

**ATTACHMENT II**  
**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  
MRI Referring Doctor Definitions And Prefix Codes  
12/18/2009

COUNTY OF RESIDENCE

<u>CODE</u>	<u>COUNTY</u>	<u>CODE</u>	<u>COUNTY</u>	<u>CODE</u>	<u>COUNTY</u>
01 =	Alcona	30 =	Hillsdale	59 =	Montcalm
02 =	Alger	31 =	Houghton	60 =	Montmorency
03 =	Allegan	32 =	Huron	61 =	Muskegon
04 =	Alpena	33 =	Ingham	62 =	Newaygo
05 =	Antrim	34 =	Ionia	63 =	Oakland
06 =	Arenac	35 =	Iosco	64 =	Oceana
07 =	Baraga	36 =	Iron	65 =	Ogemaw
08 =	Barry	37 =	Isabella	66 =	Ontonagon
09 =	Bay	38 =	Jackson	67 =	Osceola
10 =	Benzie	39 =	Kalamazoo	68 =	Oscoda
11 =	Berrien	40 =	Kalkaska	69 =	Otsego
12 =	Branch	41 =	Kent	70 =	Ottawa
13 =	Calhoun	42 =	Keweenaw	71 =	Presque Isle
14 =	Cass	43 =	Lake	72 =	Roscommon
15 =	Charlevoix	44 =	Lapeer	73 =	Saginaw
16 =	Cheboygan	45 =	Leelanau	74 =	St. Clair
17 =	Chippewa	46 =	Lenawee	75 =	St. Joseph
18 =	Clare	47 =	Livingston	76 =	Sanilac
19 =	Clinton	48 =	Luce	77 =	Schoolcraft
20 =	Crawford	49 =	Mackinac	78 =	Shiawassee
21 =	Delta	50 =	Macomb	79 =	Tuscola
22 =	Dickinson	51 =	Manistee	80 =	Van Buren
23 =	Eaton	52 =	Marquette	81 =	Washtenaw
24 =	Emmet	53 =	Mason	82 =	Wayne
25 =	Genesee	54 =	Mecosta	83 =	Wexford
26 =	Gladwin	55 =	Menominee	90 =	Indiana
27 =	Gogebic	56 =	Midland	91 =	Ohio
28 =	Gd. Traverse	57 =	Missaukee	92 =	Wisconsin
29 =	Gratiot	58 =	Monroe	99 =	All Other

Definition of "INPATIENT/OUTPATIENT"

"Inpatient" means an MRI visit involving an individual who has been admitted to the licensed hospital at the site of the MRI service/unit, or in the case of an MRI unit that is not located at that licensed hospital site, an admitted patient transported from a licensed hospital site by ambulance to the MRI service.

"Outpatient" means an MRI visit not involving an "Inpatient."

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Definitions

1. **“REFERRING DOCTOR,”** IS DEFINED TO MEAN THE DOCTOR OF RECORD WHO ORDERED THE MRI PROCEDURE(S) AND EITHER TO WHOM THE PRIMARY REPORT OF THE RESULTS OF AN MRI PROCEDURE(S) IS SENT, OR IN THE CASE OF A TEACHING FACILITY, THE ATTENDING DOCTOR WHO IS RESPONSIBLE FOR THE HOUSE OFFICER OR RESIDENT THAT REQUESTED THE MRI PROCEDURE(S).
2. **“DOCTOR”** IS DEFINED TO MEAN AN INDIVIDUAL LICENSED UNDER ARTICLE 15 OF THE CODE TO ENGAGE IN THE PRACTICE OF MEDICINE, OSTEOPATHIC MEDICINE AND SURGERY, CHIROPRACTIC, DENTISTRY, OR PODIATRY.

Prefix Codes

Michigan Doctors are assigned the following four digit prefix codes by the Michigan Department of Community Health:

<u>Doctor Type</u>	<u>Code</u>
Chiropractor	2301
Dentist	2901
Medical Doctor	4301
Osteopath	5101
Podiatrist	5901

The “Referring Doctor” license number for each non-Michigan “Doctor” must be entered. If the non-Michigan license number is shorter than 10 characters (defined in Attachment III), then right justify the number/characters and zero fill the start of the field. If the non-Michigan license number is longer than 10 characters, enter only the right-most 10 characters.

For the variable “State of Referral Doctor,” enter a “1” (one) for a Michigan doctor or a “2” (two) for a non-Michigan doctor.

**MAGNETIC RESONANCE IMAGING PROCEDURE**

"MRI procedure" means a procedure conducted by an MRI unit approved pursuant to sections 3, 4, 5, 6, 7, 8 or 10 of these standards which is either a single, **billable diagnostic magnetic resonance procedure** or a procedure conducted by an MRI unit at a site participating with an approved diagnostic radiology residency program, under a research protocol approved by an institutional review board. The capital and operating costs related to the research use are charged to a specific research account and not charged to or collected from third-party payors or patients. The term does not include a procedure conducted by an MRI unit approved pursuant to Section 9(1).

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**SCAN REGION**

The "1<sup>st</sup> Scan Region" must always have a non-zero value entered. After the "Scan Region" value for the last attempted scan has been entered – enter a "0" in the remaining "Scan Region" fields. Leave the remaining "Sedation/Special Needs Patient," "Scan Contrast Media Used," and "Scan Completed" fields BLANK.

<u>CODE</u>	<u>REGION</u>
0	= No Scan
1	= Head
2	= Cervical Spine
3	= Thoracic Spine
4	= Lumbar Spine
5	= Chest
6	= Upper Abdomen
7	= Pelvis
8	= Extremities
9	= Other
A	= Head/Neck Angio
B	= Chest/Heart Angio
C	= Extremity Angio
D	= Abd./Pelvis Angio
E	= Breast
X	= *Intra-Operative
Y	= *Diagnostic

- **\*NOTE:** To be used only by Intra-operative MRI approved service.

Definition of "SEDATED/RE-SEDATED/SPECIAL NEEDS PATIENT"

**"Sedated patient"** means a patient that meets all of the following:

- (i) whose level of consciousness is either conscious-sedation or a higher level of sedation, as defined by the American Association of Anesthesiologists, the American Academy of Pediatrics, the Joint Commission on the Accreditation of Health Care Organizations, or an equivalent definition.
- (ii) who is monitored by mechanical devices while in the magnet.
- (iii) who requires observation while in the magnet by personnel, other than employees routinely assigned to the MRI unit, who are trained in cardiopulmonary resuscitation (CPR).

**"Special needs patient"** means a non-sedated patient, either pediatric or adult, with any of the following conditions: down syndrome, autism, attention deficit hyperactivity disorder (ADHD), developmental delay, malformation syndromes, hunter's syndrome, multi-system disorders, psychiatric disorders, and other conditions that make the patient unable to comply with the positional requirements of the exam.

**"Re-sedated patient"** means a patient, either pediatric or adult, who fails the initial sedation during the scan time and must be extracted from the unit to rescue the patient with additional sedation.

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EXPECTED SOURCE OF PAYMENT

<u>CODE</u>	<u>PAY SOURCE</u>
01	= Medicare
02	= Medicaid
07	= All Other Insurance & Research
08	= Self Pay (Partial or Full)
11	= No Charge

“NO CHARGE” means an MRI visit where the patient is not charged a fee for the visit by the MRI service. This does not include inpatient or other visits where the MRI visit is included in a larger fee being paid by a third part payer such as a DRG (Diagnosis-Related Group) payment.