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Medical Services Administration

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This bulletin replaces the Traumatic Brain Injury Rehabilitation Program section of the Special Programs chapter within the Medicaid Provider Manual with a new Brain Injury Services (BIS) chapter. Currently, the Medicaid Provider Manual contains a brief section (Traumatic Brain Injury Rehabilitation Program) on the traumatic brain injury services covered by the State Plan. The Brain Injury Services chapter expands upon the Traumatic Brain Injury Rehabilitation Program policy and provides more comprehensive policy for providers of BIS and beneficiaries seeking acquired or traumatic brain injury services. For questions on Brain Injury Services or to submit an application to the BIS program, please email MDHHS-MSA-BIS@michigan.gov.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

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-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Kate Massey, Director
Medical Services Administration

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BRAIN INJURY SERVICES

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SECTION 1 – GENERAL INFORMATION

The Michigan Department of Health and Human Services (MDHHS) is committed to providing high quality services and supports to individuals who have experienced a brain injury. Brain Injury Services (BIS) provides necessary services and supports to individuals with qualifying brain injuries who, but for the provision of these services, would otherwise be served in an institutional setting. The program provides critical brain injury-specific rehabilitation and support in the post-acute injury period with the goal of assisting the individual in becoming capable of living in the most independent setting.

1.1 BRAIN INJURY SERVICES SCOPE AND PURPOSE

BIS focuses on specialized rehabilitation and supportive services required upon release from an acute care setting following a moderate or severe brain injury. A brain injury does not include damage to the brain resulting from neurodegenerative disorders such as Alzheimer's disease or dementia. These services are for beneficiaries who can benefit from the advanced level of rehabilitative therapies and other services offered. BIS can be obtained in either a transitional residential or outpatient setting. All providers for BIS must have appropriate accreditation, certifications, or specialized training in serving individuals with brain injuries. These BIS providers are contracted with MDHHS to provide services covered in this chapter. Transitional Residential services are limited to six months for each brain injury.

1.2 BENEFICIARY ELIGIBILITY

To be eligible for BIS, an individual must meet the following criteria:

- Be Medicaid-eligible.
- Have a qualifying brain injury that occurred within 15 months of application to the BIS program. (Refer to the Beneficiaries with a Traumatic Brain Injury and the Beneficiaries with an Acquired Brain Injury subsections for additional information.)
- Be medically stable.
- Be able to participate in appropriate therapies as indicated:
  - For beneficiaries using Transitional Residential services, at least 15 hours per week upon approval for BIS. These beneficiaries may decrease the number of therapy hours based upon a beneficiary evaluation when nearing discharge if most of the treatment goals have been met and the discharge plan has been reevaluated and revised to ensure it remains appropriate for the beneficiary.
  - For beneficiaries receiving Outpatient services, at least nine (9) hours per week.
- Be determined appropriate for 60 to 90 days of BIS as supported by a Physical Medicine and Rehabilitation (PMR) physician's order.
  - For beneficiaries using Transitional Residential services, the order must specify that the physician expects significant progress within the next 90 days to allow for community-based discharge.
  - In the absence of a PMR physician's order, a psychological consultation conducted by a qualified professional that substantiates the beneficiary's ability to interact with the therapy treatment team and the ability to participate in the required therapy levels will be accepted.

1.2.A. Early and Periodic Screening, Diagnosis, and Treatment Age-Outs

Beneficiaries who otherwise qualify for BIS but are receiving similar services through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and will age-out of the EPSDT program before completing brain injury treatments and therapies may enroll in BIS upon their 21st birthday. Providers should collaborate in advance of the 21st birthday to ensure minimization of interrupted services for these beneficiaries.

1.2.B. Beneficiaries with a Traumatic Brain Injury

A traumatic brain injury (TBI) is defined as a blunt force trauma to the brain. The Centers for Disease Control and Prevention (CDC) defines a TBI as "caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain." Injuries such as gunshot wounds, falls or motor vehicle accidents involving injuries to the head are considered TBIs. Explosive blasts can also cause a TBI, particularly among those who serve in the United States (U.S.) military.

1.2.C. Beneficiaries with an Acquired Brain Injury

An acquired brain injury (ABI) is an injury to the brain that is not hereditary, congenital degenerative, or induced by birth trauma. ABIs occur after birth but are not caused by an external force and are non-traumatic. Examples of ABI include stroke, near drowning, substance abuse overdose, hypoxic or anoxic brain injury, tumors, neurotoxins, electric shock, or lightning strike.

1.2.D. Time Since Injury

Beneficiaries must have sustained the qualifying brain injury within 15 months of applying for BIS.

1.2.E. Functioning Level

Beneficiaries must demonstrate functioning at a Level 5 on the Rancho Los Amigos scale based on the most recent medical records available. Beneficiaries functioning at a lower level but steadily progressing may be considered for enrollment. MDHHS will make this exception based on a review of medical documentation submitted to MDHHS.

1.2.F. Enrollment in Medicaid Health Plans and Other Programs

A program participant cannot be simultaneously enrolled in both BIS and a Medicaid Health Plan (MHP), Program of All-Inclusive Care for the Elderly (PACE) program, MI Health Link, MI Choice or any other §1915(c) waiver program. It is not necessary to either delay BIS program enrollment or withhold BIS pending the disenrollment process. Disenrollment from other programs will be coordinated by the MDHHS Home and Community-Based Services (HCBS) Section. Special disenrollment or medical exception processes for BIS program enrollment are not allowed.

1.3 Beneficiary Discharges

All beneficiaries will develop a discharge plan as a part of their care plan. The discharge plan will be altered as necessary based upon the beneficiary's goals and outcomes. Beneficiaries who have met most of their goals will begin intensive discharge planning. These beneficiaries may require other home and community-based services (HCBS) programs upon conclusion of BIS. Intensive discharge planning will include planning for enrollment in the most appropriate program for the beneficiary based upon their choice and eligibility for other programs. Every effort will be made to ensure a smooth transition out of the BIS and into other Long-Term Services and Supports (LTSS) programs, as needed, without a lapse between BIS and other program enrollment. MDHHS allows 30 days to facilitate an appropriate discharge.

Discharge from BIS will be based upon the beneficiary meeting any of the following criteria:

- The beneficiary is not eligible for Michigan Medicaid;
- The beneficiary died;
- The beneficiary is not amenable to treatment;
- The beneficiary is non-compliant with program or facility rules;
- The beneficiary has been institutionalized in a hospital or nursing facility for more than 30 days;
- The beneficiary enrolled in a hospice program;
- The beneficiary moved out of the program service area;
- The beneficiary has not shown progress for at least 30 days while approved for BIS;
- The beneficiary chooses to end BIS;
- The beneficiary transferred to a different program or service and no longer requires BIS;
- The beneficiary no longer meets program criteria;
- The beneficiary refused to accept BIS;
- The beneficiary met program goals as established in their care plan; or
- The beneficiary has been enrolled in Transitional Residential services of BIS for six months and does not require or has refused Outpatient services.

SECTION 2 – REFERRAL AND ADMISSION PROCESS

Any knowledgeable person may make a referral for BIS. MDHHS recommends, but does not require, the current social worker or nurse assigned to the beneficiary to contact MDHHS for easier processing of the referral and to provide a brief report of the beneficiary. An individual, family member or friend may contact MDHHS if they want more information about the program or feel their friend or family member may qualify. MDHHS will provide the friend or family with information about the program, answer questions, and provide a list of contracted BIS providers. The potential applicant or family member will have to decide which provider meets their needs and is right for them. MDHHS will then work with the BIS providers to get the complete admission packet and determine if the individual is eligible for the program.

MDHHS will evaluate the application of each individual with a brain injury who applies for BIS using the criteria listed below. All applicants for BIS must meet each criterion at the time of application. MDHHS will not consider applicants who do not meet all criteria specified below for enrollment in the BIS.

2.1 IN-PERSON EVALUATION

Providers must conduct an in-person evaluation to determine whether the beneficiary meets provider admission criteria before making a referral. The provider may request a joint evaluation with MDHHS HCBS staff. MDHHS reserves the right to conduct an in-person assessment of the beneficiary.

When appropriate, the evaluation may occur through telecommunication technology (telemedicine). MDHHS requires a real-time interactive system at both the originating and distant sites, allowing instantaneous interaction between the patient and the health care professional via the telecommunication system. Telemedicine should be used primarily when travel is prohibitive for the beneficiary. Providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine. (Refer to the Practitioner chapter of this manual for additional telemedicine requirements.)

2.2 MEDICAL RECORDS

Medical records from the acute or institutional care setting, hereafter referred to as "care setting," immediately prior to application for BIS must demonstrate all the following:

- The injury occurred no more than 15 months before the BIS application date or start of Brain Injury-specific services through the EPSDT program;
- The beneficiary is at least 21 years old;
- The beneficiary has been determined to have a significant functional or cognitive impairment as identified by a comprehensive assessment and must require long-term support services;
- The beneficiary must have functional or cognitive limitations that are a direct result of a brain injury as documented by a physician, neuropsychologist, or other qualified health professional;
- The beneficiary has potential to maintain skills learned at the setting such as coping mechanisms or other techniques to compensate for identified functional or cognitive deficits;
- The beneficiary does not require continuous 1:1 attention to remain free from harm within the care setting;

- The beneficiary is willing and able to participate in targeted brain injury therapies and work toward identified goals;
- The beneficiary exhibits behavior that does not pose significant harm to self or others; and
- The beneficiary has not used illegal substances or abused legal substances in the care setting or at home after discharge from the last treatment facility. For the purposes of BIS, abuse of legal substances means that for the beneficiary, using the legal substance creates a barrier to participating in and benefitting from intensive rehabilitation services.

2.3 Additional Beneficiary Records

In addition to medical records that support the medical eligibility requirements described above, the following beneficiary records, as applicable, must be submitted for consideration of approval of BIS:

- Emergency Room records for the brain injury;
- The initial post-injury computed tomography scan, magnetic resonance imaging or other report of brain;
- Neurological consultations and surgery reports related to the brain injury;
- Therapy notes including therapist evaluations;
- Social worker evaluation;
- A statement by a qualified health professional that indicates the beneficiary has functional or cognitive limitations as a direct result of the brain injury;
- Proof of guardianship or power of attorney, if applicable;
- Other documents relative to the beneficiary and their brain injury; and
- Acknowledgement (written or oral) from a qualified provider indicating a willingness to admit the beneficiary.

2.4 Submission of Records to MDHHS

MDHHS HCBS staff will review the documentation submitted to ensure the individual meets eligibility criteria. The standard of promptness for MDHHS to make an eligibility determination is ten (10) business days from receipt of a complete referral packet. Providers must plan for at least this amount of time before confirmation of approval for BIS. Submission of complete admission packets will facilitate the determination process.

In the cases where an applicant for the BIS program does not meet BIS eligibility criteria, BIS providers must send documentation to MDHHS with evidence that the individual does not meet BIS criteria. Only MDHHS can approve or deny eligibility for BIS.

2.5 MDHHS Approval

Once eligibility is verified and a qualified provider is located, MDHHS will approve BIS for up to 90 days for the beneficiary. MDHHS will provide a list of qualified BIS providers to assist the applicant in making an informed choice of providers.

2.6 Provider Responsibilities

Upon acceptance of the beneficiary, the provider agrees to do the following:

- Submit a copy of the beneficiary's Plan of Care (POC) within two weeks of admission;
- Submit any changes, reductions, or terminations in services listed in the POC to MDHHS HCBS staff at least two weeks prior to the effective date for MDHHS approval. This will allow MDHHS time to send the beneficiary proper notice. (Refer to the Appeals section for additional information.)
- Submit the Treatment Team report to MDHHS HCBS staff monthly. Reports should include progress toward discharge planning;
- Notify MDHHS HCBS staff of beneficiary hospitalizations for more than two (2) days;
- Submit a discharge plan 30 days prior to the anticipated discharge date; and
- Submit a discharge summary report within 30 days after the beneficiary's discharge from BIS.

2.7 Case Conferences

Prior to the BIS approval expiration date, MDHHS staff and the provider's treatment team will meet with the beneficiary to determine if the approval for BIS should be renewed and for how long. Renewal is based upon the beneficiary's continued ability to make progress. Renewals will not be granted if the beneficiary meets the discharge criteria. When the beneficiary continues to demonstrate progress toward rehabilitation goals, BIS may be reapproved for up to six months of Transitional Residential rehabilitation. Outpatient rehabilitation is not limited as long as the beneficiary continues to make progress toward goals identified in the POC and other Medicaid-funded services are not available to meet the individual's needs.

SECTION 3 – COVERED SERVICES

BIS covers, upon prior authorization (PA), medically necessary rehabilitation services for beneficiaries with neurological damage resulting from a brain injury. All services must be included on the beneficiary's POC. All services are available to beneficiaries in both transitional residential and outpatient settings. In addition to BIS, beneficiaries have access to Medicaid State Plan services (e.g., prosthetic and orthotic care, durable medical equipment (DME)) on a fee-for-service (FFS) basis. The following services are included as BIS when provided by or under the direction of appropriately qualified individuals.

3.1 DIAGNOSIS AND EVALUATION

Medicaid covers tests to diagnose a disease or a medical condition. Diagnostic testing must be directly related to the brain injury of the beneficiary. Medicaid covers medically necessary evaluation and management (E/M) services provided by a physician or other practitioner authorized by the Department of Licensing and Regulatory Affairs (LARA). 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, and review and explanation of diagnostic test reports to the beneficiary. Requests for individual consideration should not report the modifier for increased procedural services with E/M services unless specifically directed by this manual. This practice does not follow Current Procedural Terminology (CPT) coding guidelines and causes longer delays in processing claims for payment.

3.2 REHABILITATIVE 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). Nursing care provided by a licensed practical nurse (LPN) must be under the supervision of an RN, and the RN must co-sign the LPN's documentation.

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 indwelling catheter.
- Applying dressings that require prescribed medications and aseptic techniques.
- Teaching the beneficiary, family member, friend, neighbor, or caregiver (paid or unpaid) to carry out all or some of the services.
- Observation and evaluation.

Intermittent nurse visits are intended for beneficiaries who generally require nursing services for the treatment of an acute illness, injury, or disability. Intermittent nursing visits may last from 15 minutes to one or two hours.

The following nursing services are covered by BIS. Limitations, conditions and special considerations are noted when applicable.

3.2.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).

3.2.B. 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 gives the enema because of clinical indications.

3.2.C. Observation/Evaluation

When 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.

3.2.D. 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.

3.2.E. 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 Stage 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 Stage 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.

3.2.F. Teaching and Training Activities

Medicaid covers home health aide 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. Eligibility for teaching visits must take into account the ability of a recipient or family member to comfortably perform the task(s) taught.

Teaching and training activities covered by Medicaid include, but are not limited to:

- Giving an injection
- Prefilling insulin syringes
- Inserting/irrigating a catheter
- Administering eyedrops/topical ointments
- Caring for a colostomy or ileostomy
- Administering oxygen
- Preparing and following 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 (e.g., dressing, eating, personal hygiene) for the beneficiary through use of special techniques and adaptive devices where the beneficiary has experienced 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 are covered when they include supervision and evaluation of complex care that initially requires training by a nurse (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 their home whenever feasible.

3.3 Cognitive Rehabilitation Services

MDHHS uses the terms cognitive rehabilitation services, cognitive rehabilitation therapy (CRT), CRT and therapy interchangeably. CRT is covered when furnished by a Medicaid-enrolled therapy provider and performed by:

- A licensed cognitive rehabilitation therapist;
- A licensed and certified speech-language pathologist (refer to the Speech Language Services subsection for additional information); or
- A qualified licensed practitioner (refer to the Behavioral and Psychological Services subsection for additional information).

Cognitive rehabilitation services assist the beneficiary with relearning cognitive skills that have been lost or altered because of the brain injury. When skills cannot be relearned, new skills must be taught to enable the beneficiary to compensate for their lost cognitive functions. Cognitive rehabilitation comprises four components:

- Education about cognitive weaknesses and strengths, focusing on developing awareness of the problem.
- Process training or the development of skills through direct retraining or practicing the underlying cognitive skills. The goal of process training is to resolve the deficit.
- Strategy training involves the use of environmental, internal and external strategies to assist with compensating for the deficit rather than resolving the problem.
- Functional activities training applies the above three components (education, process training, and strategy training) in everyday life so that the beneficiary regains independence to the greatest extent possible.

Cognitive rehabilitation achieves functional changes by:

- Reinforcing, strengthening or establishing previously learned patterns of behavior.
- Establishing new patterns of cognitive activity or mechanisms to compensate for impaired neurological systems.
- Interventions that are tailored to help the beneficiary be as independent as possible in the management of their everyday routines and responsibilities in their home and community.

The cognitive rehabilitation therapist will evaluate the beneficiary to understand the beneficiary's unique needs and concerns and to create a treatment plan that describes how cognitive rehabilitation will assist the beneficiary to learn to use tools and strategies to be as independent as possible. The evaluation may include standardized or non-standardized assessments, questionnaires, testing, interviews, or observation to gain the greatest understanding of the beneficiary's abilities and limitations in managing everyday routines and responsibilities.

The beneficiary's treatment plan will summarize the beneficiary's strengths and limitations. The treatment plan will include all the activities that will help the beneficiary remediate or compensate for limitations. The therapist will continually assess the beneficiary's progress and revise goals based on that progress.

3.4 Physical Therapy Services

MDHHS uses the terms physical therapy (PT), PT and therapy interchangeably. PT is covered when furnished by a Medicaid-enrolled therapy provider and performed by:

- A licensed physical therapist;
- An appropriately supervised licensed physical therapy assistant; or
- A student completing a clinical affiliation under the direct supervision of (i.e., in the presence of) a licensed physical therapist may also be covered. All documentation must be reviewed and signed by the supervising physical therapist.

PT must be medically necessary and reasonable for the maximum reduction of physical disability and restoration of a beneficiary to their best possible functional level.

MDHHS anticipates PT will result in significant functional improvement in the beneficiary's ability to perform mobility skills appropriate to their 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 that makes changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.

PT must be skilled (i.e., require the skills, knowledge and education of a physical therapist). MDHHS does not cover PT interventions provided by non-PT practitioners (e.g., teacher, RN, occupational therapist, family, or caregiver).

MDHHS 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. MDHHS 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. Skilled PT services are designed to set up, train, monitor, and modify a maintenance or prevention program to be performed by family or caregivers. MDHHS does not reimburse for routine provision of the maintenance/prevention program. MDHHS 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 condition that creates decreased mobility and/or function; and/or

- To prevent a reduction in medical or functional status had the therapy not been provided.

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 for pain relief and inflammation reduction;
- Modalities to allow gains of function, strength, balance or mobility; and/or
- Training in the use of orthotic/prosthetic devices.

3.5 Occupational Therapy Services

MDHHS uses the terms occupational therapy (OT), OT, and therapy interchangeably. OT is covered when furnished by a Medicaid-enrolled therapy provider and performed by:

- A licensed occupational therapist;
- A licensed occupational therapy assistant under the supervision of an occupational therapist (i.e., the occupational therapy assistant's services must follow the evaluation and treatment plan developed by the occupational therapist, and the occupational therapist must supervise and monitor the occupational therapy assistant's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the appropriate supervising occupational therapist; or
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a licensed occupational therapist. All documentation must be reviewed and signed by the supervising occupational therapist.

OT is considered an all-inclusive charge and MDHHS does not reimburse for a clinic room charge in addition to OT services unless it is unrelated. MDHHS expects occupational therapists and occupational therapy assistants 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.

MDHHS anticipates that 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.

OT must be skilled (i.e., require the skills, knowledge and education of a licensed occupational therapist). MDHHS does not cover OT interventions provided by non-OT practitioners (e.g., teacher, RN, licensed physical therapist, family, or caregiver).

3.6 Speech Language Services

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.

MDHHS covers speech-language therapy provided in both transitional residential and outpatient settings. MDHHS only reimburses services for speech-language therapy when provided by:

- A speech-language pathologist (SLP) with a current license.
- An appropriately supervised SLP candidate (i.e., in their clinical fellowship year [CFY]). All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.
- A student completing their clinical affiliation under direct supervision of (i.e., in the presence of) an SLP having a current license. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

MDHHS 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.

Speech-language therapy must relate to a medical diagnosis, and is limited to services for:

- Articulation
- Language
- Fluency
- Swallowing
- Training in the use of a speech-generating device
- Training in the use of an oral-pharyngeal prosthesis
- Voice
- Cognition

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-language therapy services must be skilled (i.e., require the skills, knowledge and education of a licensed 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, RN, licensed physical therapist, licensed occupational therapist, family member, or caregiver) would not be reimbursed as speech therapy by MDHHS. (Refer to the Therapy Services Chapter of this manual for additional information regarding therapy services.)

3.7 Social Work Services

Social work services include the provision of assistance and advocacy to improve the social and psychological functioning of the beneficiary.

MDHHS covers social work services provided in both transitional residential and outpatient settings. MDHHS only reimburses services for social work services when provided by:

- A social worker with a current Michigan license;
- An appropriately supervised social work candidate (i.e., in their clinical fellowship year) or having completed all requirements but has not obtained a license. All documentation must be reviewed and signed by the appropriately credentialed supervising Master of Social Work (MSW); or
- A student completing their clinical affiliation under direct supervision of (i.e., in the presence of) a licensed MSW. All documentation must be reviewed and signed by the appropriately credentialed supervising MSW.

Services may include, but are not limited to, advising family members and caregivers, providing patient education and counseling, beneficiary advocacy, making referrals to other services, case management interventions, and discharge planning.

3.8 Behavioral and Psychological Services

A diagnostic evaluation must be performed before the beneficiary receives behavioral and psychological services (BPS). The diagnostic evaluation is a thorough review of cognitive, behavioral, emotional, and social functioning, and includes validated evaluation tools. Based on the evaluation, the practitioner determines the beneficiary's diagnosis and recommends general treatment interventions. If appropriate, the practitioner refers the beneficiary to a comprehensive neuropsychological evaluation or medical evaluation with a psychiatrist for consideration of psychiatric medication (refer to the Neuropsychological Evaluation and the Psychiatry subsections below) for holistic treatment of the psychological condition(s).

The diagnostic evaluation is performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing individuals with brain injuries.

A qualified licensed practitioner includes:

- a physician with a specialty in psychiatry;
- a physician with a specialty in behavioral health;
- a psychologist;
- a neuropsychologist; or
- a clinical social worker working within their scope of practice who is qualified and experienced in diagnosing behavioral health issues related to brain injuries.

Medical necessity and recommendation for BPS is determined by a physician or other licensed practitioner working within their scope of practice under state law. The beneficiary must demonstrate functional impairment in social, occupational, or other important areas of functioning, and/or report significant subjective distress associated with changes following the brain injury. Common cognitive, behavioral, emotional, and social changes following a brain injury require BPS to address the following areas:

- Trauma- and Stressor-Related Disorders:
  - in response to a traumatic event, individual experiences intrusive symptoms (recurrent distressing memories of the traumatic event, distressing dreams or flashbacks related to the traumatic event);
  - negative mood (persistent inability to experience positive emotions);
  - dissociative symptoms (altered sense of reality of one's surroundings or oneself);
  - inability to remember an important aspect of the traumatic event;
  - avoidance symptoms (efforts to avoid distressing memories, thoughts, or feelings about the traumatic event);
  - efforts to avoid external reminders of the traumatic event; and
  - arousal symptoms (sleep disturbance, irritable behavior, hypervigilance, problems with concentration, exaggerated startle response).
- Anxiety and Obsessive-Compulsive Disorders:
  - excessive fear or anxiety about a specific object or situation;
  - recurrent, unexpected panic attacks (abrupt surge of intense fear or intense discomfort);
  - marked fear or anxiety about using public transportation, being in open or enclosed spaces, being in a crowd, or being outside of the home alone;
  - difficulty controlling worry about a number of events or activities;
  - recurrent and persistent thoughts or urges that are intrusive and unwanted; and
  - repetitive behaviors performed in response to an obsession.
- Depressive Disorders:
  - depressed mood most of the day, nearly every day;
  - diminished interest or pleasure in activities;
  - weight fluctuations;
  - sleep pattern disruption;
  - psychomotor agitation or slowing;
  - fatigue or loss of energy;
  - feelings of worthlessness or excessive guilt;
  - diminished ability to think or concentrate;
  - recurrent thoughts of death; and
  - severe recurrent temper outbursts manifested verbally and/or behaviorally.
- Neurocognitive Disorders:
  - significant cognitive decline from a previous level of performance in areas of attention, executive function, learning and memory, language, perceptual-motor, or social cognition; and

- the cognitive deficits interfere with independence in everyday activities.
- Personality Disorders:
  - persistent personality disturbance due to a medical condition that may include affective lability, disinhibition, aggression, apathy, or paranoia; and
  - the disturbance causes distress or impairment in social, occupational, or other important areas of functioning.
- Somatic Symptoms and Related Disorders:
  - excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns;
  - disproportionate and persistent thoughts about the symptoms;
  - high level of anxiety about the symptoms;
  - excessive time and energy devoted to these symptoms or health concerns;
  - symptoms of altered voluntary motor or sensory function (weakness, paralysis, tremors, speech difficulties, attacks or seizures, sensory loss); and
  - psychological or behavioral factors adversely affect the medical condition.

3.8.A. Neuropsychological Evaluation

A qualified licensed practitioner performing the initial evaluation for BPS may determine the need for a more comprehensive psychological evaluation by a neuropsychologist. The Neuropsychological Evaluation (NPE) is a comprehensive evaluation of cognitive, academic, emotional, social, and adaptive functioning using standardized measures. The NPE may assist with treatment planning, progress monitoring, academic or occupational planning, or necessity of a guardian or conservator. The NPE may be initiated immediately following the injury, at various points throughout treatment to monitor progress, or following the completion of treatment to plan for transition to the next step in the beneficiary's recovery.

3.8.B. Psychiatry

A referral to a psychiatrist with experience in working with individuals with brain injuries may be a necessary component of rehabilitation. The beneficiary may experience significant disruption in social, occupational, or other areas of functioning, or may report significant emotional distress resulting from the injuries. Medication may be indicated for those beneficiaries whose symptoms are significantly impairing daily tasks, interfering with treatment engagement, or not responding to evidence-based interventions at a level expected for the provided treatment. These situations may warrant a referral for an evaluation by a psychiatrist for determination of an appropriate medication regimen.

3.8.C. Psychological Treatment

BPS includes a variety of behavioral interventions which have been identified as evidence-based by nationally recognized research reviews and other nationally recognized scientific and clinical evidence. BPS is designed to be delivered at a

frequency and intensity appropriate for the clinical presentation of the beneficiary. Behavioral intervention services include, but are not limited to, the following categories of evidence-based interventions:

- Cognitive Behavioral Therapy: Identifying maladaptive cognitions and patterns of behavior as a means of teaching healthy coping skills in response to stressful events.
- Exposure and Response Prevention: Systematically exposing the beneficiary to the stressful images, thoughts, or situations that provoke anxiety and teaching more adaptive responses.
- Acceptance and Commitment Therapy: Accepting thoughts and feelings as they are while identifying behaviors consistent with the beneficiary's values.
- Mindfulness-Based Treatment: Practicing a state of being psychologically present using meditation and breathing exercises to target depression and anxiety.
- Family Therapy: Teaching communication techniques and adaptability within the family unit to promote positive behaviors, connection to each other, and positive identity of each member.

The treatments and interventions listed above are not all-inclusive. BPS treatment services may also include other interventions supported by credible scientific or clinical evidence, as appropriate for each beneficiary. Based on the behavioral POC, which is adjusted over time based on progress monitoring, collaboration with other providers of care, and behavioral observations during treatment, the provider selects and adapts one or more of these services, as appropriate for the beneficiary.

3.9 Rehabilitation Aide Services

Rehabilitation Aide Services include unskilled assistance improving skills and functioning. The rehabilitation aide assists the beneficiary with meeting therapy goals and reinforcing skills learned during therapy sessions. A rehabilitation aide also provides personal care services, including help with bathing, toileting, and dressing.

SECTION 4 – APPEALS

MDHHS has established beneficiary and provider appeal processes that are applicable to BIS. The beneficiary appeals process conforms to the Medicaid fair hearing requirements found at 42 CFR Part 431, Subpart E of the Code of Federal Regulations. Provider appeal rights conform to the requirements of the Michigan Compiled Laws, MCL 400.1 et seq., and the administrative rules found at Michigan Administrative Code R 400.3402 through R 400.3425, as amended.

4.1 PARTICIPANT APPEALS

MDHHS has established notice and appeals requirements to which BIS providers must adhere when adverse action has been taken for program applicants or beneficiaries. According to 42 CFR 431.201, "Action" means a termination or suspension of Medicaid eligibility or of covered services. This also includes determinations by MDHHS that the applicant does not meet BIS eligibility criteria and other denials of Medicaid eligibility or of covered services. The beneficiary will be notified in writing of the negative action and the right to appeal.

4.1.A. ADEQUATE ACTION NOTICES

MDHHS HCBS staff will send an Adequate Action Notice to applicants or beneficiaries informing them of adverse actions and determinations taken under the following circumstances:

- when MDHHS staff determine applicants to be ineligible for BIS based upon the information provided in the application packet.
- when MDHHS staff determine an individual receiving BIS will have services end as planned in the authorization.
- when an existing benefit is reduced, suspended or terminated and meets the requirements for an exception from an Advance Action Notice as specified in 42 CFR 431.213.

BIS providers must confer with MDHHS HCBS staff prior to refusing, refusing to increase, or reducing services. MDHHS makes the final determination on furnishing, reducing, and refusing services. Upon approval of an adverse action, MDHHS HCBS staff must send an Adequate Action Notice to applicants or beneficiaries informing them of adverse actions and determinations taken under the following circumstances:

- when the provider refuses to furnish a requested service to a program applicant.
- when the provider refuses to increase a service that is currently being provided to the beneficiary.
- when the provider reduces a service that is currently being provided to the beneficiary and this reduction follows the approved POC for the beneficiary.

4.1.B. ADVANCE ACTION NOTICES

An Advance Action Notice must be sent to BIS beneficiaries when action is being taken to reduce, suspend or terminate service(s) a beneficiary currently receives. This notice must be provided 10 days in advance of the intended action.

MDHHS HCBS staff will send an Advance Action Notice to beneficiaries informing them of adverse actions and determinations taken under the following circumstances:

- When MDHHS staff determine the beneficiary is making progress toward goals and will be discharged from BIS.
- When MDHHS staff determine an individual no longer qualifies for BIS.
- When the provider (with permission from MDHHS) plans to reduce or terminate a service that is currently being provided to the beneficiary before the POC indicates.

The Advance Action Notice must inform the beneficiary that services will not be reduced, suspended or terminated until a formal decision has been rendered through the Medicaid Fair Hearings process if the beneficiary formally requests a hearing before the specified date of the intended action.

4.1.C. Request for Hearing Form

MDHHS will supply a copy of the Request for Hearing form (DCH-0092) and a return envelope with each notice sent to an applicant or beneficiary, or any time an applicant or beneficiary requests such material. Providers are required to assist applicants or beneficiaries who request help in filing a formal appeal for any reason through the Medicaid Fair Hearings process.

4.1.D. Representation at State Fair Hearing

Both a BIS provider representative and a MDHHS HCBS Section or Long Term Care Policy Section representative must be present at the hearing. The BIS provider will be expected to participate in the State Fair Hearings process to support medical documentation used to make determinations related to the hearing request.

SECTION 5 – PROVIDERS

5.1 PROVIDER QUALIFICATIONS

In addition to provider qualifications identified above in the Covered Services section, all providers for BIS must have appropriate accreditation, certifications, or specialized training in serving individuals with brain injuries.

5.1.A. ACCREDITATION, CERTIFICATION, OR SPECIALIZED TRAINING

Appropriate accreditation, certification, or specialized training includes:

- Accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) with:
  - Medical Rehabilitation accreditation as a brain injury specialty residential program;
  - Medical Rehabilitation accreditation as a brain injury specialty interdisciplinary outpatient service; or
  - Medical Rehabilitation accreditation as a brain injury specialty residential program and interdisciplinary outpatient services.
- Medicare and Medicaid certification as a Comprehensive Outpatient Rehabilitation Facility (CORF).
- Medicare accreditation as a Rehabilitation Agency or Outpatient Physical Therapy program as verified by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF).
- In areas of the state where there are limited providers with CARF, CORF, or AAAASF accreditation or certification, MDHHS may allow individual providers who are certified as Brain Injury Specialists (CBIS) through the Brain Injury Association of America's Academy of Certified Brain Injury Specialists (ACBIS) and who work in a health care program with additional licensing or accreditation to become brain injury providers.

5.1.B. PROVIDER ENROLLMENT IN CHAMPS

All providers must follow provider enrollment requirements as specified in the General Information for Providers chapter of this manual, including business location, provider ownership and control disclosures, criminal offense notification, and enrollment screening.

5.1.C. TRANSITIONAL RESIDENTIAL PROVIDER REQUIREMENTS

Transitional Residential services must be conducted in facilities licensed by MDHHS as adult foster care (AFC) facilities.

5.1.C.1. LICENSURE REQUIREMENTS

All AFC homes must maintain current licensure and follow all licensing rules and regulations, including staff qualifications and training. Direct care staff will provide

supportive services for each beneficiary 24 hours a day. The ratio of direct care staff is required to meet the acuity needs of the beneficiaries, but will not be less than one staff to five residents on day and evening shifts and one staff to eight residents during sleeping hours. Substitute employees may only be used in the case of an unexpected staff shortage. The continuity and consistency of the residents' care must be preserved to ensure maximum restorative rehabilitation progress.

5.1.C.2. ADDITIONAL STAFFING REQUIREMENTS

- A Michigan-licensed therapist must be on the premises during the time therapy is provided.
- A Michigan-licensed RN must be available for health assessments, treatments, and other nursing needs required by the residents.
- A Michigan-licensed social worker must be available for assisting in discharge planning, counseling, or other needs.
- Psychiatrists, neuropsychologists, psychologists, and other specialists must be available for consultation and treatment as needed. Evidence of appropriate availability must be documented.

5.1.C.3. PROVIDER CASE RECORD REQUIREMENTS

All BIS providers are required to keep case records for each beneficiary served according to acceptable standards of practice.

SECTION 6 – REIMBURSEMENT

Reimbursement for Transitional Residential BIS will be according to per diem rates, negotiated with the BIS providers, which reflect the service needs of the beneficiary and a reasonable cost basis for the services rendered. PA is required for the Transitional Residential BIS per diem reimbursement. Requests for PA are submitted for days of services, not for individual services (for example, PA request is for 60 days of BIS, regardless of services provided). Providers should contact the MDHHS HCBS Section regarding BIS authorization requirements. (Refer to the Prior Authorization section of the General Information for Providers chapter of this manual for additional information.)

Reimbursement for Outpatient BIS will be according to a published fee schedule based upon the services received by the beneficiary. PA is required for Outpatient BIS reimbursement. Requests for PA are submitted for individual services for a specified duration (for example, PA request is for 30 days of physical therapy BIS for eight 15-minute units per day). Providers should contact the MDHHS HCBS Section regarding BIS authorization requirements. (Refer to the Prior Authorization section of the General Information for Providers chapter of this manual for additional information.)

6.1 EXCLUDED PAYMENTS

BIS does not include payment for room and board. "Room" is defined as rent and lodging expenses. "Board" is defined as three meals per day, regardless of the method of intake for those meals.

BIS also excludes educational services, such as tutoring assistance and school-based services, and vocational services, such as services to train or build skills for the support of the individual's employment. These services are available to qualified Medicaid beneficiaries through other Medicaid programs and services.

6.2 BILLING REQUIREMENTS

BIS providers must follow the requirements of the Billing & Reimbursement for Institutional Providers and the Billing & Reimbursement for Professionals chapters of this manual.

6.3 BILLING BENEFICIARIES

BIS providers are not allowed to bill Medicaid beneficiaries for services authorized by MDHHS. Additional information about billing beneficiaries is found in the Billing Beneficiaries section of the General Information for Providers chapter of this manual.