MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

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Subject: Hospital Coverages and Limitations

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Programs Affected: Medicaid, Children's Special Health Care Services, State Medical Plan, and Maternity Outpatient Medical Services (MOMS)

This bulletin transmits a revised Hospital Manual Chapter III (Coverages and Limitations). Michigan Department of Community Health (MDCH) has removed all Hospital billing instructions. All Hospital billing information is published in the MDCH Institutional Providers Billing and Reimbursement Chapter IV that combines all current MDCH institutional billing instructions.

The effective date for the attached Chapter III is October 1, 2003. Also effective on that date, all claims submitted to the MDCH must be submitted using Institutional Claim ANSI X12N 837, version 4010A1 format, or the UB-92 paper claim form.

The format of the attached chapter is new. The MDCH is updating all its provider and hospital manuals with the goal of creating a single, all-inclusive manual that will be updated annually, distributed via compact disc, and also be available through the Internet. (The Department will continue the current process of issuing paper policy bulletins throughout the year as needed.)

In reviewing the chapter, please note the following changes:

- All current coverage policies, procedures, and enhanced reimbursement for Children's Multidisciplinary Specialty (CMS) clinics are being rescinded. Effective October 1, 2003, services provided by CMS clinics are covered according to the standard Medicaid outpatient hospital clinic policy. Clinic services are to be billed as described in Chapter III and Chapter IV of the Hospital Manual, and will be reimbursed according to the standard Medicaid fee screens.

- Current reimbursement policy related to inpatient hospital transfers from a specialty hospital/unit (e.g., burn, neonatal) is being modified effective October 1, 2003. Medicaid will no longer consider individual consideration for additional payment. See Hospital Manual, Chapter VIII, Section 2, page 9, for current policy.

- New Diabetic Self Management Education Medicaid program coverage.
- Many policies have been reworded to clarify existing policy intent.

Manual Maintenance

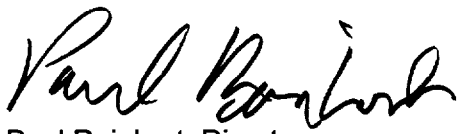
Replace your Hospital Chapter III with the attached manual pages. This will also obsolete bulletins Hospital 00-02, Hospital 00-06, Hospital 01-04, MSA 02-04, MSA 02-06, and MSA 03-13.

Retain this bulletin for future reference.

Questions

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

Approval



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Chapter III – Hospital

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SECTION 1 – GENERAL INFORMATION

This chapter applies to services provided to Fee for Service (FFS) beneficiaries in an inpatient and/or outpatient hospital setting unless otherwise indicated. Medically necessary services provided to Medicaid beneficiaries by an enrolled hospital are generally covered by Medicaid, administered through the Michigan Department of Community Health (MDCH). The attending physician (M.D. or D.O.) is responsible for determining medical necessity and appropriateness of service within the scope of current medical practice and Medicaid guidelines. Services described in this chapter must also be available to Medicaid Health Plan (MHP) enrollees; however, the MHPs may implement different authorization and service criteria. For billing purposes, a revenue code is identified as a specific accommodation, ancillary service or billing calculation for all institutional claims. The appropriate revenue code from the National Uniform Billing Committee (NUBC) and/or State Uniform Billing Committee (SUBC) manuals must be used on each claim line for all institutional claims. If a procedure code is required, a Health Care Financing Administration Common Procedure Coding System (HCPCS) code(s) must be used. Prior Authorization (PA) information in this chapter pertains to FFS Medicaid and FFS Children's Special Health Care Services (CSHCS) only. If the beneficiary is enrolled in a MHP, the hospital must obtain any required PA from the beneficiary's MHP or CSHCS Special Health Plan (SHP) when providing services**.**

1.1. INPATIENT HOSPITAL

An inpatient hospital is defined as a facility, other than psychiatric, which primarily provides medically necessary diagnostic, therapeutic (both surgical and non-surgical) or rehabilitation services to inpatients. Services provided to inpatients include bed and board; nursing and other related services; use of facility; drugs and biologicals; supplies, appliances and equipment; diagnostic, therapeutic and ancillary services; and medical or surgical services. Services of professionals (e.g., physician, oral surgeon, dental, podiatric, optometric) are not included and must be billed separately. Inpatient hospital services are:

- ordinarily furnished in a facility for the care and treatment of inpatients;
- furnished under the direction of a physician (M.D. or D.O.) or a dentist;
- furnished in a facility that is:
  - maintained primarily for the care and treatment of inpatients with disorders other than mental diseases;
  - licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
  - Medicare-certified to provide inpatient services.

An inpatient is an individual who has been admitted to a hospital for bed occupancy with the expectation that he will remain at least overnight, even when it later develops that he can be discharged or is transferred to another hospital and does not use the bed overnight. Days of care provided to a beneficiary are in units of full days, beginning at midnight and ending 24 hours later. Medicaid covers the day of admission but not the day of discharge. If the day of admission and the day of discharge are the same, the day is considered an admission day and counts as one inpatient day.

Medicaid generally covers semi-private, three-bed, or four-bed accommodation. When private accommodations are furnished to the beneficiary because the semi-private accommodations are not available, MDCH only pays for the semi-private accommodation and the beneficiary cannot be billed for

the difference. The hospital's inpatient accommodation rate includes all charges associated with routine services (e.g., linens, nursing services, etc.) rendered during the inpatient stay. All dietary services, including special diets, are included in the accommodation rate and are not allowable under any other cost center.

1.1.A. Private Rooms

Private rooms are covered by Medicaid only when determined medically necessary. Beneficiaries who request a private room when it is not medically necessary must be informed in advance that they are responsible for the entire room charge. If the beneficiary insists on a private room, the hospital should obtain the beneficiary's acknowledgement of his responsibility in writing. Hospitals may not split bill Medicaid FFS for a semi-private room and the beneficiary, or his/her family, the difference for a private room.

1.1.B. Intensive Care

Intensive care provided in an intensive care unit(s) is covered for the treatment of critically ill beneficiaries. Neonatal intensive care unit accommodations may be billed only if medically necessary, the infant is treated in this setting, and the neonatal unit has been approved by the MDCH to provide this level of service.

1.2 OUTPATIENT HOSPITAL

An outpatient hospital is defined as a portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require inpatient hospitalization. Outpatient hospital services are:

- furnished under the direction of a physician (M.D. or D.O.) or a dentist;
- furnished in a facility that is certified as a provider, or as having provider-based status, by Medicare.

1.2.A. Multiple Visits – Same Revenue Center

MDCH will review all multiple visit claims, and will not pay for more than one visit on the same date of service, in the same revenue center, unless the visits are separate, distinct and constitute independent visits. The services must be billed appropriately and supported in the hospital medical record documentation and in the claim Remarks section.

1.2.B. Multiple Visits - Different Revenue Center

MDCH will review all unrelated services performed on the same day (i.e., Emergency Room and Operating Room, Emergency Room and Treatment Room, etc.) when submitted as one claim.

1.2.C. Medical/Surgical Supplies

Supplies used during the course of treatment in the outpatient hospital are covered and billable. An itemized list of supplies used, including the number of specific items and related charges, must be recorded in the patient's record.

Use/rental of equipment and durable items routinely used for surgery cannot be billed separately as they are included in the reimbursement for the operating room. These include, but are not limited to, microscopes, monitors, drills, lasers, etc. Surgical supplies used for surgery are covered and can be billed separately with a supporting HCPCS code. All appropriate surgical supply revenue codes should be reported on the same outpatient claim and are paid as a percent of charge for billable supplies used during the surgical procedure.

1.2.D. Personal Items

Personal comfort and convenience items (e.g., toiletries, slippers, hospitality kits, etc.) cannot be billed to MDCH.

1.2.E. Take-Home Supplies

Medicaid covers a limited supply of take-home medical supplies until the beneficiary is able to obtain these items from an enrolled medical supplier and/or pharmacy.

1.3 Clinic Services

Hospital Clinic services are covered if rendered in a clinic setting that is part of the licensed and Medicaid-enrolled hospital, and that satisfies Medicare requirements for provider-based status. Clinic services rendered in the outpatient hospital include non-emergency outpatient services that are provided to ambulatory beneficiaries.

MDCH covers Urgent Care Clinics (as part of the Medicaid-enrolled hospital and that satisfies Medicare requirements for provider-based status) when the services provided are specific to urgent medical care (i.e., suturing, most fracture care) and are medically necessary for a non-life threatening condition or injury, or illness that should be treated within 24 hours. Urgent care clinic visits provided on the same date of service with any other clinic visit or emergency department service/visit (i.e., Emergency Medical Treatment and Active Labor Act {EMTALA} Screen) are not covered unless the second visit is medically necessary to treat an acute exacerbation or a new condition. Claims for more than one visit per day are manually reviewed.

1.4. Emergency Department Services

1.4.A. Screening Exam and Stabilization

The MDCH and its contracted health plans must follow the applicable requirements and definitions of the federal Emergency Medical Treatment and Active Labor Act 42USC§1395dd (EMTALA).

Medicaid covers the medical screening examination, any ancillary service(s) if performed in a hospital emergency department for the sole purpose of determining if an emergency medical condition exists, and any necessary stabilizing treatment.

For both Medicaid FFS and MHP beneficiaries, the screening examination and any physician-ordered procedures (e.g., x-rays, lab, etc.) necessary to determine the patient's condition are covered without PA. For Medicaid FFS beneficiaries, the screening examination and related diagnostic procedures are billed to MDCH. For Medicaid MHP beneficiaries, these services are billed to the beneficiary's MHP.

Facility charges for the emergency department screening exam are included in the hospital inpatient admission when services occur at the same facility. If the patient is transported to another facility for a prior authorized inpatient admission, the first hospital's facility fees for the emergency room are reimbursed separately. In both instances, the professional fees for medical screening and stabilization in the emergency room are reimbursed separately from the facility fees.

1.4.B. Treatment of Emergency Medical Condition

Prior authorization is not required for the treatment of emergency medical conditions.

An emergency medical condition is defined by the Balanced Budget Act of 1997 and its regulations.

An emergency may exist whether the patient is discharged from the emergency department or admitted to the inpatient hospital. This includes admissions where death occurs before a bed is occupied.

If an emergency medical condition exists, the medical findings must be fully documented in the patient's medical record.

1.4.C. Treatment for Non-Emergency Medical Conditions

If the medical findings from the screening determine that the patient's condition does not meet the definition of an emergency medical condition, but requires additional, follow-up treatment, the following rules apply:

- MHP enrollees must be referred to their primary care provider for treatment, or the emergency department can contact the MHP to request authorization to provide the treatment. The hospital must document all telephone calls made to the enrollee's MHP for the purpose of requesting post-stabilization authorization. If the MHP fails to respond within one hour to the request for additional services beyond those required for stabilization, the request for authorization is deemed approved.
- FFS Medicaid beneficiaries with private health insurance must follow the rules of the private health insurance. Private insurances frequently require that the primary care provider for the private insurance perform follow-up treatment. If the private insurance refuses payment for treatment because their rules were not followed, MDCH does not pay for services. Medically necessary services not covered by the primary insurer which are covered by Medicaid will be reimbursed if the Medicaid coverage requirements are followed.

- FFS Medicaid beneficiaries without private health insurance should be encouraged to obtain treatment from their primary care provider. However, treatment may be rendered in the emergency department and does not require PA.

1.4.D. Psychiatric Screen and Stabilization Services

Screening and stabilization of a psychiatric emergency does not require PA. If the treating hospital determines that the beneficiary requires post-stabilization psychiatric services, the hospital must contact the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) provider for PA. The need for PA includes, but is not limited to, inpatient psychiatric care, partial hospitalization, and/or specialized community mental health clinical rehabilitation services. If a beneficiary requires inpatient psychiatric hospitalization and is admitted directly from the emergency department to the same facility, the local PIHP/CMHSP must prior authorize the admission.

If the beneficiary is transported to another facility for a prior authorized inpatient admission, the first hospital's facility fees for the emergency department are reimbursed separately.

In both instances, the professional fees for medical screening and stabilization in the emergency department are reimbursed separately.

A psychiatric emergency is defined as a situation in which an individual must be treated to protect him from inflicting injury to self or others as the result of a serious mental illness, emotional disturbance, or developmental disability or could reasonably be expected to intentionally or unintentionally injure himself or others in the near future. The emergency may result from an inability to provide food, clothing, or shelter for him or others, inability to attend activities of daily living, or when judgment is so impaired the individual is unable to understand the need for treatment.

1.4.E. Emergency Department Post-Payment Review

The Admissions and Certification Review Contractor (ACRC) performs periodic reviews of Emergency Room services to verify that the hospital medical record supports the level of services billed. A random selection for review is used to determine if services were billed at a higher level than supported by the medical record documentation. If the review findings of the Emergency Room claims identify services provided that did not meet review criteria, an adverse action notice is sent to the providers of the determination with appeal rights.

MDCH may conduct periodic audits, by hospital, of claims to verify that the Emergency Room medical record supports the level of services billed. If a statistically valid random sample, by hospital, determines that services billed were not supported, or billed at a higher level than supported by the medical record, audit findings may be extrapolated to the entire Medicaid population receiving services in that facility, and are subject to recoupment and/or adjustment. Facilities have the option to participate in the appeal process.

1.5 THIRD PARTY LIABILITY (TPL)

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the "payer of last resort." Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage. (Refer to the Coordination of Benefits Chapter of this manual for more information.)

1.5.A. Medicare-Related Services

MDCH reimburses for Medicare-covered services up to the beneficiary's financial obligation to pay, or the Medicaid fee screen, whichever is less. This limitation also applies if the beneficiary is eligible for, but not enrolled in, Medicare. Medicare benefits must be used prior to billing MDCH or any Medicaid-capitated plan (MHP, PIHP/CMHSP, Substance Abuse Coordinating Agency {CA}) for any portion of the claim.

MDCH reimburses Medicare coinsurance and deductible amounts subject to Medicaid's reimbursement limitations on all Medicare-approved claims, even if Medicaid does not normally cover the service. Lifetime Reserve Days must be used, if available.

1.5.B. Other Insurance

Medicaid and CSHCS beneficiaries may have insurance coverage, either traditional health insurance or a Health Maintenance Organization (HMO) through private and/or employer-based commercial policies. The other insurance is always primary, and the rules of that insurer must be followed. This includes, but is not limited to, PA requirements, provider qualifications, and receiving services through the insurer's provider network. MDCH does not pay for services denied by the primary insurer because the primary insurer's rules were not followed.

Medicaid covers the appropriate co-pay and deductibles, up to the beneficiary's financial obligation to pay, or the Medicaid fee screen, whichever is less. If the primary insurer has negotiated a rate for a service that is lower than the Medicaid fee screen, MDCH cannot be billed more than the negotiated rate. MDCH reimburses Medicaid-covered services that are not included in the primary insurer's plan up to the Medicaid fee screen if all Medicaid coverage rules have been followed. If a beneficiary is enrolled in a MHP, or is receiving services through PIHP/CMHSP or CA capitation, the MHP/PIHP/CMHSP/CA is responsible for payment.

1.6 MISCELLANEOUS

1.6.A. Abuse

Providers with reasonable cause to suspect that a child or vulnerable adult may have been abused or neglected are required by law to immediately report it to the appropriate Protective Services Unit of the local Family Independence Agency (FIA). (Refer to the Directory Appendix for contact information). Inpatient hospital stays for suspected abuse or neglect are covered if the attending physician determines the beneficiary requires

further assessment and treatment. Inpatient stays for the sole purpose of custodial or protective care are not a covered benefit.

1.6.B. Administrative Services

Interns, resident physicians, dentists, or medical staff that are functioning in an administrative, teaching, or learning capacity for the hospital cannot bill the MDCH for their professional services as these costs are included in the hospital's Graduate Medical Education (GME) payments. This includes physician-owners or other staff paid by the hospital. Staff meetings for any purpose are not reimbursable. Reimbursement for administrative services is included in the DRG payment, as well as the outpatient fee screens

1.6.C. Communicable Disease

Cases of communicable disease, such as tuberculosis, hepatitis, meningitis, and enteric disease, must be reported to the local health department. For additional information, contact your local health department. (Refer to the Directory Appendix for contact information.)

1.6.D. Education Costs for Professional Education

Payments for educational costs are made directly to hospitals for health professional education in both the inpatient and outpatient hospital setting according to the requirements and formulas in the Billing and Reimbursement for Institutional Providers Chapter of this manual.

1.6.E. Hospital-Based Provider (HBP)

A hospital-based provider (HBP) is defined as a hospital-employed M.D., D.O., Certified Registered Nurse Anesthetist (CRNA), dentist, podiatrist, optometrist, or nurse-midwife. HBPs must be enrolled separately as Medicaid providers and bill MDCH directly using their own Medicaid ID number for any covered professional service(s) that they provide. (Refer to the appropriate Medicaid provider manual for policies, procedures, and billing instructions.)

1.6.F. Hospital Personnel Providing Ambulance Transport Assistance

Only enrolled ambulance providers may provide ambulance services. MDCH does not reimburse hospitals for staff personnel who assist with an ambulance transport. The cost of all hospital personnel is considered part of the normal hospital operation (included in the cost center) and may not be billed to MDCH or to the beneficiary.

1.6.G. Pharmacy

Pharmaceutical products (drugs and biologicals) provided to inpatients are covered as a component of the inpatient Diagnosis Related Group (DRG) and are not reimbursed separately.

Pharmaceutical products administered in conjunction with outpatient laboratory, radiology, or other medical procedures/treatment are covered and may be billed individually by the outpatient hospital

Take-home drugs require a written prescription and are covered only when provided by a Medicaid-enrolled pharmacy. Contact the Provider Enrollment Unit, Budget and Finance Administration to become an enrolled pharmacy provider. (Refer to the Directory Appendix for contact information.)

(See the Medicaid Pharmacy Manual for additional information.)

1.6.H. Outpatient and Emergency Services Provided on the Date of an Inpatient Hospital Admission

Outpatient surgical and emergency department services provided at the same hospital on the same day of an inpatient admission must be included as a part of the inpatient stay and are reimbursed as part of the DRG payment. Charges for emergency services or ambulatory surgery which result in admission must be reflected on the inpatient claim for that episode of care. The date of admission should be reported as the date the physician wrote the order to admit the beneficiary**.**

1.6.I. Services that Must be Billed by Other Providers

The following services may not be provided and billed as an outpatient hospital service. These services may be provided and billed by the appropriate enrolled provider:

- Ambulance
- Certified registered nurse anesthetist (CRNA)
- Chiropractor
- Dentist
- Durable medical equipment
- Hearing aids
- Home health
- Medical supplies (take-home)
- Nurse Practitioner*
- Nurse-midwife*
- Optical
- Oxygen (take-home)
- Orthotics
- Pharmacy (take-home)
- Physician
- Podiatrist
- Prosthetics
- Shoes

* If not an employee of the hospital.

1.6.J. Technician Calls

Overtime or holiday pay to technicians who are required to be at the hospital outside of their normal work hours are not separately billable to beneficiaries or to Medicaid. These charges are included in the hospital's standard charge structure.

SECTION 2 - PRIOR AUTHORIZATION (PA)

MDCH requires PA for certain procedures. The PA is to validate the medical need for the service. The following chart, intended for reference only, indicates services provided in the hospital setting that require PA, who must obtain it, how to obtain the PA, and the documentation required when the claim is submitted.

Hospital services requiring PA include:

Service	PA Obtained By	Obtained Via	Documentation for Claim
* Cosmetic Surgery	Attending Physician	Letter to Office of Medical Affairs (OMA)	Copy of Letter from OMA
* Elective Admissions, All Re-admissions, Transfers for treatment of general medical conditions	Attending Physician	Admissions and Certification Review Contractor (ACRC)	PACER Certification number
Freestanding Rehabilitation	Hospital	ACRC	Billing Authorization Number
Inpatient Psychiatric Admissions and Continued Stay	Hospital or Attending Physician	Phone call to local PIHP/CMHSP	Reimbursed by the PIHP/CMHSP, not MDCH
* Outpatient Occupational Therapy (OT) (after the initial 90 days of treatment or 36 visits)	Hospital	Occupational/Physical Therapy - Speech Pathology Prior Approval Request/Authorization (MSA-115)	PA number and, in Remarks, the From and Through dates of the PA number
* Physical Therapy (PT) (after the initial 90 days of treatment or 36 visits)	Hospital	Occupational/Physical Therapy - Speech Pathology Prior Approval Request/Authorization (MSA-115)	PA number and, in Remarks, the From and Through dates of the PA number
* Outpatient Speech-Language Pathology (after the initial 90 days of treatment or 36 visits)	Hospital	Occupational/Physical Therapy - Speech Pathology Prior Approval Request/Authorization (MSA-115)	PA number and, in Remarks, the From and Through dates of the PA number
Outpatient Psychiatric Partial Hospitalization	Hospital	Phone call to PIHP/CMHSP	Reimbursed by the PIHP/CMHSP, not MDCH
* Services for Weight Reduction (e.g., Surgery)	Attending Physician	Letter to OMA	Copy of Letter from OMA
* Organ Transplants	Attending Physician	Contact the OMA	Copy of the Letter of Authorization from the OMA
* Pediatric Multi-Channel Recording (if more than two per year are considered medically necessary)	Attending Physician	Contact the OMA	Copy of the Letter of Authorization from the OMA

*If the beneficiary is enrolled in a MHP, you must contact the individual MHP to verify PA requirements.

PA does not guarantee payment or beneficiary eligibility. The provider must check the beneficiary's Medicaid eligibility prior to rendering services. (See the Eligibility Chapter of this manual for further information. Refer to the General Information Chapter of this manual for additional information.)

PA is not required if the beneficiary is receiving Medicare benefits for a Medicare - approved service.

SECTION 3 – COVERED SERVICES

Hospital services requiring additional information are listed below in alphabetical order. **NOTE:** Some services have coverage limitations and/or PA requirements.

3.1 ABORTIONS

Abortions performed by physicians and related hospital charges are a covered service only when medically necessary to save the life of the mother and/or the pregnancy is the result of rape or incest. Copies of the "Certification for Induced Abortion" (Form MSA-4240), completed by the physician, and the "Beneficiary Verification of Coverage" (Form MSA-1550) must accompany all claims, except those for ectopic pregnancies or spontaneous, incomplete or threatened abortions. The physician certifies on the MSA-4240 that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the pregnancy terminated was the result of rape or incest.

The physician who completes the MSA-4240 must also ensure completion of the MSA-1550 and is also responsible for providing copies of both the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) who bill for services related to the abortion. Providers must obtain copies of the completed MSA-4240 and MSA-1550 from the physician and attach them to their claim when billing. (See the Forms Appendix for samples of MSA-4240 and MSA-1550.)

The medical record must include a complete beneficiary history, including the medical conditions that made the abortion necessary to save the life of the mother. When the pregnancy is the result of rape or incest, the medical record must include the circumstances of the case and documentation that the pregnancy was the result of rape or incest.

3.2 ANESTHESIA

Medicaid coverage includes anesthesia services when provided by qualified practitioners in conjunction with surgical services or other procedures when medically necessary.

Physician or CRNA professional charges may not be billed on the outpatient hospital claim format. These professional charges must be billed on a HCFA 1500 claim form. (Refer to the Medicaid Practitioner provider manual for additional information.)

3.3 APHERESIS

Apheresis (therapeutic apheresis) is a medical procedure that is a covered service in an outpatient hospital for certain conditions. Therapeutic apheresis is defined as a continuous autologous procedure and is covered by MDCH as follows:

- Plasma exchange for acquired myasthenia gravis
- Leukapheresis in the treatment of leukemia
- Plasmapheresis in the treatment of primary macro-globulinemia (Waldenstrom)
- Treatment of hyperglobulinemias, including (but not limited to) multiple myelomas, cryoglobulinemia, and hyperviscosity syndromes

- Plasmapheresis or plasma exchange and last resort treatment of thrombotic thrombocytopenic purpura (TTP)
- Plasmapheresis or plasma exchange in the last resort treatment of life-threatening rheumatoid vasculitis when all other conventional therapies have failed
- Plasma exchange in the treatment of life-threatening forms of Goodpasture's Syndrome when the beneficiary has not responded to more conventional forms of therapy
- Plasma exchange in the treatment of life-threatening forms of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage, when the beneficiary has not responded to more conventional forms of therapy
- Plasma perfusion of charcoal filters for treatment of pruritis of cholestatic liver disease
- In the treatment of chronic relapsing polyneuropathy for beneficiaries with severe or life-threatening symptoms who have failed to respond to conventional therapy
- When used in the treatment of life-threatening scleroderma and polymyositis, when the beneficiary is unresponsive to conventional therapy
- For the treatment of Guillain-Barre Syndrome
- A treatment of last resort for life-threatening Systematic Lupus Erythematosous (SLE), when conventional therapy has failed to prevent clinical deterioration.

Apheresis is not a covered service when a beneficiary donates blood preoperatively and, at a later date, the blood is transfused back to the beneficiary.

3.4 APNEA MONITORS

Program guidelines for home apnea monitors are based on the "Report of the Michigan Ad Hoc Task Force on Apnea: A Consensus" prompted by the 1986 "National Institute of Health Consensus Development Conference Statement on Infantile and Home Monitoring." Guidelines are subject to change as the consensus changes.

Monitors must be provided by a Durable Medical Equipment (DME) provider and may be covered on a rental basis without PA for up to three months from the date of discharge from the hospital for symptomatic infants discharged on a monitor. The hospital medical record should document that the infant was discharged on a monitor. The medical supplier also must note in its records that the child was discharged on a monitor, and a hospital discharge planner arranged for the apnea monitor rental.

3.5 BENEFICIARY EDUCATION

Beneficiary education in the inpatient setting is included in the DRG payment. Beneficiary education services are covered in an outpatient setting as follows:

3.5.A. Childbirth Education

MDCH covers a childbirth education program for pregnant women. The prenatal care provider must make written referrals for the pregnant woman and the program must be provided by qualified educators in a Medicaid-enrolled outpatient hospital, or by a certified maternal support services program provider. This service is not covered if

rendered by a prenatal care provider in the office setting. MDCH reimbursement is for the childbirth education (also referred to as birthing education) as a complete program.

Childbirth education includes, but is not limited to, the following topics:

Pregnancy	▪ Health care during pregnancy; ▪ Physical and emotional changes during pregnancy; and ▪ Nutrition.
Labor and Delivery	▪ Signs and symptoms of labor, including information regarding pre-term labor; ▪ Breathing and relaxation exercises; ▪ Analgesia and anesthesia; ▪ Avoiding complications; ▪ Coping skills; ▪ Types of deliveries; ▪ Episiotomy; ▪ Support techniques; and ▪ Hospital tour.
Infant Care	▪ Preparation for breast feeding; ▪ Infant feeding; ▪ Immunizations; ▪ Infant car seat use; and ▪ Parenting.
Postpartum	▪ Postpartum physical and emotional changes, including depression; ▪ Feelings of partner; ▪ Potential stress within the family; ▪ Sexual needs; ▪ Exercise; and ▪ The importance of family planning.

3.5.B. Diabetes Self-Management Education (DSME) Training Program

MDCH reimburses for Diabetes Self-Management Education (DSME) Training programs provided in an outpatient hospital if ordered by a physician and Community Public Health (CPH) certifies the program. Certification must be on file with MDCH Provider Enrollment. (Refer to the Directory Appendix for contact information.)

- An initial DSME training program is covered once within a 12-month period and may not exceed ten hours of instruction. The initial training program may include up to a maximum of one hour of individual training and up to nine hours of group training.

- A maximum of two hours per year of follow-up training (individual or group) may be provided after completion of the initial 12-month training period.

MDCH will cover more than two individual sessions on an individual basis (not to exceed a total of 10 hours initial) for a beneficiary who meets either of the following conditions:

- No group training session is available within two months of the date the training is ordered.
- The beneficiary's physician documents in the medical record that the beneficiary has special needs resulting from conditions, such as severe vision, hearing, or language limitations, that will hinder effective participation in a group training session.

MDCH does not cover DSME if provided by a physician in the office setting, or by a non-enrolled or non-CPH certified provider.

3.6 Blood Products

Hospitals and/or beneficiaries are expected to attempt to replace blood used by the beneficiary. Medicaid covers whole blood if replacement is not available from other sources. If blood is purchased (i.e., from the Red Cross), the hospital may bill for the blood not replaced, the administration, and the procedure room.

3.7 Chemotherapy Treatment

MDCH covers antineoplastic drugs when supported by reporting the appropriate HCPCS/Current Procedural Terminology (CPT) code. MDCH does not cover antineoplastic agents that are investigational or experimental.

3.8 Dental Services

Dental services are routinely rendered in the dental office unless the situation requires that the dental service be performed in the outpatient hospital setting. However, services are not covered in the outpatient hospital setting for the convenience of the dentist or beneficiary.

Non-emergency routine dental treatment provided in an outpatient hospital setting is covered only under the following conditions:

- A concurrent hazardous medical condition exists;
- The nature of the procedure requires hospitalization; or
- Other factors (e.g., behavioral problems due to mental impairment) necessitate hospitalization.

(Refer to the Medicaid Dental provider manual for additional information regarding specific dental services.)

The dentist/physician must document in the beneficiary's medical record the condition that required the dental service be done in the hospital setting.

3.9 DIALYSIS (HEMODIALYSIS AND PERITONEAL DIALYSIS)

MDCH reimbursement is an all-inclusive rate for maintenance dialysis services for beneficiaries receiving hemodialysis or peritoneal dialysis. Individual services may not be billed separately. The rate is the same whether the beneficiary dialyzes in the facility or at home, and includes all necessary home and facility dialysis maintenance services, supplies, equipment and supportive services such as:

- Oxygen;
- Filters;
- Declotting of shunts;
- Staff time to administer blood or oxygen; and
- Routine parenteral items: Heparin, Protamine, Mannitol, saline, glucose, dextrose, topical anesthetics, and arrythmics.

MDCH reimburses the physician directly for professional services related to maintenance dialysis.

Non-routine additional services must be billed using the appropriate supporting HCPCS code. The facility is responsible for making arrangements with a DME provider for supplies not available from the dialysis facility. MDCH does not reimburse the supplier separately. The facility is responsible for payment to the supplier or independent lab for services provided.

3.9.A. Dialysis Laboratory Services

Payment for laboratory services related to maintenance dialysis is included in the composite rate regardless of whether the tests are performed in the facility or an independent laboratory. The following tests are considered to be a routine part of maintenance dialysis and may not be billed separately unless it is medically necessary to perform them in excess of the frequencies indicated.

Laboratory tests for Hemodialysis, Peritoneal Dialysis, and Continuous Cycling Peritoneal Dialysis (CCPD) that are included in the composite rate:

Per Treatment	Weekly	Monthly
▪ All hematocrit or hemoglobin tests and clotting time tests	▪ Prothrombin time for patients on anticoagulant therapy; ▪ Serum Creatinine; and ▪ BUN.	▪ CBC, including platelet count and additional indices; ▪ Serum Calcium; ▪ Serum Chloride; ▪ Serum Potassium; ▪ Serum Bicarbonate; ▪ Serum Phosphorus; ▪ Total Protein; ▪ Serum Albumin; ▪ Alkaline Phosphatase; ▪ SGOT; and ▪ LDH.

Laboratory tests for Continuous Ambulatory Peritoneal Dialysis (CAPD) that are included in the composite rate on a monthly basis:

BUN	Creatinine	Sodium	CO2
Calcium Magnesium	Phosphate	Potassium	Total Protein
Albumin	Alkaline Phosphatase	LDH	AST
HCT	Hgb	Dialysate Protein	SGOT

Laboratory tests not listed above may be separately billed by the dialysis facility or Clinical Laboratory Improvement Act (CLIA)-certified lab performing the test.

3.9.B. Dialysis Self-Care Training

MDCH reimburses for dialysis self-care training provided by outpatient dialysis clinics.

- A session is considered as one training day and a complete course is considered 10 – 15 sessions.
- Sessions must be documented in the beneficiary's medical record and are subject to post-payment review.

3.10 DIAGNOSTIC TESTING

MDCH reimburses for diagnostic testing to diagnose a disease or medical condition. Outcomes must be documented in the medical record. Diagnostic testing in an inpatient hospital is included in the inpatient DRG payment. Outpatient hospitals must bill MDCH using the appropriate HCPCS code.

MDCH does **not** reimburse for:

- Routine screening, such as spirometry, holter monitor, Doppler flow-study or pelvic echography;
- Testing to establish baseline values;
- Testing for the general health and well-being of a beneficiary; or
- Any test not generally recognized as relevant to the condition being investigated.

3.10.A. Fetal Monitor – Fetal Non-Stress Test

A Fetal Non-Stress Test is covered as a diagnostic test when performed as part of routine monitoring of an ongoing pregnancy. MDCH does not cover a room charge in addition to the test when it is being performed as part of routine monitoring of an ongoing pregnancy.

3.10.B. Pediatric Multi-Channel Recording

A pediatric multi-channel recording is a continuous and simultaneous recording of at least four channels and may include electrocardiogram (ECG), thoracic impedance, airflow measurements, oxygen saturation, esophageal pH, or strain gauge measurements. Additional channels may be appropriate and do not have to include an electroencephalogram (EEG).

MDCH reimburses for two multi-channel recordings per year per beneficiary under age 21 when provided by qualified personnel and interpreted by the physician. The physician must obtain PA if more than two tests per year are considered medically necessary and must provide a copy of the PA for the hospital's medical record.

Multi-channel recordings are not covered in the beneficiary's home.

3.11 HEARING SERVICES

Hospitals may bill for speech and hearing evaluations, testing, and therapy for beneficiaries 21 years of age and over. Hospitals enrolled as a Hearing and Speech Center provider may also provide services for beneficiaries under age 21. (Refer to the Medicaid Hearing and Speech provider manual for additional information.)

MDCH requires that all Medicaid-covered newborns be screened using the auditory brainstem response (ABR) method and/or evoked otoacoustic emissions (EOAE) method as recommended by the American Academy of Pediatrics (AAP).

- Hospitals with greater than 15 or more Medicaid deliveries per year must provide newborn hearing screen using the policies and procedures recommended by the AAP.
- Hospitals with less than 15 Medicaid deliveries per year may provide the service or advise the physician, nurse-midwife, or nurse practitioner to refer the newborn for the hearing screening prior to age one month.

For hospitals that provide EOAE and/or ABR newborn hearing screening, reimbursement is included in the calculation for the DRG. MDCH recommends hospitals that provide delivery services have qualified staff to:

- Develop screening protocol;
- Appropriately train staff to perform screenings and, in matters of confidentiality, recognition of psychological stress for the parents or guardians, infection control practices, and established policies and procedures for handling newborns in the hospital;
- Develop a system for monitoring the performance of screenings;
- Inform parents or guardians about the procedure(s), potential risks of hearing loss, and the benefits of early detection and intervention;
- Allow parents or guardians an opportunity to decline screening (providers must document in the medical record if screening was declined);
- Delineate responsibility for documenting screening results;
- Develop methods for communicating results in a sensitive and timely manner to the parents or guardians and the physician. If repeat screening is recommended following discharge, establish procedures for appropriate follow-up; and
- Report critical data to the State's monitoring program.

3.12 Hyperbaric Oxygen Therapy

Medicaid covers hyperbaric oxygen therapy when provided in a hyperbaric chamber for selected indication (e.g., decompression illness, gas gangrene, etc.). It is not to be used as a replacement for standard medical management.

3.13 Hysterectomy

Federal regulations prohibit Medicaid reimbursement for hysterectomies solely for the purpose of sterilization. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications, which alone do not indicate a hysterectomy.

A hysterectomy is covered only if the beneficiary has been informed orally, prior to surgery, that a hysterectomy will render her permanently incapable of reproducing. The beneficiary or her representative must sign a written acknowledgment of receipt of that information using the Acknowledgment of Receipt of Hysterectomy Information form (MSA-2218). All items on the MSA-2218 must be completed. The beneficiary (or representative) and the physician (M.D. or D.O.) must sign the form. (Refer to the Forms Appendix for a sample form.)

> The Acknowledgment of Receipt of Hysterectomy Information form is not required if the beneficiary was already sterile before the hysterectomy.

See the Billing & Reimbursement Chapter for instructions regarding the completion and submission of the MSA-2218.

3.14 Injections / Intravenous (IV) Infusions

MDCH reimburses for intramuscular, subcutaneous or intravenous injections and intravenous (IV) infusions when medically necessary. In the inpatient hospital, reimbursement is included in the DRG payment.

In an outpatient hospital:

- Intramuscular, subcutaneous or intravenous injections require detailed coding using the appropriate Medicaid-covered CPT/HCPCS code(s). If the medication does not have a specific code, providers must supply the National Drug Code (NDC) drug detail (brand name, manufacturer, NDC drug code and drug cost) in the Remarks area of their claim. Reimbursement for the injection includes the cost of the drugs, supplies, administration and observation for any adverse reaction.
  - MDCH covers room and equipment charges for IV fluid administration. Tubing, syringes, needles, and other miscellaneous items, such as sterile gloves and gauze used during IV fluid administration, must be billed as a supply (i.e., "IV Therapy/Supplies").
  - Certain IV solutions are identified (i.e., dextrose, saline solutions) as a diluent or vehicle for drug therapy and must be billed as an IV therapy service.

- IV solutions used only as hydration solutions and not in conjunction with drug therapy must be billed as such.

3.15 LABOR & DELIVERY/ NURSERY

MDCH reimburses for labor and/or delivery room(s) or when an active labor does not progress to delivery. During active labor, the MDCH will cover a fetal contraction or fetal non-stress test in addition to the labor and delivery room charge. When there is no active labor, MDCH does not cover labor and/or delivery room charges for fetal monitoring or treatment of other medical conditions.

In an inpatient hospital, reimbursement is included in the DRG payment. Inpatient newborn nursery charges are covered and must be billed under the newborn's ID number. See the Billing & Reimbursement Chapter for additional information. In an outpatient hospital, reimbursement is by the appropriate revenue code from the National and/or State Uniform Billing manuals and the appropriate supporting HCPCS code.

3.16 LABORATORY

MDCH reimburses hospitals for medically-necessary laboratory tests:

- Performed in a laboratory certified by the Clinical Laboratory Improvement Act (CLIA);
- Needed to diagnose a specific condition, illness, or injury; and
- Ordered by physicians (M.D. or D.O), podiatrists, dentists, nurse practitioners, or nurse-midwives.

MDCH requires medical record documentation of medical necessity. An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity. For approval of payment, the laboratory procedure(s) must be specific and appropriate to the beneficiary's documented condition and diagnosis.

Reimbursement to the inpatient hospital is through the DRG payment.

Reimbursement for outpatient services is billed using the appropriate HCPCS code and includes the collection of the specimen(s), the analysis, and the lab test results. MDCH performs pre- and/or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. Outpatient hospitals are subject to corrective action, including the recovery of funds, for laboratory services not specifically ordered by a practitioner.

MDCH does not cover:

- Screening or routine laboratory testing, except as specified for EPSDT Program, or by Medicaid policy;
- "Profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition; or
- Multiple laboratory tests performed as a part of the beneficiary evaluation if the history and physical examination do not suggest the need for the tests.

Services performed by an outpatient hospital laboratory or its employees may not be billed to, or by, the ordering practitioner.

3.16.A. Pregnancy-Related Laboratory Services

The obstetric profile must be ordered by the attending practitioner and billed as an all-inclusive panel of tests for required prenatal laboratory services. It must include the following:

- Hemogram, automated, and manual differential WBC count CBC

  OR

  Hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
- Hepatitis B surface antigen (HBaAg)
- Antibody, rubella
- Syphilis test, qualitative (e.g., VDRL, RPR, ART)
- Antibody screen, RBC, each serum technique
- Blood typing, ABO
- Blood typing, Rh(D)

If all components of the obstetric panel are not performed, providers must bill using the individual HCPCS codes of the test(s) performed.

Testing for HIV is covered separately when determined to be medically necessary and ordered by the practitioner.

Only practitioners should order the serum or urine HCG qualitative method when the beneficiary requires preliminary pregnancy testing.

Nurse-midwives may order only the laboratory tests listed below. Hospitals are not reimbursed for any other tests ordered by a nurse-midwife.

- Acetone and diabetic acid (ketone bodies); qualitative; semi-quantitative
- Albumin; qualitative, semi-quantitative, quantitative (such as Esbach)
- Antibody titer Rh system; albumin, saline and/or AHG technique
- Blood count; RBC, WBC, Hemoglobin, Hematocrit, indices (MCV, MCH, MCHC)
- Blood typing; ABO, Rh(D), RBC antibody screening
- Culture, presumptive (screening), for Neisseria gonorrhea, Candida, Hemophilus, or beta hemolytic Streptococcus group A, etc.
- Culture, urine, definitive; with or without colony count
- Cytopathology, vaginal and/or cervical smears (e.g., Papanicolaou type) screening (cytopathological examination for malignancy, microbial flora, inflammatory features and hormonal evaluation)
- Glucose; qualitative, quantitative, timed specimen, tolerance
- Hemoglobin, electrophoretic separation; qualitative

- Hepatitis B test
- Human immunodeficiency virus detection;
- Pregnancy test;
- Prenatal laboratory services; routine (Obstetric panel)
- Quantitative sediment analysis and quantitative protein (Addis count); 12- or 24-hour specimen Reticulocyte count, manual
- Rubella test; titer
- Sickle cell slide test
- Skin test, tuberculosis, tine test
- Susceptibility (sensitivity) for aerobes by Kirby-Bauer procedure for specific pathogens, using 10-12 discs per pathogen; also for susceptibility (sensitivity) for anaerobes by generally accepted standard techniques using 5-12 discs per pathogen (specify number of pathogens)
- Syphilis testing, flocculation or precipitin (VDRL, RPR, etc.); qualitative
- Trepanema antibodies, fluorescent, absorbed (FTA-abs)
- Urinalysis, complete (physical appearance, pH, specific gravity, microscopic examination, qualitative chemistry with or without semi-quantitative confirmation)
- Wet mount, smear, tissue; direct microscopic examination

3.16.B. Coverage Limitations

Outpatient hospital coverage is limited to only those laboratory procedures that do not exceed the reimbursement limit of $75.00 per day. Additionally, laboratory payments are not made if rendered by the same provider for the same beneficiary on the same day of service. The following procedures are exempt from the daily reimbursement limit:

- Bone Marrow, smear interpretation
- Comprehensive Pathology Consultation
- Cytogenetics
- Cytopathology
- Electron Microscopy
- Genotype and Phenotype analysis
- Limited Pathology Consultation
- Virtual Phenotype analysis

Payment for these medically-necessary services is not included in the reimbursement calculation for a single date of service.

If the daily limit is exceeded, the outpatient hospital must request an exception to the daily reimbursement limit by submitting documentation of medical necessity from the

practitioner for each laboratory procedure with the claim. All services provided on that date of service are manually reviewed for medical necessity and payment is determined accordingly.

Daily reimbursement limits apply to beneficiaries with dual Medicaid and CSHCS eligibility if the laboratory procedures are not related to the beneficiary's CSHCS qualifying diagnosis. They do not apply to beneficiaries with CSHCS eligibility only.

3.16.C. Blood Handling

The fee for blood handling is usually included in the reimbursement for the blood test but it may be billed for situations in which the drawing, packaging, and mailing of a blood specimen are the only services provided. MDCH reimburses for blood handling only under the following circumstances:

- A beneficiary is referred to the outpatient hospital for the sole purpose of drawing, packaging, and mailing a blood sample to MDCH for blood lead analysis. The State provides lead-free vacutainers for the analysis. (Requests for vacutainers and the samples for analysis must be sent to Trace Metal Section/Bureau of Laboratories, Division of Chemistry and Toxicology, MDCH. Refer to the Directory Appendix for contact information.)
- A beneficiary requires blood tests that are not performed in conjunction with other reimbursable services. Whenever possible, the beneficiary should be sent to the laboratory that is to perform the test(s). When this is not possible (i.e., the laboratory is not a local facility), the blood-handling fee may be billed. The blood-handling fee is not a benefit when any other service is reimbursable on the same date of service.
- A beneficiary is referred to an outpatient hospital for the sole purpose of drawing, packaging and mailing a blood sample to MDCH for HIV-1 viral load analysis and/or DC4/CD8 enumeration. The State provides specimen containers and mailing kits for the analysis. (Requests for supplies and samples for analysis should be sent to Bureau of Laboratories, MDCH. Refer to the Directory Appendix for contact information.)

3.16.D. Hematology Studies

A complete blood count (CBC) with white blood cell (WBC) differential includes the RBC and WBC count, Hgb, Hct, MCH, MCHC, MCV, RBC morphology, platelet estimate, and WBC differential only. If automated instrumentation yields additional test parameters, the results are not reimbursable unless medically necessary and specifically ordered by a practitioner.

3.16.E. Microbiology Studies

Reimbursement for gram fluorescent/acid fast is included in the reimbursement for microbiology when performed on the same date of service for the same beneficiary.

3.16.F. Pap Smear

Pap smear screening by a technologist under the supervision of a pathologist is a covered service. If a suspect smear requires additional interpretation by a pathologist,

this service is also covered. Only one Papanicoleou test within a 12-month period is covered for each beneficiary, unless medical necessity or history of abnormal findings requires additional studies.

3.16.G. Substance Abuse

For direct-billed laboratory services ordered by an approved CA, Form Locator 83 (referring provider ID number) must be reported on the UB-92 claim. See the Uniform Billing Manual for Medicaid instructions regarding this form locator.

3.17 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Most mental health services provided to Medicaid beneficiaries are covered through the local PIHP/CMHSP providers. PIHPs/CMHSPs are responsible for direct payment for inpatient psychiatric or partial hospitalization services, related physician services, and specialized community mental health clinical and rehabilitation services that the PIHP/CMHSP has prior authorized. Providers should not bill MDCH for these services.

Medical/physical health care services (beyond the admission history and physical) and/or physician-ordered medical (non-psychiatric) consultations required for Medicaid beneficiaries while they are receiving psychiatric inpatient or partial hospitalization services are not the responsibility of the PIHP/CMHSP. For fee-for-service beneficiaries, these services are billed directly to MDCH. For beneficiaries enrolled in a MHP, the services must be billed directly to the MHP. These services may require PA.

(Refer to the Medicaid Pre-Paid Inpatient Health Plan/Community Mental Health Services Program provider manual for additional information regarding Medicaid Managed Care for Specialized Mental Health Services.)

3.17.A. Acute Inpatient Medical Detoxification

Medically-necessary inpatient detoxification services are covered only in a life-threatening situation. Medicaid does not cover inpatient detoxification if the beneficiary is simply incapacitated and not in a life-threatening situation. Acute medical detoxification services may be provided by a Medicaid-enrolled hospital without authorization from a CA. Acute detoxification services are reimbursed directly by MDCH for both MHP enrollees and FFS beneficiaries.

Hospitals must refer beneficiaries seeking substance abuse treatment services to the local CA.

3.17.B. Inpatient Hospital Acute Detoxification Criteria

Admission to an inpatient hospital for acute detoxification for a diagnosis of substance abuse must include, but is not limited to, one of the following criteria as documented in the physician's orders and beneficiary's medical record:

- Unconsciousness;
- Delirium tremens, (e.g., confusion, hallucinations, seizures) or a documented history of delirium tremens requiring treatment;

- Seizures or multiple seizures within the last 24 hours;
- Uncontrolled hypertension, extreme and unstable;
- Congestive heart disease, ischemic heart disease, or significant arrhythmia as examples of active symptomatic heart disease;
- Blood alcohol level 350 dl/ml with a diagnosis of alcohol abuse; or
- Blood alcohol level 400 dl/ml with a diagnosis of alcohol dependence.

3.17.C. Inpatient Psychiatric Services

Inpatient stays in a psychiatric unit of a general hospital are covered for beneficiaries of any age. Inpatient treatment, including related psychiatric visits, in a freestanding psychiatric hospital, both private and state-owned, is limited to eligible beneficiaries under age 21 and age 65 and older. If the beneficiary was an inpatient immediately prior to attaining age 21, he/she would be eligible to continue as an inpatient until age 22. If the beneficiary is discharged at some time following his/her 21st birthday, coverage terminates on the discharge date.

All psychiatric admissions and continued stays must be authorized by the local PIHP/CMHSP. Refer to the Medicaid Pre-Paid Inpatient Health Plan/Community Mental Health Services Program provider manual, Chapter III, for specific coverages and authorization requirements.)

3.17.D. Psychiatric Partial Hospitalization

Psychiatric coverage includes partial hospitalization on a day-care or night-care plan for all beneficiaries, regardless of age. To be eligible for partial hospitalization, the beneficiary must be receiving active psychiatric treatment provided under the direction of a psychiatrist.

All partial hospitalization admissions and continued stays must be authorized by the local PIHP/CMHSP. Refer to the Medicaid Pre-Paid Inpatient Health Plan/Community Mental Health Services Program provider manual, Chapter III, for specific coverages and authorization requirements.

3.17.E. Substance Abuse Services

The Program covers acute care detoxification in the inpatient hospital for fee-for-service beneficiaries and through the MHPs for beneficiaries enrolled in Medicaid Managed Care.

3.17.F. Acute Care Detoxification

Admission to the acute care setting for a diagnosis of substance abuse must meet at least one of the following criteria. Physician's orders and patient care plans must reflect the appropriate criteria:

- Vital signs, extreme and unstable. Uncontrolled hypertension, extreme and unstable.

- Delirium tremens, (e.g., confusion, hallucinations, seizures) or a documented history of delirium tremens requiring treatment.
- Convulsions or multiple convulsions within the last 72 hours.
- Unconsciousness.
- Occurrence of substance abuse with pregnancy and monitoring the fetus is vital to the continued health of the fetus.
- Insulin-dependent diabetes complicated by diabetic ketoacidosis.
- Suspected diagnosis of closed head injury based on trauma injury.
- Congestive heart disease, ischemic heart disease, or significiant arrhythmia as examples of active symptomatic heart disease.
- Suicidal ideation and gestures necessitating suicidal precautions as part of treatment.
- Blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse.
- Blood alcohol level 400 mg/dl with diagnosis of alcohol dependence.
- Active presentation of psychotic symptoms reflecting an urgent/emergent condition.

3.17.G. Other Substance Abuse Services

The Program covers other substance abuse services provided to beneficiaries. These services are covered under capitation payments to the PIHPs/CMHSPs. (Refer to the Medicaid Pre-Paid Inpatient Health Plan/Community Mental Health Services Program provider manual, Chapter III, for coverage details and authorization requirements.)

3.17.H. Coordinating Agencies (CA)

The CA may authorize the following specialized services:

- Outpatient Substance Abuse Treatment;
- Assessment, Diagnosis, Beneficiary Placement and Referral;
- Intensive Outpatient Counseling; and
- Federal Drug Administration (FDA) Approved Pharmacological Supports [Methadone; Levo Alpha Acetyl Methadol (LAAM)].

Questions regarding substance abuse services should be directed to the local CA.

3.18 Organ Transplants

MDCH requires PA from the Office of Medical Affairs for organ transplants for all beneficiaries, donors, and potential donor services related to organ transplants except for cornea and kidney. (See the General Information for Providers chapter for additional information on PA.) PA is required if additional organ(s) transplantation is to occur during the same operative session, such as a cornea or kidney.

PA is not required if Medicare makes payment and Medicaid liability is limited to coinsurance and deductible. If a Medicare application is pending, the provider must indicate that on the PA request and

notify MDCH when the determination is made. All other insurance resources must be exhausted before Medicaid is billed. The denial notice(s) must be submitted with the claim.

MDCH reimbursement for the following transplants is at the hospital's Medicaid cost-to-charge ratio:

- heart;
- bone marrow;
- liver;
- lung;
- simultaneously pancreas/kidney; and
- pancreas transplants.

For other organ transplant services not described by a specific DRG, the hospital must provide a note/remark on the claim of the "type" of transplant (i.e., small bowel transplant) performed. All organ transplant claims pend for manual review of documentation. A copy of the PA letter must be submitted with the claims. Providers must note "PA Letter submitted" in the Remarks section of the claim.

For those transplants requiring PA, the MDCH requires beneficiaries to be evaluated at an accepted transplant center to determine if they are a good transplant candidate. If the transplant is to take place at a Medicaid-enrolled, in-state hospital, then only the transplant needs PA. If the transplant is to be performed at an out-of-state hospital, then both the evaluation and the transplant must be separately prior authorized. Results from the evaluation must be submitted to the Office of Medical Affairs when requesting PA for the transplant.

If the beneficiary is Medicaid-eligible and the donor is not Medicaid-eligible, providers must bill all services under the beneficiary's ID Number and provide complete documentation. If the donor and beneficiary are both Medicaid-eligible, providers must bill the services under their respective ID numbers.

3.18.A. Donor Search

When the donor search does not result in an organ acquisition and transplant, MDCH reimburses for a donor search and related charges. These services must be billed as outpatient services, and providers are required to submit a copy of the PA letter for transplant with the claim. Providers must make reference or remark on the claim format the donor search failed at the time of claim submission.

3.18.B. Transportation and Lodging

MDCH reimburses for transportation and lodging expenses associated with the evaluation and the transplant for the beneficiary and one accompanying individual (e.g., spouse, parent, guardian). The beneficiary's local Family Independence Agency (FIA) office should be contacted to make travel arrangements if the beneficiary has Medicaid-only coverage or they are dually-eligible for CSHCS and Medicaid. If the beneficiary has CSHCS coverage only, they must contact the CSHCS office in the local health department of the county where they reside to make travel arrangements. If the beneficiary is enrolled in an MHP, contact the MHP regarding transportation arrangements.

3.19 PSORIASIS TREATMENT SERVICES

MDCH reimburses for outpatient hospital-based psoriasis treatment rendered at an equivalent intensity of service for beneficiaries with severe psoriasis but at a lower cost than inpatient services. This coverage is for conditions that would normally require hospitalization, but the associated medical conditions of the beneficiary allow the same treatment on an outpatient basis. Conditions include severe involvement of the skin that is extensive in body distribution or involves a disabling condition with no complicating conditions, such as joint disease or mental instability.

3.20 RADIOLOGY

MDCH reimburses hospitals for medically-necessary radiology services, including diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging services, ultrasound, and other imaging procedures:

- Necessitated by injury or disease, including benign or malignant conditions;
- Needed to diagnose a specific condition, illness, or injury; and
- Ordered by physicians (M.D. or D.O.), podiatrists, dentists, nurse practitioners, or nurse-midwives.

The medical record must contain documentation of medical necessity to support all radiology services billed.

Reimbursement to the inpatient hospital is through the DRG payment.

Reimbursement for outpatient services is billed using the appropriate HCPCS code and includes the use of the facility, equipment, supplies, and attendant personnel required to provide the service.

MDCH reimburses for diagnostic and therapeutic x-rays and nuclear medical services, including:

Interventional Radiology Procedures	Procedure codes support facility charges and a separate reimbursement for pharmacy, supplies, anesthesia, etc. used during the procedure.

Cardiac Catheterization	Cardiac catheterization procedures must be rendered in a separate sterile environment unit within the hospit al and include heart catheterization and coronary angiographies. Diagnostic cardiac catheterization services must be necessitated by disease or injury or be performed to diagnose a specific cardiac condition as documented in the beneficiary's record and identified by a HCPCS/CPT code. All charges related to monitoring vital signs, use of equipment (similar to the OR), and other durable items used are considered part of the room charge. Multiple injection procedures may be included in the cardiac catheterization, but MDCH does not reimburse each injection separately. MDCH reimburses Observation Room charges separately as a quantity of one when provided after a cardiac catheterization (or myleogram). MDCH reimburses when "acute" care recovery is necessary following a cardiac catheterization (or myleogram) when on the same bill as the cardiac catheterization procedure. There is a maximum quantity of eight units (one unit for each 30 minutes) or four hours.
Computerized Axial Tomography Scanning	If requested by a physician for specific diagnosis and/or localization of lesions, tumors, or trauma. CT scanning is not covered for routine screening, nonspecific diagnoses, or in situations where less costly diagnostic methods are appropriate. CT scanning procedures must be provided on equipment that has an approved Certificate of Need (CON) on file with MDCH. The owner of the equipment must submit proof of CON approval and the date the equipment became operational to Provider Enrollment Unit, Budget and Finance Administration. (Refer to the Directory Appendix for contact information.)
Multiple Radiological Procedures	Multiple radiological procedures are not covered when an area to be visualized is common to each procedure and there are no substantial spatial differences in the views, unless for trauma or arthritis conditions. (Refer to the Billing and Reimbursement Chapter for additional billing information specific to how to bill multiple procedures.)
Contrast Material	The cost of high osmolar contrast material is reimbursed as part of the technical component of diagnostic radiology procedures and is not routinely reimbursed separately. MDCH reimburses additional payment for low osmolar contrast material (LOCM) if used for beneficiaries with at least one of the following characteristics: ▪ A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting; ▪ A history of asthma or allergy; ▪ Significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension; ▪ Generalized severe debilitation; or ▪ Sickle cell disease. Paramagnetic contrast material used in MRI studies is included in the reimbursement.

Percutaneous Transluminal Coronary Angioplasty (PTCA)	PTCA is covered for those beneficiaries who meet the following criteria: failed maximum medical treatment, intractable angina and single vessel disease with left ventricular function. Charges for disposable supplies, medication and anesthesia in conjunction with a PTCA are reimbursed under the OPH group reimbursement system. Charges for a pre-op holding room are not covered. MDCH covers "acute" care recovery following this procedure when reported on the same bill as the PTCA procedure. There is a maximum quantity of eight units (each unit equals 30 minutes) or four hours.
Ultrasonography	Ultrasound procedures are reimbursed when there is clinical evidence in the beneficiary's record to substantiate the medical need for such services. Ultrasound procedures are not benefits when used as screening procedures or on a routine basis. When billing two ultrasound codes, the diagnosis must reflect the medical need for two procedures. Claims for diagnostic ultrasound procedures which are performed more than once must be documented for medical necessity. Documentation with the claim should clearly state the reason for the repeat procedure. Claims are rejected if the documentation does not support the need for the repeat diagnostic procedure.

Routine follow-up care is included in radiotherapy and nuclear medicine procedures.

3.21 STERILIZATION

A sterilization procedure is defined as any medical procedure, treatment, or operation for the sole purpose of rendering an individual (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under Medicaid's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). The physician is responsible for obtaining the signed Informed Consent for Sterilization form (MSA-1959). (Refer to the Forms Appendix for a sample.)

Sterilizations are reimbursed only if:

- The beneficiary is at least 21 years of age at time of informed consent;
- The beneficiary is not legally declared to be mentally incompetent;
- The beneficiary is not institutionalized in a corrective, penal, or mental rehabilitation facility;
- Informed consent is obtained; and
- Informed consent is not obtained while the beneficiary is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.
- Informed consent must be obtained not less than 30 days nor more than 180 days prior to sterilization.

NOTE: The only exception is in the case of premature delivery or emergency abdominal surgery. If the premature delivery or emergency abdominal surgery occurred before the 30-day waiting period is over, at

least 72 hours must have passed between the time of obtaining informed consent and the sterilization procedure.

- In some cases of premature delivery, informed consent must have been given at least 30 days before the expected delivery date. The consent form must indicate the expected date of delivery.
- In cases of abdominal surgery, the emergency nature of the surgery must be clearly identified, e.g., diagnosis, physician's statement, or hospital summary. The nature of the emergency must be included on the consent form.

Federal regulations require that the completed MSA-1959 be submitted to MDCH before reimbursement can be made for any sterilization procedure. A copy must be attached to the claim form unless submitted via fax prior to filing the claim. MDCH allows for submission of Informed Consent to Sterilization forms via fax to encourage electronic billing and reduce administrative burden. This process can also pre-confirm the acceptability of the completed consent form and reduce costly claim rejections.

See the Billing & Reimbursement Chapter for information regarding the completion and submission of the MSA-1959.

3.22 SURGERY

MDCH reimburses for surgeries performed in an inpatient hospital through the DRG payment.

MDCH reimburses for selected surgeries performed in an outpatient hospital.

When an ambulatory surgery is performed in the inpatient hospital setting, the physician must provide exception rationale (outlined below) justifying the need for an inpatient setting. The provider must obtain PA for an elective admission from the Admissions and Certification Review Contractor (ACRC). (See the Utilization Review section of this chapter for further information. Refer to the Directory Appendix for contact information.) Acceptable rationale includes:

- A medical condition that requires prolonged postoperative observation by skilled medical personnel (e.g., heart disease, severe diabetes);
- A preexisting condition significantly increases the risk of using anesthesia;
- The beneficiary has been admitted to a hospital for another procedure or condition, and the surgeon decides that one of the selected surgical procedures is also necessary;
- An unrelated procedure is being done simultaneously which, by itself, requires hospitalization;
- Another surgical procedure is expected to follow the initial procedure (e.g., gynecological laparoscopy followed by an oophorectomy);
- Technical difficulties, as documented by admission or operative notes; or
- Adequate outpatient facilities are not available within a reasonable distance (i.e., 40 miles) requiring the surgery to be rendered on an inpatient basis. In this case, MDCH allows a one-day inpatient hospital stay, unless a longer stay is medically necessary.

If the physician planned to perform the surgery on an outpatient basis, but more extensive surgery was needed or complications developed and the beneficiary had to be admitted, a Prior Authorization Certification Evaluation Review (PACER) number is not needed for the admission. This type of admission

is considered urgent or emergent. The need for the admission is, however, subject to retrospective review by the ACRC.

Medicaid defines multiple surgical procedures as when two or more consecutive surgical procedures are performed, one immediately following the other during the same operative session. MDCH covers certain procedures included as integral parts of a total procedure and does not reimburse them as separate surgeries.

MDCH does not have a formal process for a second surgical opinion but reimburses for a second surgical opinion if the beneficiary or the physician requests one.

3.22.A. Operating Room

MDCH covers operating room charges for services requiring a sterile environment, specially trained personnel to perform surgical and related procedures, and equipment found in an operating room. MDCH does not cover or separately reimburse charges for preoperative holding rooms or surgical suites used as holding rooms.

Inpatient reimbursement is through the DRG payment.

Outpatient providers must bill the appropriate HCPCS/CPT support code(s) operating room services and surgical supplies. MDCH reimburses up to a maximum quantity of six units total for the operating room (one unit is 30 minutes rounded up to the nearest half-hour) and a percent of the charge for supplies used during a reported surgical procedure.

3.22.B. Recovery Room

MDCH covers post-surgical, medically-necessary recovery room charges when provided after a surgical procedure.

Inpatient reimbursement is through the DRG payment.

Outpatient providers must bill the appropriate HCPCS/CPT code and report up to a maximum of eight units (each unit equals 30 minutes) or four hours.

3.22.C. Observation Room

Inpatient reimbursement for Observation Room is through the DRG payment.

Outpatient reimbursement is made for Observation Room only on the same claim for a cardiac catheterization or myelogram. Observation Room is not covered for any other procedures. MDCH only covers a combination of Observation Room and "Acute" Recovery Care when both services are provided following either a cardiac catheterization or a myleogram on the same claim (same date of service).

3.22.D. Cosmetic Surgery

Hospital charges related to cosmetic surgery are not reimbursable without PA for the surgery. The physician must furnish the hospital with a copy of the PA letter for the surgery, as well as the PACER certification number for the admission.

3.22.E. Minor Surgery

MDCH reimburses for minor surgery (referred to as office-based procedures) performed in the outpatient hospital setting. See Section 4 of the Billing & Reimbursement Chapter for a list of these procedures.

3.22.F. Special Procedures

MDCH covers certain procedures rendered in designated areas of the licensed hospital where specific procedures (i.e., Cardiac Cath Lab, etc.) are performed. Providers are required to use the appropriate revenue code for the service provided within the hospital facility. These services must be supported by the appropriate HCPCS/CPT code describing the procedure or service performed in the designated hospital setting.

3.22.G. Gastrointestinal Services (GI)

A gastrointestinal (GI) service provides a range of diagnostic and therapeutic procedures for digestive disorders, and may include upper endoscopy procedures of the esophagus, small and large intestine, and the rectum. MDCH reimburses for GI services rendered in a special designated area of a licensed enrolled hospital and for endoscopic procedures when not performed in the operating room. The hospital must use the appropriate supporting HCPCS code when providing GI services.

3.23 Occupational Therapy (OT)

3.23.A. Outpatient Hospital

MDCH covers Occupational Therapy (OT) Services in an enrolled outpatient hospital when provided by:

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

OT is considered an all-inclusive charge and MDCH does not reimburse for a clinic room charge in addition to OT services unless it is unrelated. MDCH expects OTR's and COTA's to utilize the most ethically appropriate therapy within their scope of practice as defined by state law and/or the appropriate national professional association. OT must be medically necessary, reasonable and required to:

- Return the beneficiary to the functional level prior to illness or disability;

- Return the beneficiary to a functional level that is appropriate to a stable medical status; or
- Prevent a reduction in medical or functional status had the therapy not been provided.

For CSHCS beneficiaries	OT must be directly related to the CSHCS-eligible diagnosis (es) and prescribed by the specialty physician who is overseeing care.
For beneficiaries 21 years of age and older	OT is only covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations or participation restrictions.

MDCH anticipates OT will result in a functional improvement that is significant to the beneficiary's ability to perform appropriate daily living tasks (per beneficiary's chronological, developmental, or functional status). Functional improvements must be achieved in a reasonable amount of time and must be maintainable. MDCH does not cover therapy that does not have an impact on the beneficiary's ability to perform age-appropriate tasks.

OT must be skilled (i.e., require the skills, knowledge and education of an OTR). MDCH does not cover interventions provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], family member, or caregiver).

OT may be covered for one or more of the following:	**OT is not covered for the following:**
▪ Therapeutic use of occupations*; ▪ Adaptation of environments and processes to enhance functional performance in occupations*; ▪ Graded tasks (performance components) in activities as prerequisites to an engagement in occupations*; ▪ Design, fabrication, application, or training in the use of assisted technology or orthotic devices; and/or ▪ Skilled services that are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers. Routine provision of the maintenance/prevention program is not a covered OT service.	▪ When provided by an independent OTR**. ▪ For educational, vocational, or recreational purposes. ▪ If services are required to be provided by another public agency (e.g., community mental health services provider, school-based services). ▪ If therapy requires PA and service is rendered before PA is approved. ▪ If therapy is habilitative. Habilitative treatment includes teaching someone how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. This may include teaching a child normal dressing techniques or cooking skills to an adult who has not performed meal preparation tasks in the past. ▪ If therapy is designed to facilitate the normal progression of development without compensatory techniques or processes.

	▪ For development of perceptual motor skills and sensory integrative functions to follow a normal sequence. If the beneficiary exhibits severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function, OT may be covered ▪ Continuation of therapy that is maintenance in nature.

* Occupations are goal-directed activities t hat extend over time (i.e., performed repeatedly), are meaningful to the performer, and involve multiple steps or tasks. For example, doing dishes is a repeated task. Buying dishes happens once; therefore, does not extend over time and is not a repeated task.

** An independent OTR may enroll in Medicaid if he provides Medicare-covered therapy and intends to bill Medicaid for Medicare coinsurance and/or deductible only.

3.23.A.1. DUPLICATION OF SERVICES

Some therapy areas (e.g., dysphasia, assistive technology, hand therapy) may be appropriately addressed by more than one discipline (e.g., OT, PT, speech-language therapy) in more than one setting. MDCH does not cover duplication of service (i.e., where two disciplines are working on similar goals/areas). The OTR is responsible to communicate with other therapists and coordinate services. MDCH requires any related documentation to include coordination of services.

3.23.A.2. SERVICES TO SCHOOL-AGED BENEFICIARIES

School-aged beneficiaries may be eligible to receive OT through multiple sources. MDCH expects educational OT to be provided by the school system, and it is not covered by MDCH or CSHCS. (Example: OT coordination for handwriting, increasing attention span, identifying colors and numbers).

MDCH only covers medically-necessary OT when provided in the outpatient setting. Coordination between all OT providers must be continuous to ensure a smooth transition between sources.

3.23.A.3. PRESCRIPTION REQUIREMENTS

MDCH requires a physician's prescription for an OT evaluation and preparation of the treatment plan. The prescription must include beneficiary name, prescribed therapy, and diagnosis(es) or medical conditions(s). MDCH requires a new prescription if OT is not initiated within 30 days of the prescription date. An evaluation may be provided for the same medical diagnosis without PA twice in a 365-day period with a physician's prescription. PA is required if an evaluation is needed more frequently.

Evaluations	Evaluations must include standardized tests and/or measurable functional baselines. OT evaluations must be completed by an OTR and include the following: ▪ Treatment diagnosis and medical diagnosis, if different from the treatment diagnosis(es) (e.g., medical diagnosis of cerebral palsy with contractures being treated); ▪ OT provided previously, including facility/site, dates, duration, and summary of change; ▪ Current therapy being provided to the beneficiary in this or other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ Standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension).
Treatment Plan	The OT treatment plan that results from the evaluation must consist of the following: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's life goals; ▪ Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy; ▪ Anticipated frequency and duration of treatment required to meet short- and long-term goals; ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs; ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational); and ▪ Physician signature verifying acceptance of the treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring physician.

Initiation of Services	OT may be initiated without PA upon completion of the assessment and development of a treatment plan that is reasonable and medically necessary as documented in the patient record. The OPH setting allows up to 36 OT services provided in the initial 90-day treatment period. If therapy is not initiated within 30 days of the prescription date, a new prescription is required. PA is not required for the initial period of skilled therapy for the first 90 consecutive calendar days in the OPH setting for a new treatment diagnosis or new medical diagnosis if: ▪ The beneficiary remains Medicaid-eligible during the period therapy is provided. ▪ A copy of the physician's signed and dated (within 30 days of initiation of services) prescription for OT is on file in the beneficiary's medical record. Providers may initiate services without PA when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability. OT must be provided by the evaluating discipline. (Example: a speech-language pathologist cannot provide treatment under an occupational therapist's evaluation). Co-signing of evaluations and sharing treatments require PA. MDCH does not cover the service when Medicare determines that the service is not medically necessary.

3.23.A.4. REQUIREMENTS TO CONTINUE THERAPY

The OTR must request PA to continue therapy beyond the initial 60 or 90 days. When requesting PA, providers must complete MDCH Occupational/Physical Therapy-Speech Pathology Prior Approval-Request/Authorization (MSA-115). PA requests must be mailed or faxed to Technical Assistance Section, Review and Evaluation Division, Quality Improvement and Customer Services Bureau. (Refer to the Directory Appendix for contact information.) MDCH returns a copy of the PA to the provider and it must be retained in the beneficiary's medical record.

To Continue Active Treatment: The OTR may request up to 90 consecutive calendar days of continued active therapy in the outpatient hospital setting.	Requests to continue active therapy must be supported by the following: ▪ Treatment summary of previous OT period, including measurable progress on each short- and long-term goal. This must include the treating OTR's analysis of the therapy provided during the previous month, rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes. ▪ Progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy. ▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.

	▪ Statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ Statement detailing coordination of services with other therapies (e.g., medical and educational) if appropriate. ▪ A copy of the prescription must be provided with each request. The prescription must be hand-signed by the referring physician and dated within 30 days prior to initiation of the continued service. ▪ A discharge plan.
Maintenance/Monitoring Services: In some cases, the beneficiary does not require active treatment, but the skills of an OTR are required for training or monitoring of maintenance programs being carried out by family and/or caregivers or continued follow-up for the fit and function of orthotic or prosthetic devices. PA is **not** required for these types of service for up to four times per 90-day period in the outpatient hospital settings.	The OTR must complete an MSA-115 and include the following: ▪ Service summary, including a description of the skilled services being provided (to include the treating OTR's analysis of the rate of progress, and justification for any change in the treatment plan). Documentation must relate to the period immediately prior to that time period that you are requesting PA. ▪ A comprehensive description of the maintenance/activity plan. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational) if appropriate. ▪ The anticipated discharge plan. ▪ The anticipated frequency and duration of continued maintenance/monitoring.

3.23.A.5. RESUMING THERAPY

PA is required when OT services must be resumed within a 12-month period for the same diagnosis. A discharge summary for the previous therapy or an explanation of the changes in functional or medical status must accompany the PA request. MDCH does not approve PA if this information is not provided with the request. The copy of MSA-115 is returned to the requesting provider and must be retained in the beneficiary's medical record. Therapy may be resumed within a 12-month period without PA if there are functional changes due to a change in the treatment diagnosis (e.g., decreased active range of motion resulting in an inability to dress the upper extremities).

3.23.B. Inpatient Hospital

Inpatient hospital occupational therapy does not require PA for reimbursement.

Occupational therapy provided in a general inpatient hospital must meet the following criteria:

- The therapy must be ordered, in writing, by the attending physician (M.D. or D.O.) initially, and reordered if additional therapy is deemed necessary after the prior approval period has elapsed. These orders must be signed by the physician and retained in the beneficiary's medical record.

- Services must be rendered by an OTR or COTA under the direct supervision of a registered occupational therapist.
- Services must be active, restorative, and designed to prevent, correct, or compensate for a specific physical and/or mental problem. (Treatment designed to improve a given environment for a beneficiary's general welfare is considered an activity program and is not a benefit.)

The initial evaluation and treatment plan must include the following information:

- Statement of the problem, i.e., the specific physical entity and functional incapacity involved or the specific diagnosis based upon results of formal/informal testing;
- Baseline condition at initial evaluation, measured in units appropriate to the problem;
- Short-term goals appropriate to the beneficiary's diagnosis, level of severity, prognosis, and functional needs;
- Restorative Physical Disability proposed technique for reaching goals, including the planned progression from the baseline condition to the goal; and
- Method by which progress is measured.

This and any other additional documentation must include the beneficiary's name and Medicaid ID number, the date, and the hospital's name and ID number.

The occupational therapist must keep progress notes on the therapy. Such notes include:

- Treatment provided;
- Date of treatment;
- Name of the individual who rendered treatment;
- Type and length of treatment; and
- Beneficiary's response to the treatment.

The progress notes must be included in the beneficiary's medical record.

In addition to the restorative physical disability occupational therapy, MDCH covers the development of a self-care program designed by the occupational therapist.

The cost of supplies and equipment needed to increase or replace a specific muscle function, which relates to the total rehabilitation of the beneficiary and is restorative in nature, is considered part of the occupational therapy program. Items available to the beneficiary in his community as a normal household item (e.g., bath brushes, can openers, electric toothbrushes) are not considered adaptive equipment and are not covered by MDCH.

3.24 PHYSICAL THERAPY (PT)

MDCH uses the terms "physical therapy" and "PT" and "therapy" interchangeably. PT is covered when provided in a Medicaid-enrolled outpatient hospital and is a covered service when provided by a

Michigan-Licensed Physical Therapist (LPT) or an appropriately supervised Certified Physical Therapy Assistant (CPTA). **NOTE:** The LPT supervises and monitors the CPTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the licensed supervising LPT.

PT must be medically necessary, reasonable and necessary to return the beneficiary to the functional level prior to illness or disability or to a functional level that is appropriate to a stable medical status within a reasonable amount of time.

For CSHCS beneficiaries, PT must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the beneficiary's care. Functional progress must be demonstrated and documented.

For beneficiaries 21 years of age and older, PT is covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant to the beneficiary's life roles despite impairments, activity limitations or participation restrictions.

MDCH anticipates PT will result in significant functional improvement in the beneficiary's ability to perform mobility skills appropriate to his chronological, developmental, or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). PT making changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks are not covered.

PT must be skilled (i.e., require the skills, knowledge and education of an LPT). MDCH does not cover interventions provided by another practitioner (e.g., teacher, RN, OTR, family member, or caregiver).

MDCH covers the physical therapist's initial evaluation of the beneficiary's needs and design of the PT program. The program must be appropriate to the beneficiary's capacity, tolerance, treatment objectives, and include the instructions to the beneficiary and support personnel (e.g., aides or nursing personnel) for delivery of the individualized treatment plan. MDCH covers infrequent reevaluations, if appropriate.

Physical therapy may be provided without PA in the hospital.

In the outpatient hospital, the cost of supplies and equipment used as part of the therapy program is included in the reimbursement for the therapy. MDCH only covers a clinic room charge in addition to PT if it is unrelated.

PT services may be covered for one or more of the following reasons:	**PT may include:**
▪ PT is expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills; ▪ PT service is diagnostic; ▪ PT is for a temporary condition and creates decreased mobility; or	▪ Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility); ▪ Stretching for improved flexibility; ▪ Instruction of family or caregivers; ▪ Modalities to allow gains of function, strength, or mobility; and/or

▪ Skilled PT services are designed to set up, train, monitor, and modify a maintenance or prevention program to be performed by family or caregivers. MDCH does not reimburse for routine provision of the maintenance/prevention program.	▪ Training in the use of orthotic/prosthetic devices.

MDCH requires a new prescription if PT is not initiated within 30 days of the prescription date.

PT is not covered for beneficiaries of all ages for the following:
▪ When PT is provided by an independent LPT. An independent LPT may enroll in Medicaid if they provide Medicare-covered therapy and intend to bill Medicaid for Medicare coinsurance and/or deductible only. ▪ When PT is for educational, vocational, or recreational purposes. ▪ If PT services are required to be provided by another public agency (e.g., community mental health services, school-based services). ▪ If PT requires PA and services are rendered prior to approval. ▪ If PT is habilitative therapy. Habilitative treatment includes teaching a beneficiary how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. For example, teaching a child normal dressing techniques or teaching cooking skills to an adult who has not performed meal preparation tasks previously. ▪ If PT is designed to facilitate the normal progression of development without compensatory techniques or processes. ▪ If PT is a continuation of PT that is maintenance in nature. ▪ If PT services are provided to meet developmental milestones. ▪ If PT services are not covered by Medicare as medically necessary.

Only medically necessary PT may be provided in the outpatient setting. Coordination between all PT providers must be continuous to ensure a smooth transition between sources.

3.24.A. Duplication of Services

MDCH recognizes some areas of therapy (e.g., dysphasia, assistive technology, hand therapy) may also be addressed appropriately by multiple disciplines (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. MDCH does not cover two disciplines working on similar areas/goals. The LPT is responsible for coordinating/communicating with other therapists and providing documentation in the medical record.

3.24.B. Services to School-Aged Beneficiaries

MDCH recognizes school-aged beneficiaries may be eligible to receive PT through multiple sources. MDCH expects educational PT (e.g., strengthening to play school sports) to be provided by the school system and is not covered by MDCH or CSHCS.

3.24.C. Prescription Requirements

MDCH covers a physician's prescription for a PT evaluation and preparation of the treatment plan. It must include the beneficiary's name, prescribed therapy and diagnosis(es) or medical condition. A new prescription is required if PT is not initiated within 30 days of the prescription date.

Evaluation: MDCH does not require PA for evaluations. An evaluation is formalized testing in the early stages of a beneficiary's treatment program followed by periodic testing and reports to indicate the disposition of the beneficiary's treatment. Evaluations may be provided for the same diagnosis without PA twice in a 365-day period with a physician's prescription. PA is required for more frequent evaluations.	PT evaluations must be completed by a LPT, include standardized tests and/or measurable functional baselines, and include: ▪ Treatment and medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with gait treatment); ▪ PT previously provided, facility/site, dates, duration, and summary of change; ▪ Current therapy provided in this or other settings; ▪ Medical history as it relates to current PT; ▪ Beneficiary's current functional status (i.e., functional baseline); ▪ Standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory, visual, and comprehensive).
Treatment Plan: MDCH requires a PT treatment plan immediately follow the evaluation.	The treatment plan must consist of: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function and/or mobility; ▪ Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy; ▪ Anticipated frequency and duration consist of treatment required to meet short-term and long-term goals; ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs; ▪ Statement detailing coordination of services with other therapies (e.g., medical and educational); and ▪ Physician signature verifying acceptance of the treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring specialist physician.

Initiation of Services: MDCH requires PT be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without PA.	For the initial period, PT may be provided up to 36 times in the 90-day OPH setting. PT must be provided by the evaluating discipline (e.g., occupational therapist cannot provide treatment under a PT's evaluation). Co-signing evaluations and sharing treatment requires PA. MDCH does not require PA for the initial period of skilled therapy the first 90 consecutive calendar days in the OPH setting for a new treatment diagnosis or new medical diagnosis if: ▪ Beneficiary remains Medicaid-eligible during the period therapy is provided; and ▪ A copy of the physician's signed and dated (within 30 days of initiation of services) prescription for PT is on file in the medical record. MDCH does not require PA when PT services are initiated when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.
Continued Active Treatment: MDCH requires providers to obtain PA to continue PT beyond the initial 90 days. Providers must complete the MSA-115 (Occupational/Physical Therapy-Speech Pathology PA-Request/Authorization). Requests for PA must be mailed to Review and Evaluation Division. (Refer to the Directory Appendix for contact information.) MDCH returns a copy of the PA to the provider after processing the request. The PA must be retained in the beneficiary's medical record.	Requests to continue Active Therapy must contain: ▪ A treatment summary of the previous period of PT, including measurable progress on each short-term and long-term goal. This should include the treating LPT's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes. ▪ A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of PT. ▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ A copy of the prescription hand-signed by the referring physician and dated within 30 days prior to initiation of continued service must be provided for each request. ▪ A discharge plan.

Maintenance/Monitoring Services: MDCH recognizes that, in some cases, a beneficiary does not require active treatment but the skills of an LPT are necessary for training or monitoring of maintenance programs being performed by family and/or caregivers. PA is not required for these types of services for up to four times in 90 days for the OPH setting. MDCH **does** require PA for **continued** maintenance/monitoring for up to 90 consecutive calendar days in the OPH setting.	The LPT must complete an MSA-115 and include: ▪ A service summary, including a description of the skilled services being provided (including the treatment LPT's analysis of the rate of progress, and justification for any change in the treatment plan). Documentation must relate to the period immediately prior to that time period for which PA is requested. ▪ A comprehensive description or copy of the maintenance/activity plan. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ A discharge plan

3.24.D. Discharge Summary

MDCH requires the LPT to document a discharge summary to identify the completion of PT services and the discharge status. This must include:

- Dates of service (i.e., initial and discharge dates);
- Description of services provided;
- Functional status related to treatment areas/goals at discharge;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- Description or copy of follow-up or maintenance program put into place, if appropriate;
- Identification of adaptive equipment provided (e.g., walker) and its current utilization, if appropriate; and
- Recommendations/referral to other services, if appropriate.

3.24.E. Resuming Therapy

MDCH requires PA if PT services must be resumed within a 12-month period for the same diagnosis. Providers must provide a discharge summary for the previous therapy or an explanation of the changes in functional or medical status when requesting PA. Providers must retain a copy in the beneficiary's medical record.

MDCH only covers PT resumed within a 12-month period without PA if there are functional changes due to a change in treatment diagnosis.

3.25 THERAPY, SPEECH-LANGUAGE PATHOLOGY

The terms "speech therapy," "speech-language pathology," and "speech-language therapy" are used to mean speech and language rehabilitation services and speech-language therapy.

MDCH covers speech-language therapy provided in the outpatient hospital setting. MDCH only reimburses services for speech-language therapy when provided by:

- A speech-language pathologist with a current Certificate of Clinical Competence (CCC) or Letter of Equivalency.
- An appropriately supervised SLP candidate (i.e., in their clinical fellowship year {CFY}) or having completed all requirements but has not obtained a CCC or Letter of Equivalency. **NOTE:** All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.
- A student completing his/her clinical affiliation under direct supervision of (i.e., in the presence of) an SLP having a current CCC or Letter of Equivalence. **NOTE:** All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

MDCH expects that all speech-language pathologists (SLP's) will utilize the most ethically appropriate therapy within their scope of practice as defined by Michigan law and/or the appropriate national professional association.

For all beneficiaries of all ages, speech therapy must relate to a medical diagnosis.	MDCH limits coverage to services for: ▪ Articulation; ▪ Language; ▪ Rhythm; ▪ Swallowing; ▪ Training in the use of an augmentative communication device; ▪ Training in the use of an oral-pharyngeal prosthesis; and ▪ Voice.
For Medicaid beneficiaries (i.e., those not enrolled with CSHCS**) under 21 years of age**	Therapy must be obtained from a Medicaid-enrolled hearing and speech center.
For CSHCS beneficiaries (i.e., those not enrolled in Medicaid; only enrolled with CSHCS)	Therapy must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the care of the beneficiary.
For Medicaid beneficiaries 21 years of age and older	Therapy may be provided by an outpatient hospital or a hearing and speech center.

Outpatient hospitals do not require PA for the first 90 consecutive calendar days of therapy with a maximum of 36 visits within those 90 days if:

- The beneficiary remains Medicaid-eligible during the period therapy is provided; and

- A copy of the physician's signed and dated (within 30 days prior to initiation of services) prescription for therapy is on file in the beneficiary's medical record.

Therapy must be reasonable, medically necessary and expected to result in an improvement and/or elimination of the stated problem within a reasonable amount of time (i.e., when treatment is due to a recent change in medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status without therapy).

Speech therapy services must be skilled (i.e., require the skills, knowledge and education of a certified speech-language pathologist to assess the beneficiary for deficits, develop a treatment program and provide therapy). Interventions that could be provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], registered occupational therapist [OTR], family member, or caregiver) would not be reimbursed as speech therapy by MDCH.

For beneficiaries of all ages, therapy is not covered:

- When provided by an independent SLP;
- For educational, vocational, social/emotional, or recreational purposes;
- If services are required to be provided by another public agency (e.g., community mental health services provider, school-based services);
- When intended to improve communication skills beyond premorbid levels (e/g/. beyond the functional communication status prior to the onset of a new diagnosis or change in medical status);
- If it requires PA but is rendered before PA is approved;
- If it is habilitative. Habilitative treatment includes teaching someone communication skills for the first time without compensatory techniques or processes. This may include syntax of semantics (which are developmental) or articulation errors that are within the normal developmental process;
- If it is designed to facilitate the normal progression of development without compensatory techniques or processes;
- If continuation is maintenance in nature;
- If provided to meet developmental milestones; and/or
- Medicare does not consider the service medically necessary.

3.25.A. Duplication of Services

Some areas (e.g., dysphasia, assistive technology) may appropriately be addressed by more than one discipline (e.g., OT, PT, speech-language therapy) in more than one setting. MDCH does not cover duplication of services. It is the treating therapist's responsibility to communicate with other practitioners, coordinate services, and document this in their reports.

3.25.B. Services to School-Aged Beneficiaries

School-aged beneficiaries may be eligible to receive speech-language therapy through multiple sources. Educational speech is expected to be provided by the school system

and is not covered by MDCH or CSHCS. Only medically-necessary speech-language therapy may be provided in the outpatient setting. Coordination between all speech-language therapy providers should be continuous to ensure a smooth transition between sources.

3.25.C. Prescription Requirements

A prescription for therapy must include beneficiary name, therapy prescribed, and diagnosis(es) or medical condition(s). If therapy is not initiated within 30 days of the prescription date, a new prescription is required.

Evaluation: does not require PA. This is formalized testing in early stages of a beneficiary's treatment program followed by periodic testing and reports to indicate measurable functional change resulting from the beneficiary's treatment. These may be provided for the same diagnosis without PA twice in a 365-day period with a physician's prescription. If an evaluation is needed more frequently, PA is required.	Evaluations must include standardized tests and/or measurable functional baselines. ▪ The speech-language evaluation must be completed by an SLP and include the disorder and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with dysphasia as the speech disorder being treated). ▪ Speech therapy provided previously, including facility/site, dates, duration and summary of measurable change. ▪ Current rehabilitation services being provided to the beneficiary in this or other settings. ▪ Medical history as it relates to the current course of therapy. ▪ Beneficiary's current functional communication status (functional baseline). ▪ Standardized and other evaluation tools used to establish the baseline and to document progress. ▪ Assessment of the beneficiary's functional communication skill level, which must be measurable. ▪ Medical, physical, intellectual deficits that could interfere with the beneficiary's improvement in therapy. Evaluations must include, but are not limited to,: ▪ Articulation- standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication and a medical diagnosis. ▪ Language- standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es). ▪ Rhythm- standardized tests that measure receptive and expressive language, mental age, oral motor skills, measurable assessment of dysfluency, current means of communication and a medical diagnosis. ▪ Swallowing- copy of a video fluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment and a standardized cognitive assessment.

	▪ Voice- copy of the physician's medical assessment of the beneficiary's voice mechanism and medical diagnosis.
Treatment Plan: is the immediate result of the evaluation.	It consists of: ▪ Time-related short-term goals that are measurable, functional and significant to the beneficiary's communication needs. ▪ Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from speech-language therapy services. ▪ Anticipated frequency and duration of treatment required to meet short-term and long-term goals ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs. ▪ Statement detailing coordination of services with other therapies (e.g., medical and educational). ▪ Physician signature verifying acceptance of stated treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring specialist physician.
Initiation of Services: Therapy must be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without PA.	For the initial period, speech may be provided up to a maximum of 36 times during the 90 consecutive calendar days in the outpatient hospital. If therapy is not initiated within 30 days of the prescription, a new prescription is required. Therapy must be provided by the evaluation discipline. An OT cannot provide treatment under a speech-language pathologist's evaluation. Co-signing of evaluations and sharing treatments require PA. PA is not required for the initial period of skilled therapy for the first 90 consecutive calendar days in the OPH for a new treatment diagnosis or new medical diagnosis if: ▪ Beneficiary remains Program-eligible during the period services are provided; and ▪ A copy of the physician's signed and dated (within 30 days of initiation of services) prescription for speech-language therapy is on file in the beneficiary's medical record. Providers may also initiate services without PA when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.
Continued Active Treatment: MDCH requires providers to request PA for therapy beyond the initial 90 days; the SLP must complete MSA-115 and submit to the technical assistance section to request continued active treatment.	The SLP may request up to 90 consecutive calendar days of continued active therapy in the OPH setting. Requests to continue active treatment must be accompanied by: ▪ Treatment summary of the previous service period, including measurable progress on each short-term and long-term goal. This must include the treating SLP's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. Do <u>not</u> send daily treatment notes. ▪ A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy.

	▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested. ▪ A statement of the beneficiary's treatment response, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and education), if appropriate. ▪ Anticipated frequency and duration of maintenance/monitoring. ▪ A discharge plan. ▪ A copy of the prescription hand-signed by the referring physician and dated within 30 days prior to initiation of continued service must be provided with each request.
Maintenance/Monitoring: A beneficiary may not require active treatment, but the skills of an SLP are required for training or monitoring of maintenance programs that are being carried out by a family member and/or caregiver. In the OPH, these types of service may be provided without PA up to four times per 90-day period.	Continued maintenance/monitoring requires PA in all settings. The SLP must complete the PA request and include: ▪ A service summary including, a description of the skilled services being provided. This should include the treating SLP's analysis of the rate of progress and justification for any change in treatment plan. Documentation must relate to the period immediately prior to that time period for which PA is requested and can cover up to three months. ▪ A comprehensive description or copy of the maintenance/activity plan. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of service with other therapies (e.g., medical and educational) if appropriate. ▪ The anticipated frequency and duration of continued maintenance/monitoring. ▪ A discharge plan.

3.25.D. Discharge Summary

When the beneficiary is discharged from therapy services, the SLP must maintain a discharge summary on file with the SLP as a mechanism for identifying completion of services and status of discharge. The discharge summary should include:

- Dates of service (initial and discharge);
- Description of services provided;
- Functional status related to treatment area goals at discharge;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- Description or copy of follow-up or maintenance program put into place, if appropriate;
- Identification of adaptive equipment provided and its current utilization, if appropriate;
- Recommendations/referral to other services, if appropriate.

3.25.E. Resuming Therapy

If services must be resumed within a 12-month period for the same diagnosis, PA is required. A discharge summary of the previous therapy or an explanation of the changes in functional or medical status must accompany the PA request.

3.25.F. Prior Authorization (PA)

Speech-language pathology services, provided during an inpatient admission, do not require PA.

3.25.G. Supplies and Equipment

The cost of supplies and equipment used as part of the speech pathology is included in the reimbursement for the pathology codes.

3.25.H. Nursing Facility Beneficiaries

Speech-language pathology may be provided to nursing facility beneficiaries in the outpatient department of a general hospital.

3.26 WEIGHT REDUCTION

MDCH reimburses obesity treatment when done for the purpose of controlling life-endangering complications such as hypertension and diabetes. This does not include treatment specifically for obesity, weight reduction and maintenance alone. The physician must request PA and document that other weight reduction efforts and/or additional treatment of conservative measures to control weight and manage the complications have failed.

The request for PA must include

- The medical history;
- Past and current treatment and results;
- Complications encountered;
- All weight control methods that have been tried and failed; and
- Expected benefits or prognosis for the method being requested.

If surgical intervention is desired, a psychiatric evaluation of the beneficiary's willingness/ability to alter their lifestyle following surgical intervention must be included.

Mail requests to Office of Medical Affairs. (Refer to the Directory Appendix for contact information.)

If the request is approved, the provider receives an authorization letter for the service, including billing instructions. A copy of the authorization letter must be attached to all claims submitted to MDCH for weight reduction services.

SECTION 4 – NON-COVERED SERVICES

MDCH does not reimburse hospitals (inpatient or outpatient) for the following services:

- Acupuncture;
- Autopsy; and
- Biofeedback.

SECTION 5 – UTILIZATION REVIEW

5.1 NON-COVERED ADMISSIONS

For Medicaid reimbursement, all inpatient admissions must be medically necessary and appropriate. MDCH does not cover inpatient hospital admissions for the sole purpose of:

- Cosmetic surgery (unless prior authorized);
- Custodial or protective care of abused children;
- Diagnostic procedures that can be performed on an outpatient basis;
- Laboratory work, electrocardiograms, electroencephalograms, diagnostic x-rays;
- Observation;
- Occupational therapy;
- Patient education;
- Physical therapy;
- Routine dental care;
- Routine physical examinations not related to a specific illness, symptom, complaint, or injury;
- Speech pathology; or
- Weight reduction; weight control (unless prior authorized).

Hospitals may not bill beneficiaries for any medical charges for goods and services provided during a non-allowable admission. The beneficiary is assumed to be following the physician's advice. MDCH does not reimburse any accommodation or ancillary services provided during non-allowable admissions or parts of stays.

Any accommodations or ancillary services provided during non-allowable admissions or parts of stays will not be reimbursed.

5.2 PACER DRG INPATIENT ADMISSIONS PRIOR AUTHORIZATION CERTIFICATION EVALUATION REVIEW

A MDCH subcontractor performs inpatient admission and certification reviews. This section contains information on these reviews, the review process and the appeals processes.

Elective admissions, all readmissions within 15 days, and all transfers for surgical and medical inpatient hospital services to and from any hospital(s) enrolled in the Michigan Medicaid Program require authorization through the Authorization and Certification Review Contractor (ACRC). This includes transfers between a medical/surgical unit and an enrolled distinct-part rehabilitation unit of the same hospital. All cases are screened using the Medicaid-approved Severity of Illness/Intensity of Services (SI/IS) criteria, and the clinical judgment of the review coordinator. An ACRC physician advisor makes all adverse determinations using SI/IS criteria and clinical judgment for evaluating the case.

If an admission, readmission, transfer, or continued stay is not approved, MDCH does not reimburse the hospital or attending physician for inpatient services rendered. The provider may request reconsideration by the ACRC, either verbally or in writing. Reconsideration must be requested within three working days of the original denial.

The ACRC performs medical/surgical and rehabilitation admission, readmission, and transfer review through the Prior Authorization Certification Evaluation Review (PACER) system and assigns PACER numbers.

The attending/admitting physician or representative is responsible for obtaining the authorization number (PACER number) before admitting or readmitting the beneficiary to the hospital or before transferring the beneficiary (with exceptions as noted below). Should the consulting physician become the attending physician, he may obtain the PACER number. Physicians are asked to provide the CPT/HCPCS Procedure Code when a surgical admission/readmission is proposed.

(Refer to the Directory Appendix for the telephone number to obtain PACER authorization.)

Authorization through the ACRC for the hospital admission does not remove the need for PA required by Medicaid for specific services. The hospital must still attach documentation with its claim for such services (example, the hospital would still have to attach a copy of the Letter of Authorization from the Office of Medical Affairs for cosmetic surgery). The approval for the service must be obtained before the ACRC authorization is requested.

Admissions that do not require ACRC approval	▪ Emergent admissions. All transfers and readmissions do require PACER. (Hospital admission services billed as emergent are reviewed on a post-payment sample basis.) ▪ Transfers to distinct-part psychiatric units or freestanding psychiatric hospitals. ▪ Obstetrical patients admitted for any delivery. ▪ Newborns admitted following a delivery. **Exception:** All transfers of newborns following delivery require a PACER. The initial and any subsequent transfers of the newborn must be authorized by the ACRC. ▪ CSHCS Program beneficiaries. ACRC approval is required if not related to the qualifying diagnosis. ▪ Beneficiaries enrolled in a Medicaid Health Plan. ▪ CSHCS beneficiaries enrolled in a SHP. ▪ When a beneficiary is admitted to a hospital not enrolled with the Michigan Medicaid Program. ▪ When a patient is determined Medicaid-eligible after the admission, readmission, transfer, or certification review period for which the ACRC review was required. **NOTE:** The Remarks section of the claim must include a statement that a PACER number or ACRC approval was not requested because the beneficiary was not Medicaid-eligible on the date of admission but eligibility was made retroactive. The admitting history and physical, face sheet, and discharge summary must be attached to the claim. MDCH verifies that eligibility was retroactive.

The physician is not exempted from obtaining PA through the ACRC solely because: ▪ A beneficiary has any other insurance, including Medicare Part A. A PACER number is needed if the beneficiary has Medicare Part B only or if Part A coverage is exhausted. ▪ The physician is not enrolled in the Michigan Medicaid Program.	
PACER Elective Approval Admission	The physician is responsible for providing the PACER number to the admitting hospital. The PACER number is issued on the day that the admission is approved by the ACRC. This number is valid for the entire medical or surgical admission unless otherwise noted in the manual. PACER authorization must be requested prior to the admission of the patient. Approval of an admission only confirms the need for services to be provided on an inpatient hospital basis. Payment for the admission is subject to eligibility requirements, readmission, and third-party liability reimbursement policy, along with any pre and post-payment determinations of medical necessity.
PACER Readmissions	To be separately reimbursable, all readmissions (whether to the same or different hospital) for hospital services must be prior authorized through the ACRC. The request for a PACER number for an elective readmission, whether to the same or a different hospital, must be made prior to readmission. The request for a PACER number for an urgent or emergent readmission to the same hospital must be made by the next working day following the readmission. The request for a PACER number for an urgent or emergent readmission to a different hospital must be made prior to the patient's discharge. Medicaid defines readmission, for purposes of review, as any admission/hospitalization of a beneficiary within 15 days of a previous discharge, whether the readmission is to the same or different hospital. If the hospital intends to combine an admission and a readmission into a single episode for DRG payment purposes, the ACRC should not be contacted for a separate PACER number for the readmission. Before calling the ACRC, the requestor should assemble as much information as possible regarding the medical condition of the patient upon the first discharge and at the time of the readmission. When called for a PACER number, the ACRC either: ▪ Agrees that the original admission and the readmission are unrelated, as well as medically necessary, and issues a PACER number so that the stays may be billed and paid separately by the same hospital; ▪ Authorizes a readmission to a different hospital as medically necessary and issues a PACER number. If there is a question of relatedness, the ACRC may flag the two-stay episode for retrospective medical record review; ▪ Asks the caller to obtain additional information and call back no later than the next working day; or ▪ Questions the relatedness of two stays at the same hospital or the medical necessity for the readmission and refers the call to a physician advisor who may issue or deny a PACER number.

	If a PACER number is not provided for a readmission due to relatedness (required as a consequence of the original admission), the hospital may combine the two stays into a single episode for DRG payment purposes (using the "leave of absence" Revenue Code 0180 for the time between discharge and readmission), or request reconsideration of the ACRC physician advisor's decision. If the initial admission has already been billed, the hospital may submit a claim replacement to combine the two stays. If it is determined a readmission is medically unnecessary, the hospital and physician may only bill for the first admission.
PACER Transfers	If a beneficiary needs to be transferred, authorization for the transfer must be obtained through the ACRC. Authorization for a transfer is granted only if the transfer is medically necessary and the care or treatment is not available at the transferring hospital. Transfers for convenience are not considered. Transfers include any of the following situations: transfer from one inpatient hospital to another; transfer from one unit of an inpatient hospital to another unit of the same hospital (i.e., distinct-part rehabilitation unit) which has a separate Medicaid ID number. Transfer to a distinct-part psychiatric unit of a general hospital or a freestanding psychiatric hospital is subject to review and approval by the beneficiary's PIHP/CMHSP. **Do not** contact the ACRC for a PACER number. The following describes the appropriate requestor and timeframes for transfer authorization: ▪ Elective transfers--the transferring physician or designee must obtain authorization prior to transfer. ▪ Emergency transfers -- The authorization must be obtained by the transferring physician no later than the next working day, or by the receiving physician or hospital before discharge. If the transfer is approved, a PACER number is issued. The receiving hospital must use this number when billing. The transferring hospital continues to use the original PACER number if a PACER number was required for the admission.

5.3 POST-PAYMENT REVIEW OF TRANSFERS AND READMISSIONS

Transfers and readmissions are reviewed on a post-payment basis. If it is determined that the information provided to justify the transfer/readmission is not validated by evidence in the medical record, the ACRC may reverse its PACER authorization decision. If, in the post-payment review, the transfer/readmission is determined to be inappropriate, related monies are recovered. If post-payment review indicates that the patient no longer required inpatient care at the time of the transfer/readmission, monies are recovered from the transferring/admitting hospital.

5.4 INAPPROPRIATE OR UNNECESSARY ADMISSIONS

No reimbursement is made by MDCH to the hospital for inappropriate or unnecessary inpatient admissions, readmissions within 15 days, transfers that are not authorized through the ACRC system, and admissions or readmissions that have been inappropriately coded as urgent or emergent. This includes selected ambulatory surgeries inappropriately performed on an inpatient basis or any other inpatient

elective admission determined not to have been medically necessary. In addition, the hospital is not reimbursed if errors were made in identification of the beneficiary or the time period of the admission.

If MDCH does not reimburse the physician or hospital, the physician or hospital must not bill the beneficiary, a member of the beneficiary's family, or other beneficiary representatives.

Services during inpatient stays or parts of stays where that stay has been denied as inappropriate or unnecessary may not be resubmitted to MDCH as outpatient charges. Charges resubmitted as outpatient charges are monitored, and any payment made recovered during post-payment audit.

If a PACER number was not requested in a timely manner (as described throughout this chapter), the physician or hospital should call the ACRC as soon as the omission is noted. The ACRC requests a written explanation of the reason for the untimely request. Each case is reviewed individually. The ACRC responds in writing to the hospital.

If the call to the ACRC is not made in a timely manner, the hospital risks denial on that basis unless circumstances causing the late call are explained completely and acceptably.

5.5 Authorization for Non-DRG Admissions to Freestanding Rehabilitation Hospitals

Inpatient stays beyond 30 days in freestanding rehabilitation hospitals require additional inpatient authorization. The hospital must call the ACRC between the 27th and 30th day of the stay if the stay is expected to exceed 30 days. If the extended stay is certified, a nine-digit certification number is given. That number must appear on the hospital's claim if the stay is greater than 30 days but less than 60 days. The hospital must call the ACRC between the 57th and 60th day of the stay if the stay is expected to exceed 60 days. If the extended stay is approved, the hospital is given another authorization number. This second number must appear on the hospital's claim if the stay is greater than 60 days.

Exceptions	▪ CSHCS Program beneficiaries (including those having dual eligibility for the CSHCS and Medicaid Program); ACRC approval is required if not related to the qualifying diagnosis. ▪ CSHCS Program beneficiaries enrolled in a SHP; ▪ Resident County Hospitalization (RCH) beneficiaries; ▪ Admissions covered by Medicare Part A; and ▪ Beneficiaries enrolled through Medicaid in a MHP.

Reconsiderations	The attending physician or the hospital may request reconsideration of the adverse determination of the ACRC regarding the need for admission or continued stay. This reconsideration right applies regardless of the current hospitalization status of the patient. Reconsiderations must be requested via the appropriate toll-free number within three working days of the adverse determination. (Refer to the Directory Appendix for contact information). If requested by the ACRC, the provider must provide written documentation. The provider is notified of the reconsideration decision within one working day of receipt of the request or the date of receipt of written documentation. If the initial adverse determination is overturned, the adverse determination is considered null and void. If the initial adverse determination is upheld or is modified in such a manner that some portion of the hospital care is not authorized, the hospital is liable for the cost of care provided from the date of the initial determination, unless this determination is overturned in the Medicaid appeals process.
Technical Denials	If the provider fails to request an authorization number on a timely basis (as described previously in this chapter), the provider should make this request as soon as the omission is noted. When the provider contacts the ACRC by telephone with an untimely request, the review coordinator sends the provider a form to complete explaining the circumstances of the untimely request. If upon review of this written documentation the untimeliness is waived, the case is reviewed for medical necessity and the appropriateness of the admission, transfer or readmission. If approved, the ACRC gives the provider a PACER number. If the untimeliness issue is not approved, the attending physician and the hospital are notified in writing within 24 hours of the decision. The hospital may request further review of the ACRC decision by Medicaid relative to timeliness.
Continued Stay Denials	If the ACRC does not authorize the admission or the continued stay for an admission and the patient remains in the hospital for one or more day(s) after Medicaid payment is not authorized, the hospital is at risk of Medicaid non-payment for those days. The provider may request post-discharge review by the ACRC, regardless of whether reconsideration was requested on the case, in writing within 30 days of the discharge from the hospital. The post-discharge review request must be accompanied by a copy of the medical record. Post-discharge review is conducted on only those days which were not authorized during the telephone review. The ACRC informs the provider, in writing, of the ACRC decision within fourteen days of the receipt of the request and documentation. If some or all of the previously non-authorized days are approved, a new billing authorization number is issued and included in the notification of the decision. If the initial adverse determination is upheld, the notification includes the previously issued billing authorization number. If the provider is dissatisfied with the decision of the ACRC, the decision may be appealed to Medicaid. The hospital may bill the Medicaid program only for the days authorized by the ACRC. If the ACRC has made an adverse determination and issued a final billing authorization number, the hospital may submit an invoice with this billing authorization number for only the authorized days while the case is in the reconsideration, post-discharge review, or formal appeals process. Submission of such an invoice does not imply acceptance of the ACRC determination.

5.6 Utilization Review

The objective of utilization review is to ensure that care paid by MDCH is medically necessary and provided in the appropriate setting, that the diagnostic and procedural information is valid, and that the care meets quality standards.

Post-discharge utilization reviews of medical/surgical and rehabilitation stays are conducted by the ACRC. Review occurs monthly on:

- At least a 10 percent sample of prior authorized elective admissions.
- At least a 10 percent sample of urgent and emergent medical/surgical admissions (excluding normal deliveries and normal newborns), all readmissions within 15 days, and all transfers.

Cases are reviewed using Medicaid-approved SI/IS criteria, clinical judgment and generic quality screens.

All reviews include consideration of medical necessity, appropriateness of setting, coding validity/accuracy, and the quality and intensity of care provided to the beneficiary. The ACRC assures that the quality and intensity of inpatient hospital services conform to acceptable standards of medical practice and to Medicaid policies, procedures, and guidelines. Cases referred by the review coordinator during review must be copied for physician advisor review.

Hospitals with a very low Medicaid volume may have Medicaid-selected cases reviewed. Cases involving transfers and readmissions within 15 days where two hospitals rendered care are reviewed. The hospital(s) are required to provide a copy of the full medical record for these reviews.

An ACRC physician advisor makes all adverse determinations requiring medical judgment, including admission denials and the determination of a quality of care problem. Adverse determinations regarding a diagnostic or procedural-coding rule are made by a medical records professional. All adverse determinations are subject to reconsideration, and reconsideration must be requested within 30 days of a denial.

5.6.A. Intensified Review

Hospitals exhibiting a three percent (with a minimum of three cases) or greater noncompliance rate during any two-month review period may be subject to an intensified review of admissions for the subsequent two-month period. This review may involve up to 100 percent of a provider's admissions or may focus on a subset for a period of two months.

- If the noncompliance rate is less than three percent during the subsequent two-month period, review reverts to the original sample size in the third month.
- If the noncompliance rate continues at three percent or more, the intensified review continues for another two-month period, and so on.

If the noncompliance rate continues at three percent or more for two successive two-month periods, the ACRC may recommend to Medicaid that a program participation sanction or other action be taken against the hospital. The ACRC may determine that a particular provider, group of providers, or cases involving specific diagnoses or procedures should receive expanded review. The ACRC justifies such a recommendation to Medicaid prior to implementation.

The ACRC and Medicaid agree on certain DRGs which merit intensified review. These DRGs may change periodically as internal reporting evidences the need for intensified review.

5.6.B. Post-Payment Denials

DRG Validity	The ACRC verifies the diagnosis and procedure codes on the hospital's claim on a post-payment basis for all claims paid on a DRG basis. If the ACRC determines that the record does not support the diagnosis and procedure coding on the claim, the hospital and MDCH are notified of the errors, and MDCH notifies the provider of a negative action. The provider may appeal these negative actions. If not appealed within 30 days, Medicaid submits a claim adjustment of the hospital's account.
Medical Necessity/ Appropriateness	The ACRC also performs retrospective review for medical necessity of admissions, transfers and readmissions. If the review coordinator cannot approve the case, an ACRC physician advisor reviews the medical record. If review indicates the existence of a problem, the hospital receives written notice of this determination from the ACRC. If the provider disagrees with this decision, the attending physician and/or hospital may request reconsideration by the ACRC. The provider is encouraged to supply the ACRC with additional medical documentation that is of the same time period of the service. The reconsideration request must be made within 30 days of the ACRC determination. The ACRC has the case reviewed by a different physician of an appropriate specialty during the reconsideration. The provider and MDCH receive notification of the ACRC decision. If reconsideration is upheld, MDCH then issues an adverse action notice to the hospital that includes further appeal rights and procedures. If the hospital does not appeal, any monies paid are recovered. Services provided during inpatient stays or parts of stays where that stay has been denied as inappropriate or unnecessary may not be resubmitted to MDCH as outpatient charges. Charges resubmitted as outpatient charges are monitored, and any payment made is recovered during post-payment audit.
Technical Denials	If the hospital fails to send medical records when required, the hospital receives an adverse action notice and all payments are recovered. The hospital is also advised of its right to appeal. If during the appeals process the hospital produces the medical records, MDCH requests informal ACRC review of medical necessity. If the ACRC approves the entire stay, or if the ACRC makes an adverse decision, MDCH notifies the provider. The provider then may continue the appeal to the next level.

5.7 QUALITY REVIEW

The ACRC performs a review of the quality of care provided to the patient. This review occurs only on cases selected for a retrospective review. Nurse screening is conducted using quality screens which have been approved by MDCH. Potential quality problems are referred for physician review, and the attending physician has an opportunity to respond to any potential quality problem.

If the ACRC's post-payment review identifies quality of care issues, the attending physician and/or hospital is notified and the peer review procedures for quality review are followed. Ultimately, the ACRC notifies MDCH of any serious quality findings and recommended interventions which may include, but are not limited to,:

- Suspending or terminating a provider's participation in the Medicaid Program;
- Requiring PA of specific cases;
- Requiring intensified review of specific cases; and/or
- Limiting the provider's scope of participation in the Medicaid Program.

5.8 CONTRACTOR MONITORING

MDCH monitors the ACRC's review process and case determinations to verify that the ACRC is:

- Appropriately applying review criteria in compliance with Medicaid Program policy;
- Making proper determination of medical necessity and appropriateness of setting; and
- Performing all duties in a manner acceptable to the program.

The ACRC may be monitored to assure timeliness of post-discharge medical record review. Penalties may be assessed if the ACRC fails to maintain timely reviews.

5.9 CONFIDENTIALITY

As an agent of the State, the ACRC may access all records related to care provided to Medicaid beneficiaries and is subject to the same state and federal confidentiality requirements as Medicaid staff. The failure of a provider to make all records available to the contractor results in denial of that case and subject that provider to program participation sanctions. Additionally, the contractor makes allowable disclosures of statistical information after MDCH's review and approval. This information is directly releasable to, and reviewable by, the Health Care Fraud Division of the Attorney General's Office.

5.10 DISCHARGE PLANNING

As part of utilization review, the hospital should consider various alternatives for care of the beneficiary through discharge planning. The medical and social services personnel of the hospital should assist in this effort. If so requested by the hospital, the FIA local county office assists in relocating the beneficiary. The following explains possible alternatives for care:

Home Help	The beneficiary is able to remain in his/her own home. Home Help providers perform unskilled household and personal care tasks that the beneficiary cannot do himself/herself.
Home Health Care	The beneficiary resides in his own home or other place of residence (e.g., foster care, home for the aged), is under a physician's (M.D. or D.O.) care, and requires intermittent nursing care for a specified period of time. Intensive care may be approved as an exception, or appropriateness of other home care services is determined.
Private Duty Nursing	The beneficiary requires more individualized and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or skilled nursing facility. Private duty nursing (PDN) enables the beneficiary to remain in their home. This service is a state plan benefit for beneficiaries under age 21.

	If the beneficiary is enrolled in, or receiving case management services from, one of the following programs, the applicable program authorizes the private duty nursing (PDN): ▪ Children's Special Health Care Services (CSHCS) ▪ Home and Community-Based Services Waiver for the Elderly and Disabled ▪ Children's Waiver (Community Mental Health Services Program (CMHSP) ▪ Habilitation/Support Services Waiver (CMHSP). For a beneficiary not receiving services from one of these programs, the CSHCS Program will review the request for authorization. For beneficiaries age 21 and older, this service is a waiver service that may be covered for qualifying individuals enrolled in MI Choice Waiver or Habilitation/Support Services Waiver.
Home for the Aged	The beneficiary (age 62 or older) receives supervision and non-nursing care in a licensed home.
Adult Foster Care Home	The beneficiary is in a licensed home that provides supervision, assistance, protection, and personal care, in addition to room and board. This type of home does not provide continuous medical care.
Home and Community Based Waiver for the Elderly and Disabled	The beneficiary meets the requirements for the nursing home level of care and at least one waiver service. Referrals are made to regional waiver providers who are responsible for screening and assessing the beneficiary for waiver eligibility. Once determined eligible, the beneficiary receives services in their home to help them remain as independent as possible. These services may include skilled nursing, homemaker, respite care, counseling, etc.
Nursing Facility	If the beneficiary requires less than acute, continuous medical care, a nursing facility may be appropriate. This includes a nursing home, medical care facility, or hospital long-term care unit. The Eligibility Chapter provides instructions for placing the beneficiary in such a facility. (Any other alternatives for care, e.g., home help, may not be provided to the beneficiary while he is in the nursing facility.) Prior to admission to a Medicaid-certified nursing facility, MDCH requires a Level I preadmission screening on all beneficiaries. The purpose of the screening is to prevent placement of beneficiaries with mental illness or mental retardation in a nursing facility unless their medical needs clearly indicate that they require the level of care provided by a nursing facility. Level I screening is documented on the "Pre-admission Screening (PAS)/Annual Resident Review (ARR) (Mental Illness/Developmental Disability Identification)", (DCH-3877). The Level I screening is part of the hospital discharge planning process and must be completed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or physician. The PASARR Process is not required in the following situations: ▪ When an individual is admitted to an Intermediate Care Facility for the Mentally Retarded (ICF/MR – Provider Type 65) ▪ When an individual is admitted to, and residing in, a hospital swing bed. However, the PASARR process must be completed prior to admission if the individual transfers to a nursing facility.

	▪ When a resident is readmitted to a nursing facility after a hospital stay. If the Annual Resident Review date occurs during a period of hospitalization, the screening must be completed within 30 days of admission or readmission to the nursing facility. Level II Evaluation: All individuals identified by Level I screening as possibly mentally ill or mentally retarded (a "yes" response to any question on the Level I screening form, DCH-3877) must receive a Level II evaluation, unless it is documented that they meet one of the exemption criteria outlined on the Mentall Illness/Developmental Disability Exemption Criteria Certification form, DCH-3878 or the DCH/PIHP/CMHSP finds that the individual does not meet the criteria for a serious mental illness under the PASARR provisions. (See the Forms Appendix for a sample form. Refer to the Directory Appendix to download the form.)
Special Nursing Facility Placement	There may be occasions when a beneficiary requires specialized care in a nursing facility (skilled nursing facility or hospital long term care unit). Such circumstances include ventilator-dependent patients or beneficiaries with complex, severe medical/nursing problems who require extensive and intensive amounts of care and services. The MDCH reviews special placement requests and special payment arrangements under a Memorandum of Understanding (MOU) between MDCH and the nursing facility prior to the placement on an individual basis. Request for special placement is considered if: ▪ The patient is dependent on life-supporting mechanical equipment for at least 6 hours per day. ▪ The patient has a complex case with at least three serious medical problems, and placement has been denied in 10 nursing facilities. Medicaid must be the sole payer before special placement requests are made. The hospital is to initiate this request by calling or writing the MDCH Long Term Care Section. (Refer to the Directory Appendix for contact information.) The hospital then receives a request for more detailed information regarding the condition of the patient and the circumstances requiring special placement. Placements are not approved until after the detailed information has been reviewed. Transfers to ventilator-dependent care units are normally approved only when the high day outlier threshold has been reached. In those situations where a beneficiary cannot be immediately placed in a nursing facility, MDCH covers nursing days in the inpatient hospital. Ancillary services that are normally rendered and billed for beneficiaries receiving acute care may be rendered and billed for beneficiaries receiving nursing care in the hospital. Ancillary services rendered during the nursing days may also be billed to MDCH. No payment for nursing days is made until the outlier status is reached. The hospital cannot charge the beneficiary the difference between the hospital charge and MDCH's payment.

	If the beneficiary refuses placement in the first appropriate setting, he/she is responsible for any hospital charges incurred after that time.

These services may be provided singly or in combination. For example:

- The beneficiary may receive home health care and home help. Home health care would attend to the beneficiary's medical/nursing needs and home help would provide health-related personal care services such as bathing or meal preparations. These two distinct services should be provided by two separate entities. Home Help funding cannot be used to pay for skilled nursing care.
- The beneficiary resides in an adult foster care home and also receives home health care. The adult foster care home would provide personal care and home health care would provide medical/nursing care, such as wound care.

5.11 Termination of Benefits

The hospital's utilization review committee may issue a notice of non-coverage to the patient if it determines that the admission or continued stay in the hospital is not medically necessary. The notice should be substantially similar to the sample letter contained in the Forms Appendix of this manual.

If the patient or patient representative disagrees with the notice, the patient or representative may contact the ACRC to appeal the decision. If the ACRC has previously issued an adverse determination for the period of hospitalization covered by the notice, the ACRC informs the patient of concurrence with the hospital decision. If the ACRC has not previously issued an adverse determination for the period, a review of the medical record is conducted. The ACRC contacts the hospital to obtain a copy of the medical record. An ACRC physician advisor reviews the medical necessity of the admission or continued stay. The ACRC reviews and issues a decision on the case within three days of the receipt of the final determination and the related documentation.

If issued, the notice is the responsibility of the hospital's utilization review committee and is not related to any decision that may have been rendered by the ACRC on the case. The decision must be based on the findings of the utilization review committee and not on the determination of the ACRC.

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal provides an administrative hearing to appellants requesting a hearing who do not agree with a decision made by MDCH or a MDCH contracted agency (i.e., any agency, organization, or health plan contracted by the MDCH) that either determines eligibility for a department program, or delivers a service provided under a department program to a beneficiary, patient or resident. The Administrative Tribunal issues timely, clear, concise and legally accurate hearing decisions and orders. The Administrative Tribunal Policy and Procedures Manual explains the process by which each different type of case is brought to completion. Refer to this manual for Administrative Tribunal form information. (Refer to the Directory Appendix for Administrative Tribunal contact information.)

5.12 Outpatient Hospital Post-Payment Review

The Admission Certification and Review Contractor (ACRC) performs reviews of outpatient medical records and itemized bills to verify services provided, amount billed, and appropriateness of setting. Records are reviewed to assure that services were rendered in accordance with professionally-recognized

standards of care and in compliance with Medicaid coverage. All outpatient hospital services are eligible for this review and billing validation including, but not limited to, surgeries, endoscopies, and other special procedure room services. MDCH may conduct periodic audits of claims by hospital to verify that the outpatient hospital medical record supports the level of services billed. If a statistically-valid random sample by hospital determines that services billed were at a higher level than supported by the medical records, audit findings may be extrapolated to the entire Medicaid population receiving services in that facility and are subject to recoupment and/or adjustment. Claims are selected for review that have procedure and diagnosis codes identified as areas of concern based on previous review activity. Codes selected for review may vary between facilities. Facilities have the option to participate in the appeal process.

The ACRC sends to the facility a request for a copy of the medical record and itemized bill applicable to the service being reviewed. Facilities have 30 days in which to provide the documents to ACRC for review. If reconsideration is requested by the provider, the request, along with any additional documentation, must be in writing and received by the ACRC prior to an appeal. If all documents requested are not provided to the ACRC within the 30-day timeframe, a final determination will be issued by the ACRC as defined by Michigan Administrative Rule 400.3401. The final determination notice will contain the timelines which must be met for the MDCH appeals process.