Box 1-11	MDCH Use Only
Box 24	Check Yes if beneficiary is in NF or No if the beneficiary is not in an NF. Provide NF Address and Phone Number in Box 37
Box 31	Enter a complete description of the item, including manufacturer, model, style, etc. requested..
Box 32	Enter the HCPCS Procedure Code
Box 35	Enter the applicable HCPCS Modifier
Box 36	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). Provider Types 85 and 87 must submit the prescription/CMN with this form.
Box 37	Any additional remarks regarding the request should be listed in this box such as NF Name, Address, and Phone Number, verbal authorization date, retroactive date of service if being requested, etc.

See the Directory Appendix for form submission contact information.

Michigan Department of Community Health

VISION SERVICES APPROVAL / ORDER

For MDCH Consultant Use Only

1. Prior Authorization Number

2 | 3 | 4 | 5 | 6

NOTE: Approval refers to services and does NOT guarantee beneficiary eligibility.

7. **Provider** Name (Last, First, Middle Initial)			9. Phone No. ( )	10. Provider ID Number
8. Address (No. & Street, Suite, Lot, etc.)			11. Provider Signature	12. Provider Type
City	State	ZIP Code		13. Date of Order
14. **Beneficiary** Name (Last, First, Middle Initial)			16. Sex ☐ **FEMALE** ☐ **MALE**	
15. Address (No. & Street, Apt. No., etc.)			17. Birth Date	18. Beneficiary ID Number
City	State	ZIP Code	19. Diagnosis:	

	20. DESCRIPTION OF SERVICE(S)	R	L	21. PROC. CODE	22. QUANTITY	23. CHARGE
01	Spectacle Lens(es)	☐	☐			
02	Frame	☐	☐			
03		☐	☐			
04		☐	☐			
05		☐	☐			
06		☐	☐			
07		☐	☐			

24. Reason: ***Note:*** *If prior authorization is required, attach documentation of medical necessity pursuant to Medicaid Vision Manual.*

☐ **INITIAL GLASSES** ☐ **REPLACEMENT** ☐ **DIOPTER CHANGE**

25. Lens Type:

☐ **PLASTIC** ☐ **GLASS** ☐ **POLYCARBONATE** ☐ **LENS(ES) ONLY** ☐ **FRAME ONLY**

26. Lens Style:

☐ **SINGLE VISION** ☐ **BIFOCAL** ☐ **TRIFOCAL** ☐ **HI INDEX** ☐ **CATARACT**

27. Frame Name		Manufacturer	
Color	Eye Size	Bridge Size	Temple Style & Length

LENS SPECIFICATIONS

28.	SPHERE	CYLINDER	AXIS	PRISM POWER & BASE DIRECTION	MRP HORIZONTAL	MRP HEIGHT
R						
L						

	ADD	SEGMENT HEIGHT	WIDTH & STYLE	SEGMENT INSET	TOTAL INSET	PD
R						Far:
L						Near:

29. Special Instructions to Laboratory:

PREVIOUS LENS SPECIFICATIONS

30.	SPHERE	CYLINDER	AXIS	ADD	PRISM / DIRECTION	LENS STYLE
R						
L						

31. ***For MDCH Consultant Use Only***

☐ **Approved** ☐ **Disapproved -** Exceeds Frequency ☐ **No Action**

☐ **Amended** ☐ **Disapproved -** Criteria Not Met ☐ **Insufficient Documentation**

Initials and Date

Authority: Title XIX of the Social Security Act
Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.

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