MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 20-71

Distribution: All Providers

Issued: December 1, 2020

Subject: Updates to the Medicaid Provider Manual; Disposable Hearing Aid Battery Prescription Clarification

Effective: January 1, 2021

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Children's Waiver, Maternity Outpatient Medical Services, MI Choice Waiver

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the January 2021 quarterly update of the MDHHS Medicaid Provider Manual. The Manual is maintained on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual. A compact disc (CD) version of the manual is available to enrolled providers upon request.

The January 2021 version of the manual does not highlight changes made in 2020. Refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Subsequent changes made for the April, July, and October 2021 versions of the manual will be highlighted within the text of the on-line manual.

Disposable Hearing Aid Battery Prescription Clarification

Disposable hearing aid batteries must be ordered by a Medicaid-enrolled physician or qualified non-physician medical practitioner (e.g., physician assistant, nurse practitioner, clinical nurse specialist). The dispensing supplier may require a written prescription from the prescribing provider. The prescription must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner’s name, address, and telephone number;
- Prescribing practitioner’s signature;
- Date the prescription was written;
- Description of the item prescribed, including the battery size;
- Quantity to be dispensed and number of applicable refills. Providers should note the item maximums when determining these amounts; and
- Diagnosis supporting the medical necessity of the item.

Prescriptions are valid for one year from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription.

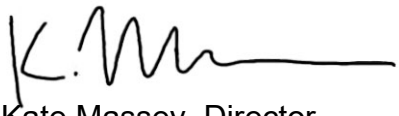
Manual Maintenance

If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms, this bulletin and those referenced in this bulletin may be discarded. If using a CD version of the manual, providers should retain all bulletins issued since the version date of the CD. Providers are encouraged to use the MDHHS Medicaid Provider Manual on the MDHHS website; the online version of the manual is updated on a quarterly basis.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit a question, be sure to include your name, affiliation, NPI number and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

Approved



Kate Massey, Director
Medical Services Administration

Medicaid Provider Manual
January 2021 Updates
TECHNICAL CHANGES

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.2 Program Enrollment Type (PET) Codes (new subsection)	New subsection added. 2.2 Patient Pay Information was re-numbered as 2.3	Update.
Beneficiary Eligibility	2.3 Scope/Coverage Codes	Subsection was deleted. Following subsections were re-numbered.	Removal of obsolete information.
Beneficiary Eligibility	2.4 mihealth Card	Replacement of the miHealth card sample.	Update.
Coordination of Benefits	2.2 Automobile Insurance	The 1st paragraph was revised to read: Under Michigan's no-fault law, drivers may choose various levels of personal injury protection (PIP) coverage as part of their automobile insurance coverage. The automobile insurance carriers ~~are~~ is required to pay the medical expenses for injuries incurred in an automobile accident consistent with the level of PIP coverage selected by the insured. ~~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 or the Medicaid managed care plan. Billing Medicaid or a Medicaid managed care plan 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.	Changes were made to align with Michigan's changes to Personal Injury Protection auto insurance requirements.

CHAPTER	SECTION	CHANGE	COMMENT
		The 3rd and 4th paragraphs were revised to read: ~~Medicaid or the Medicaid managed care plan must be billed within six months from the date of filing the no-fault claim to keep the claim active. 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. The automobile insurance carrier must be billed within 12 months from the date of the accident in order to preserve the right of recovery under the no-fault statute. ~~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. If benefits associated with the auto insurance coverage are exhausted, the provider may bill Medicaid for Medicaid covered services consistent with the beneficiary's benefit plan. Medicaid or the Medicaid managed care plan pursues reimbursement from the other insurance through subrogation. For the purposes of this section, a Medicaid managed care plan must follow Medicaid policy regarding TPL.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under "Team Composition and Size", the following text was added as a first paragraph: All ACT team members, including the team leader, perform all team functions for which they are qualified. An ACT team member's individual scope of service allows for variance in the frequency of community contacts, and responsibility for primary caseload responsibilities; beneficiary assessment, after hours crisis coverage, person-centered planning and development of individual plans of service, while not exclusive, are examples of activities all team members perform and share.	Reworded and expanded the scope of service and responsibilities descriptions of ACT team members to clarify that all team members, including team leaders, perform all functions within their scope of service.

CHAPTER	SECTION	CHANGE	COMMENT
		The second paragraph was revised to read: 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 ACT staffing requirements are below. ~~The scope of services for individual ACT staff members requires that some staff will work in the community more often than others.~~ An ACT team operates minimally with 4 FTE staff and with no more than 9 FTE staff members. Teams average 6-7 FTE staff. If an ACT team believes it is necessary to operate outside of team requirements, consult with MDHHS regarding feasibility. If appropriate, a waiver request may be submitted to the PIHP. If approved, the PIHP will submit the request to MDHHS for consideration of approval.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	18.3 Comprehensive Diagnostic Evaluations	The 2nd paragraph was revised to read: The determination of a diagnosis by a qualified licensed practitioner is accomplished by direct observation and utilizing the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2), and by administering a comprehensive clinical interview including a developmental symptom history (medical, behavioral, and social history) such as the Autism Diagnostic Interview-Revised (ADI-R) or clinical equivalent. In addition, a qualified licensed practitioner will rate symptom severity with the Developmental Disabilities Children's Global Assessment Scale (DD-CGAS). Other tools should be used ~~if the~~ when a clinician feels it is necessary to determine a diagnosis and medical necessity service recommendations. Other tools ~~may~~ include:	Clarification.

CHAPTER	SECTION	CHANGE	COMMENT
Hearing Services and Devices	5.5.A. Standards of Coverage	Text was revised to read: Medicaid covers replacement of disposable hearing aid batteries, as appropriate, up to a quantity of 36 batteries per hearing aid per DOS when dispensed by a hearing aid dealer, audiologist, hearing center, or medical supplier. A maximum of 72 batteries per aid per year is covered. Disposable hearing aid batteries must be ordered by a Medicaid enrolled physician or qualified non-physician medical practitioner (e.g., physician assistant, nurse practitioner, clinical nurse specialist). The dispensing supplier may require a written prescription from the prescribing provider. The prescription must contain all the following: • Beneficiary's name; • Beneficiary's date of birth; • Prescribing practitioner's name, address, and telephone number; • Prescribing practitioner's signature; • Date the prescription was written; • Description of the item prescribed, including the battery size; • Quantity to be dispensed and number of applicable refills. Providers should note the item maximums when determining these amounts; and • Diagnosis supporting the medical necessity of the item. Prescriptions are valid for one year from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription. 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 and medical suppliers may not bill for replacement of disposable batteries for cochlear implant devices.	Clarification.

CHAPTER	SECTION	CHANGE	COMMENT
Hospice	6.7.D. Adult Home and Community Based Waiver Beneficiaries (MI Choice)	The 3rd paragraph was revised to read: If the beneficiary is receiving hospice and becomes eligible to receive waiver services, the waiver agency contacts the hospice to establish the first date of service for the waiver services. It is the responsibility of the waiver agent to complete the beneficiary's MI Choice waiver enrollment in CHAMPS. However, if the beneficiary is receiving waiver services and becomes eligible for hospice, it is the responsibility of the hospice to complete the hospice admission in CHAMPS. The appropriate Program Enrollment Type (PET) identifies a beneficiary receiving hospice services and Adult Home and Community Based Waiver for the Elderly and Disabled (MI Choice Waiver) services concurrently (e.g., ~~MIC-HOSP or~~ MIC-HSSP). The waiver agency and the hospice provider must discuss and coordinate services in order to prevent delays in access of care.	Update.
Hospital	3.7.B. Diabetes Self-Management Education (DSME) Training Program	In the 1st paragraph, the 2nd bullet point was revised to read: • ~~American Association of Diabetes Educators (AADE)~~ Association of Diabetes Care and Education Specialists (ADCES) accreditation by the Diabetes Education Accreditation Program (DEAP); or	Reflects a name change in a national DSMES certification organization.
Hospital Reimbursement Appendix	8.3 GME Funds Pool	The 2nd paragraph was revised to read: The dollar amount of this pool is appropriated annually by the legislature. To calculate each eligible hospital's share of the GME Funds Pool, the following formulas are used: FTEs x Case Mix x (Hospital's Title V & Title XIX Days / Hospital's Total Days) = Adjusted FTEs Pool Size~~*~~ x (Adjusted FTEs / Σ Adjusted FTEs) = Hospital's Distribution ~~* GME Funds Pool size: $52,565,600~~	This pool size is maintained on the MDHHS Inpatient Hospital Providers website as indicated in the first sentence in this section.

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	8.4 Primary Care Pool	The 2nd paragraph was revised to read: The dollar amount of this pool is appropriated annually by the legislature. To calculate each hospital's share of the Primary Care Pool, the following formula is used: FTEs x (Hospital's Title V & Title XIX Outpatient Charges/Hospital's Total Charges) = Adjusted FTEs Pool Size* x (Adjusted FTEs / Σ Adjusted FTEs) = Hospital's Distribution ~~* Primary Care Pool size: $10,322,700~~	This pool size is maintained on the MDHHS Inpatient Hospital Providers website as indicated in the first sentence in this section.
Medical Supplier	1.11 Noncovered Items	In the 1st paragraph, the following bullet point was added: • Items that are not defined by the American Medical Association (AMA), the Food and Drug Administration (FDA), and the Pricing, Data Analysis, and Coding (PDAC) contractor as medical devices or dedicated durable medical equipment (e.g., personal tablets, computers, iPads, iPhones, Smart devices, etc.).	Revision made to incorporate current language indicated in continuous glucose monitoring and speech generating device policies.
Rural Health Clinics	5.3 Quarterly Payments	Text was revised to read: 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. This quarterly amount may be adjusted periodically by MDHHS to account for changes in the payment limits, cost, utilization, and other factors that affect Medicaid reimbursement to RHCs. The RHC may request a change in the quarterly payment through the MDHHS HCRD.	Adding language to inform providers on potential quarterly payments adjustments.

CHAPTER	SECTION	CHANGE	COMMENT
Tribal Health Centers	8.1 Quarterly Payments	Text was revised to read: 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, managed care encounters, and other third party payments (including Medicare) during the year and the amount due the center based on the THC encounter rate. This quarterly amount may be adjusted periodically by MDHHS to account for changes in the payment limits, cost, utilization, and other factors that affect Medicaid reimbursement to THCs. The THC may request a change in the quarterly payment through the MDHHS HCRD.	Adding language to inform providers on potential quarterly payments adjustments.
Acronym Appendix		Removal of: AADE - American Association of Diabetes Educators Addition of: ADCES - Association of Diabetes Care and Education Specialists	Update.
Directory Appendix	Prior Authorization (Authorization of Services)	Under "Program Review Division (FFS Medicaid & CSHCS)", text for "Information Available/Purpose" was revised to read: Prior authorization for all services except hospital, specified durable medical equipment, ~~and~~ pharmacy, and non-emergency medical transportation.	Revised to exclude NEMT since NEMT received its own "Contact/Topic" information row.

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Prior Authorization (Authorization of Services)	A new row was added with the following information: Contact/Topic: Prior Authorization – Non-Emergency Medical Transportation (NEMT) Phone # Fax #: 800-622-0276; fax 517-241-7813 Mailing/Email/Web Address: MDHHS Program Review Division PO Box 30170 Lansing, MI 48909 Information Available/Purpose: Prior authorization for FFS Medicaid non-emergency medical transportation.	A NEMT-specific row was created to reflect a change in the prior authorization fax number.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 20-26	7/31/2020	Medical Supplier	1.8.J. Beneficiary Death Prior to Delivery (new subsection)	New subsection text reads: Reimbursement may be made for custom fabricated durable medical equipment, prosthetics, and orthotics (e.g. custom wheelchair seating system) not supplied due to the beneficiary's death prior to delivery or product completion. To be considered for reimbursement, the provider may contact the MDHHS Program Review Division (PRD) to request authorization for reimbursement of incurred costs. (Refer to the Directory Appendix for contact information.) Reimbursement will not be considered for prefabricated or off-the-shelf DMEPOS items. Requests are made through the PRD Director and are determined on a case-by-case basis upon provider submission of supporting documentation including: • original PA tracking number, • beneficiary date of death, • date the provider learned of beneficiary's death, • invoice with itemized cost for materials, number of hours of labor (up to date the provider learned of the beneficiary's death) and any salvage value*, and • provider statement of stage of fabrication completed. *Salvage value applies when the provider can gain further profit by reusing materials/components for another device or by returning the materials/components to the manufacturer for credit. The salvage value must be clearly documented on the provider's invoice and deducted from the provider's usual and customary charge for the item. An example of an item with salvage value would be a prefabricated component such as a joint for a knee/ankle/foot orthosis. MDHHS reserves the right to request other supporting documentation to substantiate provider incurred costs. The beneficiary must have been Medicaid eligible throughout the original PA period, up to and including the date of death. The provider must submit an official invoice to receive reimbursement and not a quote.

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				The PRD Director will determine the date of service within the date range of the initial approved PA up to the beneficiary's date of death. MDHHS will not approve requests past the authorization period of the original approved PA request.
MSA 20-31	7/31/2020	Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 19 – Opioid Health Home	Numerous changes were made throughout the section/subsections.
		Directory Appendix	Mental Health/ Substance Abuse Resources	New entry for the "Contact/Topic" of 'Opioid Health Home'.
MSA 20-35	7/21/2020			See bulletin MSA 20-62.
MSA 20-48	7/31/2020	Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 20 – Behavioral Health Home (new section)	The bulletin was incorporated through the addition of a new section: Section 20 – Behavioral Health Home.
		Directory Appendix	Mental Health/ Substance Abuse Resources	New entry for the "Contact/Topic" of 'Behavioral Health Home'.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 20-50	7/31/2020	Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.G.4. Youth Peer Support Services	Text was revised to read: Youth Peer Support is a peer-delivered service for youth and young adults. It is designed to support youth and young adults with a serious emotional disturbance/serious mental illness (SED/SMI) through shared activities and interventions in the form of direct support, information-sharing and skill-building. The goals of Youth Peer Support include supporting youth and young adults by building a strong relationship based on mutual respect and strategic self-disclosure to increase hope, confidence, self-advocacy skills, and decision-making abilities ~~empowerment, assisting youth in developing skills to improve their overall functioning and quality of life, and working collaboratively with others involved in delivering the youth's care. Youth Peer Support services can be in the form of direct support, information sharing and skill building~~. Youth Peer Support Services are provided by trained youth peer support specialists, one-on-one or in a group, for youth with ~~serious emotional disturbance~~ SED and young adults with SMI. ~~who are resolving conflicts, enhancing skills to improve their overall functioning, integrating with community, school and family and/or transitioning into adulthood. Services provide support and assistance for youth in accordance with the goals in their plan of service to assist the youth with community integration, improving family relationships and resolving conflicts, and making a transition to adulthood, including achieving successful independent living options, obtaining employment, and navigating the public human services system.~~ Youth Peer Support Specialists must have lived experience navigating behavioral health systems and must participate in and complete the approved MDHHS training curriculum. Youth Peer Support activities are identified as part of the assessment and the person-centered/family-driven, youth-guided planning process. The goals of Youth Peer Support services shall be included in the individualized plan of service where interventions are provided in the home and community. These goals will be mutually identified in active collaboration with the youth receiving services and must be delivered by a Youth Peer Support Specialist with lived experience.

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				Youth Peer Support is intended to be provided to children, ~~and~~ youth, and young adults who are middle school to ~~21~~ 26 years of age. It is not intended to substitute for other services such as respite or community living support services. The Youth Peer Support Specialist shall receive regular supervision by a child mental health professional and shall participate as an active member of the treatment team. Qualified Staff Youth Peer Support Specialists must have lived experience navigating behavioral health systems and must actively participate in and complete the approved MDHHS core training and ongoing certification requirements and expectations. Qualifications for the Youth Peer Support Specialist include: • Young adult, ages 18 through ~~26~~ 28, with lived experience with mental health challenges as a youth or young adult and who received mental health ~~services~~ support as a youth. • Willing and able to self-identify as a person who has received or is receiving behavioral health services and is prepared to use that experience in helping others. • Experience receiving services ~~as a youth in complex, child serving systems preferred (behavioral health, child welfare, juvenile justice, special education, etc.)~~ in a variety of systems (such as child welfare, education, the justice system, vocation, housing, etc.) as a youth or young adult is preferred. • Employed by PIHP/CMHSP or its contract providers. • Trained in the MDHHS approved curriculum and ongoing training model.
MSA 20-51	7/1/2020	Pharmacy	Section 1 – General Information	The 1st paragraph was revised to read: Michigan Department of Health and Human Services (MDHHS) administers the fee-for-service (FFS) programs for Medicaid, Healthy Michigan Plan, Children's Special Health Care Services (CSHCS), and Maternity Outpatient Medical Services (MOMS). This chapter, ~~and~~ the Michigan Pharmaceutical Product List (MPPL), and the Michigan Preferred Drug List (PDL)/Single PDL comprise program policies and explain coverage and reimbursement for the services dispensed and billed by enrolled pharmacies.
			1.1 MDHHS Pharmacy Benefits Manager and Other Vendor Contractors	In the 2nd paragraph, the 3rd bullet point was revised to read: • Michigan Preferred Drug List (PDL)/Single PDL

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		Acronym Appendix		Addition of: PDL – Preferred Drug List
		Directory Appendix	Pharmacy Resources	Under "MDHHS Pharmacy Benefit Manager (PBM) 24/7/365", text for "Information Available/Purpose" was revised to read: General information, MPPL, Michigan Preferred Drug List (PDL)/Single PDL, claim submission instructions, etc. See Prior Authorization Section of this Directory for additional PBM contact information.
MSA 20-52	7/31/2020	Laboratory	2.2.C. Independent Laboratory	Text was revised to read: An independent laboratory ~~meets the following parameters~~ is a freestanding clinical laboratory that is not part of a physician office, hospital, or hospital-based facility. It may be owned by: • ~~It may be owned by:~~ • A physician or a medical group practice. • A pharmacy. • A non-physician. ~~The physician-owned independent laboratory is subject to the following policies:~~ • ~~The laboratory must not accept referrals from the physician owner or his immediate family members.~~ • ~~Laboratory claims are billed using the independent laboratory NPI number.~~ The ~~non-physician owned~~ independent laboratory is subject to the following policies: • The laboratory must not accept referrals from the owner or his immediate family members. • The laboratory must have a CLIA certificate. • Laboratory claims are billed using the independent laboratory's NPI number.

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MSA 20-54	10/2/2020	Home Health	Section 3 – Plan of Care	In the 2nd paragraph, the 4th bullet point was revised to read: • Name~~,~~ and address ~~and provider NPI number~~ of the HHA, and the beneficiary's name, date of birth, and Medicaid ID number.
MSA 20-62	9/2/2020	Home Health	1.1 Face-to-Face Encounter	Text was revised to read: ~~A~~ The physician or permitted non-physician practitioner (NPP) certifying eligibility for home health services must provide documentation of a face-to-face encounter with the beneficiary within 90-days prior to or 30-days after the start of care. The face-to-face encounter may occur through telehealth in compliance with Section 1834(m) of the Social Security Act. Permitted NPPs include: • A nurse practitioner or clinical nurse specialist (as defined in section 1861(aa)(5) of the Social Security Act) who is working in collaboration with the physician in accordance with State law. • A physician assistant (as defined in section 1861(aa)(5) of the Social Security Act) under the supervision of the physician. NOTE: The face-to-face encounter requirement pertains only to initial certification for home health services. ~~Only a physician may order home health services and certify a beneficiary's eligibility for the benefit.~~ The face-to-face encounter ensures that the orders and certification for home health services are based on current knowledge of the beneficiary's clinical condition, and will identify the primary reason for home health services. In a situation where a physician or permitted NPP orders home health services based on a new condition that was not evident during a visit within the 90-days prior to the start of care, the certifying ~~physician or non-physician practitioner (NPP)~~ practitioner (e.g. physician or permitted NPP) must see the beneficiary within 30 days of admission to home health services.

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				The certifying ~~physician~~ practitioner must document the face-to-face encounter ~~regardless of whether the physician or a permitted NPP performed the encounter~~. When the face-to-face encounter is performed by a ~~NPP~~ certified nurse-midwife (as defined in section 1861(gg) of the Social Security Act, as authorized by State Law), he/she must document the clinical findings of the face-to-face encounter and communicate those findings to the physician; the physician must then sign the certification. Permitted NPPs must not certify face-to-face encounters performed by a certified nurse-midwife. ~~Permitted NPPs include:~~ • ~~A nurse practitioner or clinical nurse specialist (as defined in section 1861(aa)(5) of the Social Security Act) who is working in collaboration with the physician in accordance with state law;~~ • ~~A certified nurse-midwife (as defined in section 1861(gg) of the Social Security Act, as authorized by State law); or~~ • ~~A physician assistant (as defined in section 1861(aa)(5) of the Social Security Act) under the supervision of the physician.~~ Documentation of the face-to-face encounter must reflect the certifying practitioner's assessment of the beneficiary and include: • Date of the encounter, • Primary reason for the encounter (medical condition), • Clinical findings that support the need for skilled nursing, therapy, or home health aide services, and • Clinical findings that support home health eligibility.

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				An addendum may consist of clinical documents from a hospital or post-acute facility (e.g.~~,~~ emergency visit record or discharge summary). It is allowable for the certifying ~~physician~~ practitioner to use such a document as an addendum for the face-to-face encounter if: • The addendum contains all the documentation requirements for face-to-face documentation; and • The certifying ~~physician~~ practitioner signs and dates the addendum~~,~~; or • The certifying physician signs and dates the addendum, demonstrating that the certifying physician received that information from the ~~allowed NPP or physician~~ certified nurse-midwife who performed the face-to- face encounter, and that the certifying physician is using ~~that~~ the addendum document as his/her documentation of the face-to-face encounter. While typically the same ~~physician~~ practitioner (e.g. physician or permitted NPP) will certify, establish and sign the POC, it is allowable for ~~physicians~~ practitioners who attend to the beneficiary in the acute and post-acute settings to certify the need for home health care based on their face-to-face contact, initiate the orders (POC) for home health services, and "hand off" the beneficiary's care to the community-based ~~physician~~ practitioner to review and sign off on the plan of care.
		Medical Supplier	1.3.B. Practitioners Who May Perform the Face-To-Face Visit	Text was revised to read: The face-to-face evaluation may be provided by a physician (MD or DO) or any of the following NPPs: • Physician Assistant (PA) • Certified Nurse Practitioner (NP) • Certified Clinical Nurse Specialist (CNS) ~~Although the PA, NP or CNS may conduct the face-to-face visit, they may not write prescriptions/orders for the specified equipment or medical supplies, and the physician must certify that the face-to-face occurred.~~

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				Effective March 1, 2020, Interim Final Rule CMS-5531 permanently amends 42 CFR 440.70 (a)(2) to allow NPPs (i.e., PA, NP, and CNS), within their scope of practice, to perform face-to-face encounters, and document, certify and order Medicaid Home Health Services (including durable medical equipment, prosthetics, orthotics and medical supplies). The NPP is not required to communicate the clinical findings of the face-to-face encounter with the physician. Physician certification of the face-to-face encounter performed by an NPP is not required.
		Medical Supplier	1.3.C. Physician Certification of the Face-to-Face Visit	The subsection title was revised to read: Physician or NPP Certification of the Face-to-Face Visit The 1st and 2nd paragraphs were revised to read: The ordering physician or ordering NPP must certify that a face-to-face visit occurred within six months prior to the written order whether he/she performed the visit or another treating or attending physician or NPP performed the visit. The physician or NPP must document the date of the face-to-face visit and specify the name of the practitioner who performed the evaluation, document the clinical findings that support the need for the item(s), and confirm the primary reason for the visit that relates to the need for the item(s). A treating or attending physician (e.g., inpatient hospital physician) or NPP may conduct the face-to-face visit and order the item(s) if all criteria of the face-to-face rules are met. If the treating or attending physician or NPP performs the face-to-face evaluation but does not write the initial order; he/she must communicate the details of the visit to the ordering physician or ordering NPP.

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		Medical Supplier	1.3.D. Face-to-Face Prescriptions/ Orders	Text was revised to read: ~~DME and medical supplies that require a face-to-face visit may only be ordered by a physician regardless of State licensing rules that may allow NPPs to write orders.~~ MDHHS recommends the ordering physician or NPP include the face-to-face visit information on the written order or CMN; however, it is acceptable for this information to be indicated on other medical documentation (e.g. discharge summary). If the ordering physician or NPP chooses to document the face-to-face visit on the order, he/she must include the date of the visit, the name of the physician or NPP that performed the evaluation, and document the visit was related to the primary condition that supports the need for the item(s). The face-to-face visit requirement applies to initial orders and not to supply refills, equipment repairs, the servicing of equipment, or to accessories (except for those accessories indicated on the CMS list). The ordering physician or NPP must assess the continued need for the medical supply or equipment on an annual basis. For refills of supplies, the ordering physician must indicate "renewal" on the order.