MEDICAL SERVICES ADMINISTRATION

Bulletin

Distribution: Practitioner 03-07
(Physicians, Medical Clinics, Certified Nurse Midwives, Nurse Practitioners, Certified Registered Nurse Anesthetists, Optometrists, Oral Surgeons, Physical Therapists, Podiatrists)

Issued: December 1, 2003

Subject: Chapter III (Coverages and Limitations for Practitioners)

Effective: January 1, 2004

Programs Affected: Medicaid, Children's Special Health Care Services, Adult Benefits Waiver I, Maternity Outpatient Medical Services (MOMS) Program

This bulletin transmits the revised Chapter III (Coverages and Limitations for Practitioners). As a part of the chapter revision process, previously issued policy bulletins have been incorporated. Rewording and clarification of existing policy and policy changes have been incorporated which reflect issues raised and clarifications requested by the provider community and within the Michigan Department of Community Health (MDCH).

The attached Chapter III is effective for dates of service on and after 01/01/2004. The revisions to this chapter include HIPAA mandates and further refine the uniform billing project goal of consistency between Medicaid and other payers.

Chapter Formatting

The Chapter was formatted to facilitate it's incorporation into a single all-provider electronic manual, and references other chapters that may not be part of your current provider-specific manual. Until the all-provider manual is issued on CD in early 2004, providers may access these chapters (e.g. hospital, medical supplier, etc.), on the MDCH website at www.michigan.gov/mdch. Click on Providers, click on Information for Medicaid Providers, click on Medicaid Policy. Providers may also access forms on the website.

Chapter Changes

In reviewing this chapter, please note the following:

- Improved alignment with CPT and CMS coverage and coding guidelines in several areas.

- Assistant at surgery coverage for physician assistants and nurse practitioners.

- Further alignment with the Medicare Correct Coding Initiative (CCI).

- Reorganization of information into major heading areas.

- Private duty nursing has been eliminated from this chapter and providers are referred to the Private Duty Nursing chapter of the manual. The current private duty nursing bulletin (MSA 03-11) is available from the MDCH website.

- Durable medical equipment has been eliminated from this chapter and providers are referred to the Medical Supplier chapter of the manual. The current Medical Supplier chapter (Medical Suppliers 03-05) is available from the MDCH website.

- Pharmacy has been eliminated from this chapter and providers are referred to the Pharmacy chapter of this manual. The current Pharmacy chapter is available from the MDCH website.

- The Chapter refers Practitioners to the Mental Health/Substance Abuse Chapter, which is currently referred to as "Chapter III – Coverages and Limitations, Prepaid Inpatient Health Plans (PIHP), Mental Health, Substance Abuse, and Children's Waiver."

Emergency Department Physician Services

Coverage and reimbursement for emergency department (ED) attending physician services have been modified to implement changes required by Section 1711 of Public Act 159 of 2003.

Effective for dates of service on or after 01/01/2004, the two-tiered evaluation and management rate for ED attending physicians will be based on whether the beneficiary is released from the ED or admitted to the hospital/transferred to another hospital. The 2003 two-tiered reimbursement rate for ED attending physician E/M services will continue to be used as fee screens. The lower rate will be applied if the beneficiary is discharged and the higher rate if the beneficiary is admitted/transferred.

Per existing policy, the two-tiered rate applies only to the attending ED physician. The rate does not apply for other physicians, such as specialists, who provide evaluation and management services in the ED.

Due to the complexity of the programming needed to reinstate the disposition-based ED rate, it is anticipated that the MDCH claims processing system will not be able to process claims based on the above criteria until 02/01/2004. New billing instructions for these services, as well as confirmation of the date the system changes will be completed, will be issued in a future bulletin.

Physicians providing these services can continue to bill as they currently do and then submit claim replacements to correct any payment discrepancies after these processing changes have been completed or they may hold their invoices until the processing changes have been made and then submit them for payment.

Manual Maintenance

Discard the entire Practitioner Chapter III, Coverages and Limitations, and replace with the attached Chapter III, Coverages and Limitations for Practitioners dated 01/01/2004.

The following bulletins no longer apply to the practitioner manual, are obsolete and should be discarded:

SDP 5310.1-91-03, MSA 92-06, MSA 93-16, MSA 94-05, Practitioner 94-05, MSA 94-06, MSA 96-02, MSA 96-06, MSA 97-10, MSA 97-15, MSA 97-17, MSA 97-21, MSA 98-06, MSA 98-09, MSA 99-04, MSA 00-01, MSA 00-04, MSA 00-10, MSA 00-12, MSA 01-06, MSA 01-07, MSA 01-08, MSA 01-09, MSA 01-15, MSA 01-22, MSA 01-29, MSA 01-30, MSA 02-04, MSA 02-05, MSA 02-06, All Provider 02-06, MSA 02-12, All Provider 03-02, MSA 03-03, MSA 03-16.

Retain this bulletin until new billing instructions have been incorporated into the Billing & Reimbursement for Health Care Professionals Chapter.

Questions

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

Approved

Paul Reinhart, Director
Medical Services Administration

NOTICE TO PODIATRISTS

MSA Policy Bulletin All Provider 03-09, which suspended coverage of podiatry services for beneficiaries age 21 and older, remains in effect.

If funding for podiatry services is restored, providers will be notified and the policies contained in this chapter will apply.

PRACTITIONER

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SECTION 1 - GENERAL INFORMATION

Generally, medically necessary services provided to a Medicaid beneficiary by an enrolled practitioner are covered. The services addressed in this chapter include services that require explanation or clarification, have special coverage requirements, require prior authorization (PA), or must be ordered by a physician (MD or DO).

Information is included to assist the practitioner in determining how the Michigan Department of Community Health (MDCH) covers specific services. This information should be used in conjunction with the Billing & Reimbursement for Professionals Chapter of this manual, as well as the practitioner and related procedure databases located on the MDCH website. (Refer to the Directory Appendix for contact information.)

1.1 ADMINISTRATIVE SERVICES

Services of physicians, medical staff or other licensed or certified health professionals functioning in an administrative or teaching capacity for a hospital or nursing facility (including physician-owners or other staff paid by the physician) are not covered separately as physician services.

Pathology services or interpretive studies done for hospital or nursing facility quality improvement purposes or other reasons which do not directly assist with the specific care of a specific beneficiary are considered to be administrative services and are not separately covered as physician services. These services are included in the facility's allowable costs and are paid to the facility.

1.2 BILLING FOR DELEGATED SERVICES

Physician services provided by the physician's employees or employees of the same legal entity that employs the physician are billed under the delegating physician's identification (ID) number as if he performed the services personally. Services performed by a physician's assistant may be billed to MDCH only by the physician who has complied with all requirements for utilizing physicians' assistants per Public Act 368 of 1978, as amended, and any related rules promulgated by the State of Michigan or its Departments.

1.3 COMPONENT SERVICES

Many physician services are covered as global services. A global service includes all resources necessary to perform the procedure (e.g., office overhead, equipment, supplies, and staff) and the services provided by the physician (e.g., interpretation of results and preparation of a report of findings).

Some services are divided into a professional component and a technical component for coverage purposes. The professional component includes the services provided by the physician while the technical component includes equipment, supplies, and technical staff.

Coverage for the professional component or the technical component generally depends on where the service is provided and who provides that portion of the service. Services for which the professional component is covered for the physician are identified in the practitioner databases on the MDCH website by the modifier that designates a professional component. If this modifier is not present in the databases for a specific procedure code, the professional component is not covered for the physician.

Global services are covered for the physician in nonhospital settings and the professional component is covered for the physician in any setting. The technical component is only covered when the service is provided in a hospital setting and is payable to the hospital. The global service and its professional component service cannot both be covered for the same service since the professional component is included in the global service.

1.4 CO-PAYMENTS

The applicable co-payments that a beneficiary is required to pay for certain services (e.g., podiatry services to beneficiaries age 21 and over) are identified in the appropriate section of this manual. The physician should note that a co-payment is not required for:

- Beneficiaries under age 21.
- Beneficiaries in a nursing facility.
- Beneficiaries having Medicare when Medicare covers the service.
- Pregnancy-related drugs. (The pharmacy has a list of these drugs.)

If the beneficiary is unable to pay a required co-payment on the date of service (DOS), the provider cannot refuse to render the service. Providers may bill the beneficiary for the co-payment amount, and he is responsible for paying it.

If the beneficiary fails to pay a co-payment, the provider could, in the future, refuse to serve the beneficiary.

1.5 FACILITY AND NONFACILITY REIMBURSEMENT

Medicaid reduces payment for specified procedures provided in a facility setting. This policy is consistent with the Center for Medicare and Medicaid Services (CMS) facility and nonfacility reimbursement determination. When a provider performs services in a facility setting, costs for certain procedures are reduced because the practitioner does not incur certain overhead expenses (such as clinical staff, supplies, equipment) necessary to provide the service. When a service is performed in a nonfacility setting, the payment rate is based on the nonfacility relative value units (RVUs). When the service is provided in a facility setting, the payment rate is based on the facility RVUs. The payment difference takes into account the higher expenses for the provider in the nonfacility setting. For the purpose of this payment policy, a facility includes the following:

- Hospital inpatient and outpatient facilities;
- Psychiatric facilities;
- Skilled nursing facilities;
- Ambulatory surgery centers; and
- Rehabilitation facilities.

1.6 HOSPITAL-BASED PROVIDER

Medicaid covers services by hospital-based providers (HBPs). A hospital-based provider is employed by the hospital. Each HBP is assigned his own Medicaid ID number.

For purposes of Medicaid, a HBP includes physicians (MD, DO, DPM). Some nonphysician practitioners, such as certified registered nurse anesthetists (CRNAs), nurse practitioners (NPs), and certified nurse midwives (CNMs) can also be considered HBPs under certain circumstances.

Medicaid follows Medicare guidelines for the coverage of HBP services provided by physicians. Generally, professional services provided by nonphysician providers that are employed by a hospital are included in the hospital cost report and are reimbursed to the hospital.

(The HBP should refer to their provider-specific chapter of this manual for policies, procedures, and coverage information.)

1.7 Medicare Related Services

MDCH reimburses physicians for the coinsurance and deductible amounts subject to Medicaid reimbursement limitations on all Medicare approved claims even if Medicaid does not normally cover the service. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual for additional information.)

1.8 Physician Delegation and Supervision

All physician services covered by Medicaid must be performed by the physician personally, the physician's employee, or an employee of the same legal entity that employs the physician, under the physician's delegation and supervision. Only persons currently licensed/certified in an appropriate health occupation/profession (e.g., physician's assistant, NP, CNM) as authorized by Public Act 368 of 1978, as amended, may provide direct patient care under the delegation and supervision of a physician when the physician is not physically present on the premises. The delegating/supervising physician must be continuously available through direct communication such as telephone, radio, or telecommunication when not on the premises.

In the physician's absence, licensed persons who are under the physician's delegation and supervision at the medical care site where the physician regularly sees beneficiaries may provide medical services. Records must demonstrate that the licensed physician is regularly available and provides medical care to beneficiaries at the site on a routine basis. This does not preclude licensed persons under the physician's delegation and supervision from making calls or going on rounds to private homes, public institutions, hospitals, or other health care facilities, as long as the care is a supplement to and does not replace the physician's personal services.

Care and treatment of Medicaid beneficiaries may only be delegated to unlicensed/certified persons when the physician is physically present and providing direct supervision.

1.9 Physician Responsibility

Determination of medical necessity and appropriateness of services is the responsibility of the physician within the scope of currently accepted medical practice and Medicaid limitations. The physician is held responsible if he orders excessive or unnecessary services (e.g., diagnostic tests, prescriptions) regardless of who actually renders or who receives payment for the service. The physician may also be subject to any corrective action related to these services, including recovery of funds.

Services generally must be ordered by a physician to be covered by Medicaid. Some services provided by other providers, such as medical supplies, lab services, and prescriptions, may require the physician to provide written documentation to support the need for the service. If the practitioner is not certain whether a service is a covered benefit, he can refer to the practitioner databases posted on the MDCH website or contact MDCH for coverage information. (Refer to the Directory Appendix for contact information.)

1.10 PRIOR AUTHORIZATION

Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:

- Procedures identified as requiring PA on the procedure code databases on the MDCH website;
- Procedures that are normally noncovered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery); and
- Referrals for elective services by out-of-state nonenrolled providers.

1.10.A. TO OBTAIN PRIOR AUTHORIZATION

Providers must submit a letter to the MDCH Prior Authorization Division to obtain PA. (Refer to the Directory Appendix for contact information.) The letter and materials submitted requesting PA must include:

- Beneficiary's name and Medicaid ID number,
- Provider's name, address, Medicaid provider ID number,
- Contact person and phone number,
- A complete description, including Current Procedural Terminology (CPT)/ Health Care Financing Administration Common Procedure Coding System (HCPCS) procedure codes as appropriate, of the procedure(s) that will be performed, and
- The beneficiary's past medical history, including other treatments/procedures that have been tried and the outcome, diagnostic test results/reports, expectations and prognosis for the proposed procedure, and any other information to support the medical need for the service.

Providers receive a written response from MDCH. If the authorization is granted, the provider receives a nine-digit authorization number to report on the claim. The physician obtaining PA must make the PA number available to other providers, such as other practitioners or the hospital, for billing purposes.

If the beneficiary has Medicare and Medicare covers the service, the provider does not have to obtain PA from Medicaid. If Medicare denies a service as not medically necessary, Medicaid does not cover the service even if a PA has been obtained. If Medicare identifies a service as an excluded benefit under Medicare and Medicaid requires PA, the provider must pursue PA from Medicaid and a coverage determination is made. If the beneficiary has commercial insurance that covers the service and the

provider reports the coverage correctly on the claim, the provider does not have to obtain PA from Medicaid. If a primary insurer covers a service but requires PA and the provider does not follow the primary insurance PA process, Medicaid does not make payment for the service either.

1.10.B. Special Authorizations

Special authorization requirements must be met for selected surgeries performed in the inpatient setting, all elective inpatient admissions, all readmissions within 15 days, and all transfers to an inpatient hospital/unit. Physicians should refer to the Hospital Inpatient Physician Services and the Surgery Sections of this chapter for specific information.

Some beneficiaries may need authorization of services because they are enrolled in special programs, such as the Beneficiary Monitoring Program. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

1.11 Services in a Teaching Setting

Administrative costs associated with teaching physician services, as well as payment for direct patient care services provided by a resident (including interns or fellows) in a teaching setting and supervised by a teaching physician, are subject to guidelines and conditions developed and published by CMS for Medicare. Services covered by Medicaid under these guidelines must be identified with the appropriate modifier.

Teaching institutions and teaching physicians within those institutions must abide by the CMS teaching physician guidelines which explain when services provided in teaching settings can be covered by Medicaid or must be included as allowable medical education costs in the hospital's cost report.

Guidelines require the presence of the teaching physician during the key portion of the performance of the service in which a resident is involved and the teaching physician seeks payment (or the hospital on the behalf of the physician). The medical record must fully support the physician's presence and participation in the service provided. There are exceptions and other considerations that may apply; therefore, the full text of the guidelines must be consulted to ensure compliance. Any services that meet the teaching physician criteria must be reported with the appropriate modifier.

CMS provides an exception to the physician presence requirement for some low- and mid-level Evaluation and Management (E/M) services furnished in certain primary care centers when specified conditions are met. For Medicaid, the preventive medicine E/M visits are also included under the "presence" exception for services provided in the primary care centers by residents. The appropriate modifier must be reported using the "presence" exception when residents provide E/M services. The E/M services that can be reported with this modifier include office or other outpatient visits requiring straightforward or low complexity medical decision making and comprehensive preventive medicine visits. For higher-level services and all invasive procedures, the teaching physician must be present.

Services of residents or physicians/medical staff functioning in an administrative, teaching or learning capacity in the hospital or long term care facility that are covered as individual physician services are subject to post payment review and recovery of funds unless the provider can present proof that the services were not included in the allowable facility costs.

1.12 SERVICES TO NEWBORNS

Physician services provided to newborns are covered under the newborn's Medicaid ID number. The mother's Medicaid ID number cannot be used.

If the delivering physician performs the newborn's care and circumcision during the mother's inpatient stay, these services can be covered under the mother's Medicaid ID number if they are billed on the same claim as the services to the mother.

1.13 UNIFORM REPORTING OF SERVICES

MDCH uses the Medicare Correct Coding Initiative (CCI) policy as a guideline for determining when services are covered in addition to, or are included in, other services provided on the same day. The CPT/HCPCS procedure code descriptions are based upon current medical practice. In order to submit a CPT/HCPCS code to Medicaid, providers must have performed all of the services included in the code description. Providers must not submit codes describing components of a comprehensive code in addition to the comprehensive code (unbundling). Components are individual services necessary to accomplish the more comprehensive procedure/service.

Mutually exclusive code pairs represent services or procedures that would not or could not be reasonably performed on one beneficiary during the same session by the same provider based on standard medical practice. Codes representing these services cannot be submitted together.

Certain codes are identified as separate procedures. These are commonly carried out as an integral part of another service and are not covered separately. However, at times, these services may be provided independently, or unrelated or distinct from other procedures on the same day. It may be appropriate to report a separate procedure with the distinct procedural service modifier in these instances. The addition of this modifier to a procedure code indicates that the procedure represents a distinct procedure or service from others billed on the same date of service. This may represent a different session, different surgery, different anatomical site, different agent, different lesion, or a different injury or area of injury (in extensive injuries).

When CPT/HCPCS descriptions designate several procedures of increasing complexity, only the code describing the most extensive procedure actually performed is covered. Certain CPT/HCPCS descriptions designate procedures performed with or without other services. Providers must submit only the code(s) describing the service(s) actually performed. When the descriptions identify procedures requiring a designation for male or female, submit the appropriate code for the gender of the patient.

SECTION 2 - ANESTHESIA SERVICES

Medicaid covers anesthesia services provided by qualified practitioners in conjunction with covered surgeries and other procedures. (Refer to the anesthesia database on the MDCH website for specific covered anesthesia services.) Medicaid does not cover any anesthesia service related to the treatment of infertility.

2.1 MEDICALLY DIRECTED ANESTHESIA SERVICES

Medicaid covers anesthesia services provided by physicians and CRNAs for medically directed anesthesia services consistent with anesthesia team practice. (Refer to the CRNA Section of this chapter for additional information). Medicaid recognizes medical direction of general anesthesia, regional anesthesia, and reasonable and medically necessary Monitored Anesthesia Care (MAC). Physicians cannot medically direct more than four concurrent anesthesia cases at one time and cannot perform any other services during the same period of time except as outlined below. In all cases in which medical direction is furnished, the physician must be physically present in the operating suite.

All of the following conditions must be met for medically directed anesthesia services to be reimbursed to the physician. For each beneficiary, the physician must:

- Perform a pre-anesthetic examination and evaluation;
- Prescribe the anesthesia plan;
- Personally participate in the most demanding procedures in the anesthesia plan including, if applicable, induction and emergence;
- Ensure that a qualified individual performs any procedures in the anesthesia plan that he does not personally perform;
- Monitor the course of anesthesia administration at frequent intervals;
- Remain physically present and available for immediate diagnosis and treatment of emergencies; and
- Provide indicated post-anesthesia care.

A medical direction service furnished by a physician is not covered if the physician directs a nonqualified individual. A qualified individual is a CRNA, a student anesthetist, an anesthesiologist's assistant, or an intern or resident.

Physicians must document in the beneficiary's medical record that he performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and present during the most demanding procedures, including induction and emergence, where indicated. Total anesthesia time must be documented in the medical record.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another physician member fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. The medical record must indicate the services were furnished by physicians and identify the physician(s) who rendered them.

A physician who is directing the concurrent administration of anesthesia to four or fewer surgical patients should not be involved in furnishing additional services to other patients. If the physician is addressing an emergency of short duration in the immediate area, or administering an epidural or caudal anesthetic to ease labor pain, or providing periodic rather than continuous monitoring of an obstetrical patient, it does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. A physician may also receive patients entering the operating suite for subsequent surgeries, may check on or discharge patients from the recovery room, and may handle scheduling matters while directing concurrent anesthesia procedures without affecting coverage for medical direction.

If the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case, or is not available to respond to the immediate needs of the surgical patients, the physician's services are considered supervisory and are not covered as medical direction.

Medically directed anesthesia services are covered when provided by an anesthesiologist who is monitoring more than four concurrent anesthesia procedures, or who is performing other services while directing the concurrent procedures, in select instances. The physician must personally provide the pre-anesthesia exam and evaluation, prescribe the anesthesia plan, and be in the operating suite during the entire procedure. A flat rate payment is made to cover the physician's involvement in pre-surgical anesthesia services. Medically supervised CRNA services are covered and are reported with the appropriate modifier.

Medicaid covers anesthesia services consistent with Medicare guidelines when provided under an attending physician relationship in a teaching hospital and/or in accordance with the coverage guidelines established by the Medicare policies for teaching physicians.

2.2 Nonmedically Directed Anesthesia Services by the CRNA

Anesthesia services provided by a CRNA under the supervision of the surgeon or another physician who is immediately available if needed are covered as nonmedically directed anesthesia services. MDCH reimburses CRNAs for these services if all of the following conditions are met:

- The facility in which the services are rendered ensures that the anesthesia services are provided in a well-organized manner under the supervision of a physician (MD or DO).
- The facility is responsible for all anesthesia administered in the facility.
- A physician (MD or DO) or a CRNA under the supervision of a physician provided a pre-anesthetic exam and evaluation within 48 hours prior to the surgery.
- An intra-operative anesthesia record identifies the CRNA providing the anesthesia service and the supervising physician.
- For inpatients, the person administering the anesthesia writes a post-anesthesia follow-up report within 48 hours after surgery.
- For outpatients, a post-anesthesia evaluation for proper anesthesia recovery is performed in accordance with the policies and procedures approved by the medical staff.

There is no separate coverage for physicians for any portion of nonmedically directed anesthesia services. The physician's supervisory service is covered as part of the facility charge where the surgery is

performed. The pre-anesthetic exam and post-anesthesia evaluation is included in the anesthesia coverage for the nonmedically directed CRNA care and is not separately covered. Payment for the nonmedically directed anesthesia service provided by the CRNA is made to the CRNA or the legal entity employing the CRNA.

There is no separate coverage for anesthesia services performed by physicians who are also performing the medical or surgical service requiring the anesthesia. Any anesthesia service provided personally by the surgeon is included in the coverage for the surgical procedure itself.

2.3 MONITORED ANESTHESIA CARE

Monitored Anesthesia Care (MAC) is covered on the same basis as other anesthesia services as long as it is reasonable and medically necessary. MAC involves intra-operative monitoring by a physician, or by a qualified anesthesia provider under the medical direction of a physician, or by a CRNA under the supervision of a physician of the beneficiary's vital physiological signs, in anticipation of the need for administration of general anesthesia or the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., Atropine, Demerol, Valium) and provision of indicated post-operative anesthesia care.

2.4 MEDICAL AND SURGICAL SERVICES FURNISHED IN ADDITION TO ANESTHESIA SERVICES

2.4.A. ALLOWABLE SERVICES

Separate coverage is available for certain medical or surgical services furnished by a physician while furnishing anesthesia services to the beneficiary. The services may be furnished in conjunction with the anesthesia procedure to the beneficiary or as single services (e.g., the day of or the day before the anesthesia service). These services include insertion of a Swan Ganz catheter, insertion of central venous pressure lines, emergency intubation, and critical care. Separate coverage is not available for medical or surgical services, such as the pre-anesthetic examination of the beneficiary, pre- or post-operative visits, or usual monitoring functions, that are ordinarily included in the anesthesia service.

2.4.B. POST-OPERATIVE PAIN MANAGEMENT

Post-operative pain management is the responsibility of the surgeon (except in special circumstances) and is covered as part of the global service provided by the surgeon.

Placement of a continuous epidural to manage post-operative pain is separately covered under the appropriate CPT/HCPCS code for a continuous epidural when the physician (or CRNA under a physician's supervision) performed the service for post-operative pain management and the procedure was not used as the mode of anesthesia for the surgery. Daily management of a continuous epidural on subsequent post-operative days is covered under the appropriate procedure code.

2.5 Anesthesia Time

Anesthesia time means the time during which the anesthesia provider (physician providing anesthesia or the CRNA) is furnishing continuous anesthesia care to the beneficiary. It starts when the anesthesia provider begins to prepare the beneficiary for induction of anesthesia and ends when the beneficiary may be safely placed under post-operative supervision and the anesthesia provider is no longer in personal attendance. In counting anesthesia time when an interruption in the anesthesia service occurs, only the actual anesthesia time is counted. The anesthesia start and stop times must be documented in the medical record.

2.6 Electro-Convulsive Therapy

Anesthesia services related to electro-convulsive therapy are covered by the beneficiary's Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) or Medicaid Health Plan (MHP). The attending physician must obtain authorization from the PIHP/CMHSP or the MHP. Payment is made by the PIHP/CMHSP or MHP that authorized the service.

2.7 Prior Authorization for Anesthesia Services

If a surgical procedure requires PA, the operating surgeon is responsible for obtaining the authorization to perform the service. The anesthesia provider is not responsible for providing proof that the surgical procedure was authorized.

2.8 Hysterectomies and Sterilization Procedures

By federal statute, all services, including anesthesia services related to hysterectomies or sterilization procedures, must be supported by an informed consent that meets Medicaid's consent requirements before the service can be covered. It is the responsibility of the operating surgeon to obtain this consent.

2.9 Using Modifiers

Anesthesia services must be coded using the appropriate CPT/HCPCS anesthesia codes with the appropriate modifiers. Anesthesia services for multiple surgeries are reported under the anesthesia procedure code with the highest base unit value with the total anesthesia time, in minutes, including all surgical procedures. (Refer to the MDCH website for specific modifiers required for use with anesthesia services.)

2.10 Anesthesia Add-On Codes

Anesthesia add-on codes are covered in addition to the primary anesthesia code. Coverage for anesthesia add-on codes is based on the anesthesia base units (ABUs) established by CMS for the specific anesthesia add-on code.

Obstetrical anesthesia add-on codes are covered based on the ABUs assigned by CMS plus the anesthesia time units associated with the anesthesia add-on code.

2.11 LABOR AND DELIVERY

Coverage of anesthesia services associated with labor and delivery is based on the type of anesthesia provided. If anesthesia is provided by placement of an epidural catheter, it is covered under the appropriate anesthesia code depending on the type of delivery. The coverage for this service includes any needle placement, drug injection, and any replacement of the epidural catheter during labor. If endotracheal or general anesthesia is provided for the delivery, it is covered under the appropriate anesthesia code. If an epidural catheter is inserted for labor and delivery but it is later necessary to provide endotracheal anesthesia for the delivery, the surgical code for the epidural insertion is covered in addition to the anesthesia service code for the delivery. The medical record must fully document the circumstances requiring both types of anesthesia.

SECTION 3 - EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) to eligible Medicaid beneficiaries under 21 years of age; however, beneficiary participation is voluntary. The intent of EPSDT is to find and treat problems early so they do not become more serious and costly. Accordingly, EPSDT visits and any needed follow-up services are covered.

The main parts of the EPSDT program that providers are responsible for are:

- Well child visits, including immunizations.
- Referrals for:
  - Other preventive health care;
  - Medically necessary follow-up services to treat detected conditions; and
  - Transportation and reporting.

Well Child Visits	MDCH supports the concept of a medical home for each Medicaid beneficiary. A medical home is a primary care provider who assumes responsibility for assuring the overall care of a beneficiary, and for the maintenance of a beneficiary's medical record. When a physician or other primary care provider accepts a child in a primary care relationship, the provider takes responsibility for arranging or providing well child/EPSDT visits and updating the child's medical record at each visit. Well child visits are the health checkups, newborn, well baby, and well child exams represented by appropriate CPT preventive medicine services procedure codes if they are used in conjunction with the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes V20.0 - V20.2, V70.0, and/or V70.3 - V70.9 The EPSDT periodicity schedule (located later in this section) indicates all components and age-specific indicators for performing the various components.
Outreach	MDCH provides outreach to beneficiaries through various means, including informational publications and other beneficiary contacts. When the **mihealth card** is issued, it is mailed with the MDCH Pub 492 (containing English, Spanish, and Arabic text). Pub 492 is entitled "A Hug Shows You Care" and it explains the benefits of a well child visit, indicates the recommended periodicity schedule, describes procedures included in the free health checkup, and presents information about transportation. Soon after the **mihealth card** is issued, the case is included in a monthly outreach list and the grantee receives a letter that stresses the importance of well child visits and provides transportation information. ▪ **Fee-for-Service (FFS):** For beneficiaries under two years of age, the letter is sent every six months. The grantee is encouraged to schedule the visits recommended during those six months with the child's provider. For beneficiaries two years of age and older, if a claim for a well child visit has not processed through the Medicaid system by the time the child is halfway to his next due date according to the periodicity schedule, the grantee receives the letter again. The letters generate a list of FFS beneficiaries that goes to the local health department (LHD). LHDs may assist in informing beneficiaries of the EPSDT program, scheduling appointments, and explaining transportation options.

	▪ **Medicaid Health Plan (MHP)/Children's Special Health Care Services (CSHCS) Special Health Plan (SHP):** Each MHP/SHP is able to download an electronic monthly outreach list of enrollees due or overdue. The health plan must either notify the grantee directly or may have the LHD assist in notification, scheduling appointments, and explaining transportation options. Once each year, "A Hug Shows You Care" is mailed to the grantee of each Medicaid case.
Transportation	Transportation is available (free of charge to the beneficiary) for travel to and from well child visits, if requested by the family. ▪ For those enrolled in an MHP or SHP, the family needs to make arrangements directly through that plan or with the assistance of the LHD. ▪ Beneficiaries not enrolled in an MHP or SHP need to contact their local Family Independence Agency (FIA) directly or with the assistance of the LHD to make transportation arrangements for the EPSDT visit. It may take some time to make these arrangements, so the FIA needs to be contacted as soon as the date and time of the appointment are known.

3.1 PERIODICITY SCHEDULE AND COMPONENTS

The table titled EPSDT Components By Age of Beneficiary in the EPSDT Periodicity Schedule subsection (later in this section) indicates the periodicity schedule and components for well child visits.

Head Start agencies are directed by federal regulation to meet state EPSDT standards for health screening. MDCH urges providers to cooperate with these agencies. Results of well child visits may be shared if requested, since Head Start agencies are bound by confidentiality standards.

Providers must complete all testing components at the specific ages indicated on the periodicity schedule. Well child visits may be performed more frequently than the periodicity schedule indicates if required by court order, foster care standards, or if considered medically necessary. The child's medical record must reflect documentation of the circumstances.

The following sections are meant to provide further guidance to providers when following the EPSDT Components By Age of Beneficiary table.

3.2 HISTORY

Immunization Review	A review shall be performed at each visit, with immunizations administered according to current recommendations and standards of practice recognized by the American Academy of Pediatrics (AAP) and the US Public Health Service Advisory Committee Immunization Practices (ACIP). Providers are reminded that all immunizations should be reported to the Michigan Childhood Immunization Register (MCIR).
Initial/Interval History	An initial history must be obtained for each new patient at the first well child visit, with an update (interval history) at each subsequent well child visit.

Sample history forms from other states are located on the MDCH website. (Refer to the Directory Appendix for contact information.)

3.3 MEASUREMENTS

Blood Pressure	Providers must obtain a blood pressure reading at each well child visit beginning at three years of age.
Head Circumference	This measurement is required at each well child visit through 24 months of age.
Height and Weight	Height and weight must be measured each time the provider conducts a well child visit, with good practice requiring graphing of the measurements. A suitable graphing document may be found on the Centers for Disease Control (CDC) website. (Refer to the Directory Appendix for contact information.).

3.4 SENSORY SCREENING

3.4.A. HEARING

Newborn	All newborns must be screened using evoked otoacoustic emissions (EOAE) and/or auditory brainstem response (ABR) methods. This screening must be accomplished in one of the following ways: ▪ If the hospital delivered 15 or more Medicaid-covered babies between October 1, 1997 and September 30, 1998, the hospital must provide newborn hearing screenings for Medicaid-covered newborns using the policies and procedures recommended by the AAP. If the newborn fails the first screening, another shall be conducted prior to the newborn's discharge. Coverage for the EOAE and ABR newborn hearing screenings is included within the applicable diagnosis related group (DRG) payment for the newborn's inpatient stay. ▪ If the hospital delivered fewer than 15 Medicaid-covered babies between October 1, 1997 and September 30, 1998, the following options are available: ➢ The hospital may obtain the appropriate equipment and train staff to perform newborn hearing screenings using policies and procedures recommended by the AAP. If the newborn fails the first screening, another shall be conducted prior to the newborn's discharge. Coverage for the EOAE and ABR newborn hearing screenings is included within the applicable DRG payment for the newborn's inpatient stay. ➢ FFS Beneficiaries: If the hospital is not equipped for EOAE and/or ABR, the child's physician, nurse-midwife, or nurse practitioner shall be made aware of this fact by the hospital so the newborn can be referred to a Medicaid-enrolled hearing and speech center for screening prior to one month of age. ➢ Beneficiaries Enrolled in an MHP or SHP: If the hospital is not equipped for EOAE and/or ABR, the child's primary care provider (physician, CNM, or NP) shall be made aware of this fact by the hospital so the child can receive an appropriate referral for screening prior to one month of age.

Preschool	Subjective hearing screening (i.e., by history) must be performed at each well child visit. Objective screening may be performed by the primary care provider or referred to the LHD. A Head Start agency (with approval from the child's primary care provider) may refer preschool-aged children to the LHD for objective hearing screening. The results must be reported to the child's primary care provider. The results must also be shared with the Head Start agency if that agency was the referral source.
School Age	Subjective hearing screening (i.e., by history) must be performed at each well child visit. Children with symptoms or risk factors should be referred to a hearing and speech center, an otologist, or CSHCS-sponsored otology clinic at a LHD for further objective testing or diagnosis.
All Ages	For children of any age, a subjective hearing screening (i.e., by history) must be performed at each well child visit. Referral to a hearing and speech center, an otologist, or CSHCS-sponsored otology clinic at a LHD should be made if there are symptoms (e.g., parent or caregiver has suspicions about poor hearing in the child), risk factors (e.g., exposure to ototoxic medications, family history of hearing deficits), or other medical justification.

3.4.B. VISION

Providers must perform a subjective vision screening (i.e., by history) at each well child visit. For asymptomatic children three years of age and older, objective screening must occur as indicated on the periodicity schedule. For children of any age, referral to an optometrist or ophthalmologist must be made if there are symptoms or other medical justification.

Preschool	Since most children cannot cooperate prior to three years of age, the standard screening is subjective. Objective screening should begin at age three. Referrals for objective vision screening by the LHD may be made directly by the primary care provider or a Head Start agency (with approval from the child's primary care provider). The results must be reported to the child's primary care provider. The results must also be shared with the Head Start agency if that agency was the referral source.
School Age	Subjective vision screening must be performed at each visit; objective screening shall be performed as indicated on the periodicity schedule.

3.5 DEVELOPMENTAL/BEHAVIORAL ASSESSMENT

Screening for development and behavior is accomplished by observation, history, and appropriate physical examination. The provider may administer a:

- Standardized developmental instrument, such as the Developmental Screening Test II or Bayley Scales of Infant Development.
- Mental health screening.
- Substance abuse screening.

If suspected problems are observed, specific objective testing must be administered either directly by the primary care provider or referred as appropriate.

3.6 INSPECTIONS

Dental	The dental health of beneficiaries depends a great deal on the child's primary care provider. Therefore, MDCH requires providers to stress the importance of preventive and restorative dental care and adhere to the following: ▪ The oral cavity must be inspected at each well child visit regardless of whether teeth have erupted. ▪ Beginning at three years of age (younger if the individual child exhibits needs) it is extremely important that the child see a dentist every six months for prophylaxis and other preventive care. If the child does not have his next preventive dental appointment scheduled, the provider must make a referral. When restorative dental care is needed, the child must be referred for treatment.
Physical Examination	A complete physical examination must be performed at each well child visit. Infants are to be totally unclothed; all other children must be undressed and suitably draped.

3.7 PROCEDURES - GENERAL

Anticipatory Guidance	Anticipatory guidance explains any and all changes that will most likely occur before the next recommended well child visit, and offers strategies for dealing with the anticipated changes. This applies to all aspects of the child's life (e.g., physical, developmental, nutritional, psychosocial).
Hematocrit or Hemoglobin	The child's hematocrit or hemoglobin must be tested according to the periodicity schedule.
Hereditary/ Metabolic Screening	As required by law, hospitals must test newborns for biotinadase, congenital adrenal hyperplasia, galactosemia, hemoglobinopathies, hypothyroidism, maple syrup urine disease, phenylketonuria (PKU), and sickle cell. If sickle cell testing is appropriate (as explained on the periodicity schedule), a capillary blood sample may be mailed to the Sickle Cell Detection and Information Center. (Refer to Directory Appendix for contact information.) Tubes, forms, and envelopes may be obtained from the Center.
Injury Prevention	Injury prevention must be discussed at each well child visit.
Interpretive Conference	The interpretive conference explains the results of the well child visit. Depending on the age and/or family status of the beneficiary, the conference may be held directly with the beneficiary, the beneficiary and parent/guardian, or only with the parent/guardian. If a beneficiary has a potential or apparent abnormality, the provider is responsible for providing or referring for follow-up diagnostic services and treatment.
Nutritional Assessments	Nutritional assessments must be based on height, weight, and their relatedness; the most recent hematocrit/hemoglobin value; physical examination; and health history. Age appropriate nutrition counseling must be provided at each visit.

Sleep Position Counseling	Positioning of infants through six months of age for sleep must be discussed at each visit. Healthy infants should be placed on their backs; side positioning is a reasonable alternative but has a slightly higher risk of Sudden Infant Death Syndrome (SIDS).
Urine Testing	A urinalysis (at a minimum, via dipstick) must be performed for all beneficiaries at five years of age and for sexually active male and female adolescents.
Violence Prevention	Prevention of violence must be discussed at each visit.

3.8 PROCEDURES - CHILDREN AT HIGH RISK

3.8.A. CHOLESTEROL

High-risk children should be tested according to current AAP guidelines. Beginning at two years of age, children must be screened if:

- Parents or grandparents, at <55 years of age, underwent diagnostic coronary arteriography and were found to have coronary atherosclerosis. This includes those who have undergone balloon angioplasty or coronary artery bypass surgery. Perform a fasting lipoprotein analysis.
- Parents or grandparents, at <55 years of age, had a documented myocardial infarction, angina pectoris, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death. Perform a fasting lipoprotein analysis.
- A birth parent has an elevated blood cholesterol level. Perform a random serum cholesterol.

If a family history cannot be ascertained and other risk factors exist, testing is at the provider's discretion.

3.8.B. DIABETES (TYPE 2)

High-risk children must be tested according to the current AAP guidelines.

Beginning at age 10 (or at the onset of puberty, if it occurs at a younger age), a risk assessment must be performed at each well child visit. Children at risk should be tested using the fasting plasma glucose, two-hour oral glucose tolerance, or two-hour plasma glucose tests.

A child is considered high risk if he is overweight (i.e., body mass index >85th percentile for age and sex, weight for height >85th percentile, or weight >120 percent of ideal for height) and has any two of the following factors:

- A family history of Type 2 diabetes in first- and second-degree relatives;
- Belongs to a certain race/ethnic group (American Indian, African-American, Hispanic, Asian/Pacific Islander); and
- Signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, polycystic ovarian syndrome).

3.8.C. Pelvic Exams, Pap Smears, Breast Exams, Counseling and Risk Factor Interventions

Beginning at puberty, all females must receive clinical breast exams and be taught self-breast examination.

All sexually active females must have a pelvic, Pap smear, and breast exam as indicated on the periodicity schedule. Pelvic exams and Pap smears must be offered to all females 18 years of age and older. Whenever a pelvic exam is provided, a breast exam, counseling, and risk factor interventions must be provided.

3.8.D. Sexually Transmitted Diseases

All sexually active patients must be screened for sexually transmitted diseases (STDs) according to the periodicity schedule.

3.8.E. Tuberculosis Testing

CMS recommends that children be tested for tuberculosis (TB) according to the guidelines of the AAP, which is based on risk. A risk assessment must be completed at each visit. For assistance in determining high risk and testing, providers may refer to the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases, or contact MDCH's Communicable Disease and Immunization Division. (Refer to the Directory Appendix for contact information.)

Based on current standards of good practice, Mantoux testing is the preferred testing method.

3.8.F. Blood Lead

All Medicaid-covered children are considered at high risk for blood lead poisoning. The CMS has mandated that these children be tested at 12 and 24 months of age. In addition, CMS mandates that if a Medicaid-covered child is between the ages of 36 and 72 months of age and has not previously been tested for blood lead, he must be tested. If the parent or guardian is unsure if the child was previously tested, he must be tested.

For children who have been tested, the following questions are intended to assist physicians and nurse practitioners in determining if further testing is necessary in addition to that completed at the mandated ages:

- Does the child live in (or often visit) a house built before 1950 with peeling or chipping paint? This could include day care, preschool, or home of a relative.
- Does the child live in (or often visit) a house built before 1978 that has been remodeled within the last year?
- Does the child have a brother or sister (or playmate) with lead poisoning?

- Does the child live with an adult whose job or hobby involves lead? (The chart following these questions presents examples.)
- Does the child's family use any home remedies that may contain lead? (The chart following these questions presents examples.)

Possible Means of Exposure

Occupational	Hobbies	Environmental
▪ Auto repair ▪ Battery manufacturing or repair ▪ Bridge reconstruction worker ▪ Chemical manufacturing ▪ Construction worker ▪ Glass manufacturing ▪ Industrial machine operator ▪ Migrant farm worker ▪ Plastics manufacturing ▪ Plumber, pipe fitter ▪ Police officer ▪ Printing ▪ Radiator repair ▪ Rubber products manufacturing ▪ Steel welding and cutting	▪ Brass/copper/aluminum processing ▪ Car or boat repair ▪ Casting lead figures (e.g., toy soldiers) ▪ Furniture refinishing ▪ Jewelry and pottery making ▪ Lead soldering (e.g., electronics) ▪ Making lead shot, fishing sinkers, bullets ▪ Painting ▪ Stained glass making ▪ Target shooting at firing ranges	▪ Burning lead-painted wood ▪ Ceramicware/pottery ▪ Lead crystal ▪ Lead-soldered cans (imported) ▪ Lead paint ▪ Lead-painted homes ▪ Living near lead-related industries ▪ Renovating/remodeling older homes ▪ Soil/dust near industries and roadways ▪ Use of water from lead pipes
Other	▪ Asian cosmetics ▪ Folk remedies and/or food additives (e.g., Greta, Azarcon, pay-loo-ah, ghasard, Hai ge fen, Bali Goli, Kandu, Kohl, X-yoo-Fa, Mai ge fen, poying tan, lozeena)	

Publications and other materials concerning blood lead may be obtained from the MDCH Childhood Lead Poisoning Prevention Program. The MDCH Blood Lead Laboratory can also be contacted. (Refer to the Directory Appendix for contact information.)

There are pediatricians in all areas of the State who have expertise in the treatment of blood lead and are available to discuss blood lead issues with other providers. Providers with questions concerning blood lead testing or treatment should call the Childhood Lead Poisoning Prevention Program to obtain the names and telephone numbers of these pediatricians. (Refer to the Directory Appendix for contact information.)

For blood lead analysis, the blood sample may be obtained via the capillary method (i.e., heel prick or finger stick) or venipuncture. The sample may be sent to the MDCH Blood Lead Laboratory or to any laboratory qualified to do blood lead testing. If the MDCH Blood Lead Laboratory is used, blood lead supplies may be obtained. (Refer to the Directory Appendix for contact information.)

Michigan has established a statewide blood lead registry. This requires that certain information accompany each blood lead specimen (or request, if the specimen is drawn elsewhere) to the laboratory.

- Before providers begin sending blood lead samples to the MDCH Blood Lead Laboratory, they must obtain a Submitter Clinic Code. If providers send blood lead samples to the MDCH Blood Lead Laboratory, the Blood Lead Sampling Request (DCH-0696) must be used. Providers may obtain a Submitter Clinic Code and a supply of the DCH-0696 forms by calling the MDCH Blood Lead Laboratory. (Refer to the Directory Appendix for contact information.)
- If blood lead samples are sent to a private laboratory or if the private laboratory draws and tests the sample, copy the Michigan Department of Community Health Blood Lead Analysis Report (DCH-0395) for use or develop a form that includes all of the information from the DCH-0395. When testing is completed, the laboratory completes the information contained in Part III of the form and submits it to the registry.

Primary care providers must draw blood in their offices for all children needing blood lead testing. There may be instances when a blood draw is not accomplished. If this occurs and the child resides in a jurisdiction where the LHD agrees to obtain a blood sample for blood lead testing, the primary care provider may refer a child to the LHD for the service.

The MDCH Blood Lead Laboratory reports all results to the child's ordering provider if information about the ordering provider is included. When ordering provider information is not available, results are sent to the appropriate LHD.

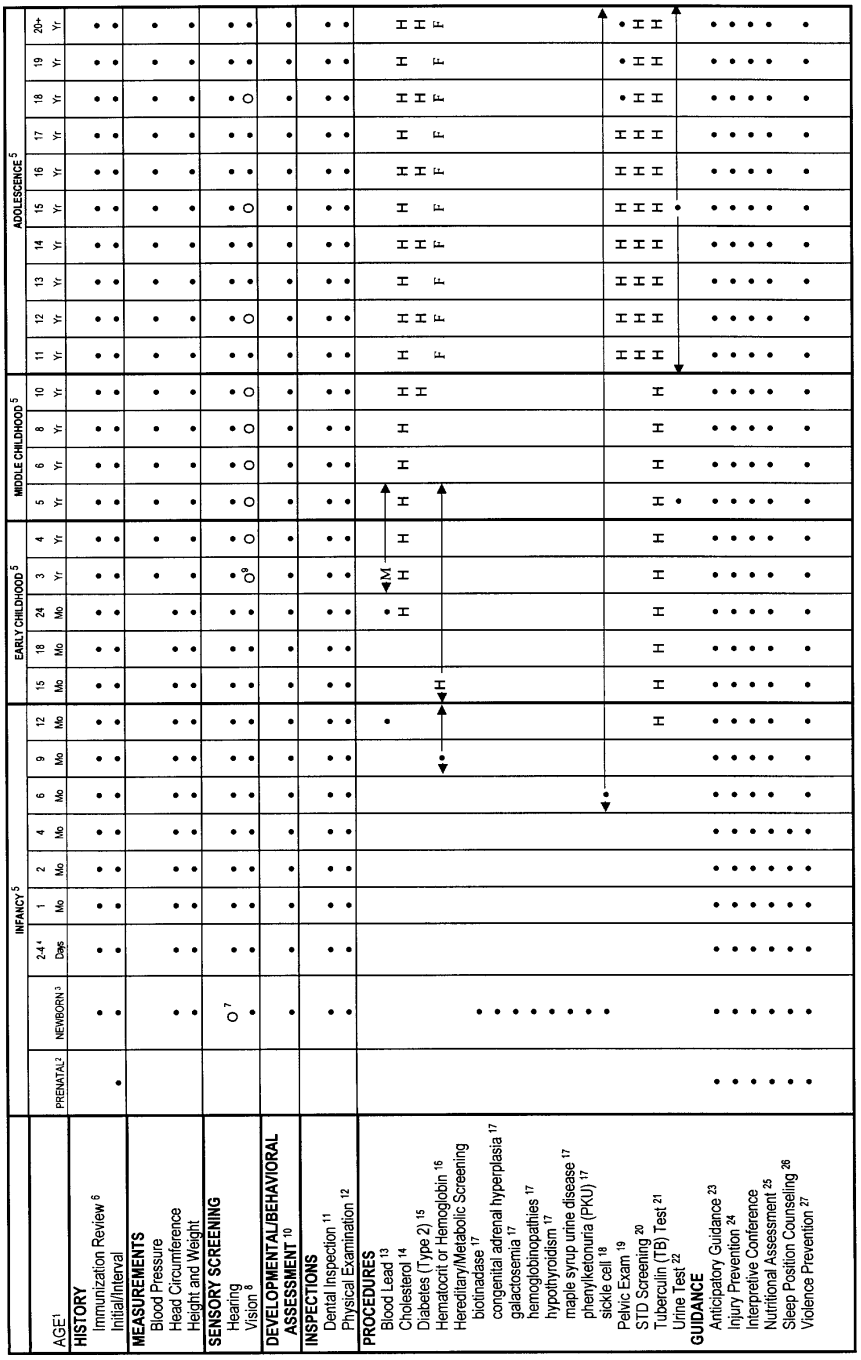
If the results of a capillary blood lead sample indicate an elevated value, a confirmatory venous sample must be obtained. The capillary and venous blood lead value/action charts follows.

Blood Lead (Pb) Interpretation			
Capillary (Microblood) Samples		**Venous (Macroblood) Samples**	
PB Result (micrograms per deciliter of blood)	**Action**	**PB Result (micrograms per deciliter of blood)**	**Action**
≤ 9	No action needed.	≤ 9	No action needed.
10 – 14	Obtain venous sample within one month. Emphasize the importance of the venous confirmation.	10 – 19	Refer within one month for medical evaluation and retesting. The provider shall contact the LHD to determine if resources are available to provide follow-up services for this Pb range.
15 -19	Obtain venous sample within two weeks. Emphasize the importance of the venous confirmation.		
20 - 44	Obtain venous sample within one week. Emphasize the importance of the venous confirmation.	20 – 44	Refer within five working days for a complete medical evaluation. Refer to the LHD within ten working days for blood lead poisoning follow-up services.
45 – 69	Obtain venous sample within 48 hours. Emphasize the importance of the venous confirmation.	45 – 69	Refer within 48 hours for medical intervention. Refer to the LHD within five working days for blood lead poisoning follow-up services.
≥ 70	Obtain venous sample immediately. Emphasize the importance of the venous confirmation.	≥ 70	Refer immediately for a complete medical evaluation. Refer to the LHD within 24-48 hours for blood lead poisoning follow-up services.
N.R. (no results-insufficient or clotted blood)	Repeat capillary sample one time or obtain venous sample.	N.R. (no results-insufficient or clotted blood)	Repeat venous sample.
For values above 9, the provider shall always provide general health education to the parents regarding nutrition, house-cleaning techniques, and lead poisoning prevention. (This is considered part of the interpretive conference and is not separately reimbursable.)		For values above 9, the provider shall always: ▪ Emphasize the importance of following through with any retesting, evaluation, or intervention. ▪ Provide general health education to the parents regarding nutrition, house-cleaning techniques, and lead poisoning prevention. This is considered part of the interpretive conference and is not separately reimbursable.	
KEY: **#** = Less than or equal to **$** = greater than or equal to			

3.9 EPSDT PERIODICITY SCHEDULE

FRONT

EPSDT COMPONENTS BY AGE OF BENEFICIARY



Back

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include pertinent medical history, injury prevention, and anticipatory guidance. The benefits of breastfeeding should be discussed as well as the planned method of feeding per AAP statement "The Prenatal Visit" (RE0053), Pediatrics, Volume 107, Number 6, June 2001, pp. 1456-1458.
3. Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged and instruction and support offered. Every breastfeeding infant should have an evaluation 48-72 hours after discharge from the hospital to include weight, formal breastfeeding evaluation, encouragement, and instruction as recommended in the AAP statement "Breastfeeding and the Use of Human Milk" (RE9729), Pediatrics, Volume 100, Number 6, December 1997, pp. 1035-1039.
4. For newborns discharged within 48 hours of delivery, per AAP statement "Hospital Stay for Healthy Term Newborns" (RE9539), Pediatrics, Volume 96, Number 4, October 1995, pp. 788-790.
5. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
6. An immunization review shall be performed at each appointment, with immunizations being administered at appropriate ages, or as needed. See schedules published annually in the January edition of Pediatrics.
7. **ALL** Medicaid-covered newborns must be screened using evoked otoacoustic emissions (EOAE) and/or auditory brainstem response (ABR) methods per AAP statement "Newborn and Infant Hearing Loss: Detection and Intervention" (RE9846), Pediatrics, Volume 103, Number 2, February 1999, pp. 527-530.
8. A subjective vision screening (i.e., by history) shall be performed at each appointment. For asymptomatic children three years of age and older, objective screening shall occur as indicated. For children of any age, a referral to an optometrist or ophthalmologist shall be made if there are symptoms or other medical justification.
9. If the patient is uncooperative, rescreen within six months.
10. By history and appropriate physical examination and/or via a screening instrument. If suspicious, by specific objective developmental, mental health, or substance abuse testing. Parenting skills should be fostered at every visit.
11. A dental inspection should be performed at each screening. Provide reinforcement of routine preventive dental care, stressing the recommended schedule of the American Academy of Pediatric Dentistry. If the next preventive dental visit is not scheduled, if the beneficiary does not have a dentist, or if restorative dental care is needed, a referral shall be made.
12. A complete physical examination shall be performed at each appointment. Infants should be totally unclothed, older children undressed and suitably draped.
13. Medicaid children are considered high risk and shall be tested accordingly. Information relative to testing, treatment, and referrals may be obtained by calling the Childhood Lead Poisoning Prevention Program at (517) 335-8885.
14. Test high risk children per AAP statement "Cholesterol in Childhood" (RE9805), Pediatrics, Volume 101, January 1998, pp. 141-147. If a family history cannot be ascertained and other risk factors are present, testing is at the discretion of the provider.
15. Test high risk children every two years beginning at ten years of age (or at onset of puberty if it occurs at a younger age). Refer to the AAP statement "Type 2 Diabetes in Children and Adolescents, Consensus Statement of the American Diabetes Association" in Pediatrics, Volume 105, March 2000, pp. 671-680.
16. See AAP *Pediatric Handbook of Nutrition* (1998) for a discussion of universal and selective screening options. Consider earlier screening for high risk infants (premature infants, low birth weight infants). Also see "Recommendations to Prevent and Control Iron Deficiency in the United States" *MMWR*, 1998; 47 (RR-3):1-29.
17. By law, these newborn tests should be initiated before the child is discharged from the hospital.
18. If the child was born in a Michigan hospital on or after October 1, 1987, the test should have been performed on the newborn. For other children with all or some black heritage, the test is required prior to the child's 21st birthday unless electrophoresis for sickle cell was done when the child was at least six months of age and the results are known to the parent.
19. All sexually active females (high risk) shall have a pelvic exam and Pap smear. A pelvic exam, breast exam, and Pap smear should be offered to all females beginning at 18 years of age.
20. All sexually active patients (high risk) shall be screened for sexually transmitted diseases (STDs).
21. Test high risk children according to the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. Based on standards of good practice, Mantoux testing is the preferred method.
22. A urinalysis (at a minimum, via dipstick) for all children at five years of age and for sexually active male and female adolescents.
23. Age-appropriate discussion and counseling should be an integral part of each visit per the AAP "Guidelines for Health Supervision III" (1994).
24. From birth to 12 years of age, refer to the AAP injury prevention program as described in *A Guide to Safety Counseling in Office Practice* (1994).
25. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP *Pediatric Handbook of Nutrition* (1998).
26. Parents and caregivers shall be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of Sudden Infant Death Syndrome (SIDS). Consult the AAP statement "Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position" (RE9946), Pediatrics, Volume 105, Number 3, March 2000, pp. 650-656.
27. Violence prevention and management per AAP statement "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level" (RE9832), Pediatrics, Volume 103, Number 1, January 1999, pp. 173-181.

If any problems are detected or suspected, a referral should be made.

If a test is contraindicated at the time of appointment, it need not be performed; if the provider wishes to perform certain tests more frequently (e.g., take blood pressure at each visit, test an older child for blood lead), they may be provided; or if the child requires more frequent health checkups, they may be provided. If additional tests are required, they may be performed or referred, as appropriate.

3.10 REFERRALS

If a problem is found or suspected during a well child visit, the (suspected) problem must be diagnosed and treated as appropriate. This may mean referral to another provider or a self-referral for further diagnosis and treatment. Referrals must be made based on standards of good practice and MDCH's established periodicity schedule or presenting need, if outside the normal schedule.

When a FFS provider performs medically necessary treatment involving diagnostic or therapeutic procedures beyond examination of the child (e.g., wart removal) for a condition found during a well child visit, these procedures are covered in addition to the well child visit. Other medical visits/examinations are not covered separately if performed on the same date of service as the well child visit by the same provider. If the provider cannot perform the needed treatment, a referral must be made to an appropriate provider. If providers are not familiar with other providers in the area, the LHD can be of assistance with referrals.

MHP and SHP providers must follow the referral procedures for the specific plan in which the beneficiary is enrolled.

Psychiatric (e.g., suspected behavioral disorder)	Limited psychiatric services are available for Medicaid FFS beneficiaries under 21 years of age with mild/moderate mental health conditions through the FFS program. (Refer to the Psychiatric and Substance Abuse Services Section of this chapter for specific coverages.) The MHP and SHP contracts include a limited mental health benefit coverage for beneficiaries with mild/moderate mental health conditions. PIHPs/CMHSPs are responsible for the provision of covered specialty mental health services necessary for the treatment of Medicaid beneficiaries with more significant, persistent, complex, and/or serious psychiatric conditions.
Women, Infants and Children (WIC)	The Women, Infants and Children (WIC) program located at LHDs, Indian Tribal Clinics, and federally-funded clinics is a special supplemental feeding program that provides food coupons and nutritional education to eligible children under five years of age and pregnant women. The provider is expected to make referrals to a WIC site for eligibility determination.
Other Programs	There are other programs that could benefit Medicaid beneficiaries, such as Head Start, intermediate school district services, genetics counseling, nutrition programs, and public health nursing. Providers are encouraged to become familiar with available programs and make full use of them whenever referrals are appropriate.
Blood Lead Poisoning Follow-Up Services	Many LHDs provide blood lead poisoning follow-up services which consist of environmental investigations and nursing assessment/investigation visits. Providers must contact the LHD to determine if services are available in the area and the blood lead levels at which referrals are accepted. LHDs may provide blood lead poisoning follow-up services provided to any Medicaid-covered child, regardless if the child is enrolled with an MHP, SHP, or is in the FFS program. Authorization for these services is not required by the MHP/SHP; however, LHDs must notify the plan of the service(s) provided and provide the plan with a summary of each.

	Documentation of the child's blood lead poisoning level that initiated service must be maintained, as well as documentation of all environmental investigations and nursing assessment/investigation visits.
Environmental Investigations	Environmental investigations are covered for the LHD if the health officer from the LHD completes a copy of the Blood Lead Poisoning Follow-Up Services Assurance of Provision form (DCH-1530). The form must be mailed to Medicaid Payments Division. (Refer to the Directory Appendix for contact information.) If more than one child in the home has blood lead poisoning, the LHD must select one child's Medicaid ID Number and report a single initial and a single follow-up environmental visit.
	Initial - A risk assessor certified by the State of Michigan's Lead Hazard Remediation Program must conduct the investigation of the child's home. If necessary, an investigation may be covered at a second site if the child spends time regularly at that site and it is a possible source of lead exposure. MDCH covers a maximum of two such investigations per episode of blood lead poisoning. The investigation must follow the Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels and risk assessment activities per the Lead Abatement Act of 1998. The investigation must include testing of appropriate potential sources of paint, house dust, soil, water, and other household risk factors such as pottery and home remedies. Education must be provided regarding known and potential sources of lead poisoning, reduction of future exposures, and suggestions for specialized cleaning techniques. Risk assessors must prepare a risk assessment report per rule R325.9916 promulgated pursuant to the Lead Abatement Act that includes lead hazard control recommendations and the potential relocation of the child depending upon the severity of the lead hazards found. Discussion with the family must include agencies that may be able to provide assistance with lead hazard control recommendations provided in the risk assessment report. An episode includes a venous blood sample indicating the child is at risk according to recommendations of the Centers for Disease Control and Prevention (CDC), and also includes resulting treatment and follow-up services.
	Follow-up - MDCH covers one follow-up environmental investigation per episode of poisoning to determine if lead hazard control interventions were performed satisfactorily and verified by a visual inspection and dust wipe clearance sampling. If a second site was investigated as the possible source of lead exposure and had lead hazard control interventions performed, MDCH also covers a follow-up environmental investigation performed at that second site.
	Resource Documents - Providers may obtain the Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels, a list of certified risk assessors, applications for training and certification, and education materials from the MDCH Lead Hazard Remediation Program. (Refer to the Directory Appendix for contact information.)

Nursing Assessment/Investigation Visits	MDCH covers up to two nursing assessment/investigation visits per episode of blood lead poisoning. If more than one child in the home has blood lead poisoning, the nursing assessment/investigation visits are covered for each child. Blood lead nursing visits must be provided in the child's home. For FFS beneficiaries, an enrolled home health agency, a LHD or other medical clinic, or a physician may conduct the visits. This procedure is not covered for Maternal Support Services and Infant Support Services (MSS/ISS) providers. Blood lead nursing visits provided through a MHP or SHP are covered by the individual MHP or SHP. The first nursing assessment/investigation visit focuses on: ▪ Assessment of the growth and developmental status of the child, including any symptomatology that may be present in the child. ▪ Behavioral assessment of the child, including any aggressiveness and/or hyperactivity. ▪ Nutritional assessment of the child. ▪ Assessment of typical family practices that may produce lead risk (e.g., hobbies, occupation, cultural practices). ▪ Limited physical identification of lead hazards within the dwelling. ▪ Identification and planning for testing for any other family member at risk for sequelae of lead hazard exposure. ▪ Education and information regarding lead hazards and ways to minimize those risks in the future. ▪ Development of a family plan of care to increase the safety of the child from lead hazards. The second blood lead nursing visit focuses on: ▪ Reinforcement of the educational information presented to the family during the first visit. ▪ Validation of the family's ability to carry out activities to minimize risks of continued lead exposure. ▪ Modifications of the plan to minimize lead risks, as needed.
Blood Lead Resource Documents	Providers are encouraged to review Guidelines for Environmental and Nursing Investigations for Children with Elevated Venous Blood Lead Levels and apply these standards. This publication, plus other materials concerning blood lead poisoning, may be obtained from the MDCH Childhood Lead Poisoning Prevention Program. (Refer to the Directory Appendix for contact information.)

SECTION 4 - GENERAL PRACTICE

4.1 ALLERGY TESTING AND IMMUNOTHERAPY

Medicaid covers allergy testing and immunotherapy services. Testing is covered under the appropriate CPT/HCPCS code with the appropriate quantity as indicated by the code description. A visit is covered in addition to the testing. Coverage of the testing includes the interpretation of the test results in relation to the history and physical examination of the beneficiary.

Immunotherapy services are covered under the appropriate CPT/HCPCS component codes. The services of the provider who actually prepares and provides the antigens/venoms are covered on a per dose basis. Services of the provider who parenterally administers the antigen/venom are covered under the appropriate injection codes. The injection and the antigen/venom preparation services are covered separately.

Allergy injection services are not covered in addition to the visit unless the visit represents another significant, separately identifiable service above and beyond the antigen/venom immunotherapy and the appropriate modifier is reported.

MDCH assumes antigens are prepared for administration over a period of time in increasing doses. Antigens are covered at the same rate per dose regardless of whether multiple or single dose vials are used. Medicaid covers the dose administered and the preparation of the dose administered.

Any allergy testing and treatments that have not been proven to be effective are not covered.

4.2 AMBULANCE SERVICES

Coverage for ambulance services is restricted to medically necessary and appropriate services when medical/surgical or psychiatric emergencies exist or no other effective or less costly mode of transportation for medical treatment can be used because of the beneficiary's medical condition.

Emergency ambulance services do not require a physician's order.

The physician must order all nonemergency, medically necessary ambulance transportation and the order must contain the following information:

- Beneficiary's name and Medicaid ID number;
- Medical necessity of an ambulance transport; and
- Physician's signature and Medicaid Provider ID number.

Physicians are responsible for providing documentation of the medical necessity for ambulance transport to the ambulance provider for their files. A physician may write a single prescription for nonemergency ambulance transport of a beneficiary with a chronic condition to planned treatments for a period up to one month. The prescription must include the type of transport necessary, why other means of transport could not be used, the frequency of needed transport, origin, destination, diagnosis, and medical necessity for the transport. For all other nonemergency transport, a separate physician's order is required for each individual transport.

(Refer to the Ambulance Chapter of this manual for additional information.)

4.3 AUDIOLOGICAL AND HEARING SERVICES

Medicaid covers hearing evaluations and other audiological function testing by a physician. Hearing evaluations are covered when they include pure-tone audiometry, speech audiometry, and a report of findings.

A hearing aid is covered if all of the following criteria are met:

- The physician performs an evaluation within six months prior to the beneficiary obtaining a hearing aid.
- The evaluation reveals that the beneficiary needs a hearing aid and that there is no contraindication to the use of a hearing aid.
- The physician prescribes a hearing aid.
- The beneficiary presents the prescription and a written statement of the evaluation to an enrolled hearing and speech center.
- The enrolled hearing and speech center determines the type of hearing aid that is needed.
- The beneficiary is referred to an enrolled hearing aid dealer for provision of the aid.

4.3.A. NEWBORN HEARING SCREENING EXAMINATION

MDCH requires that all Medicaid-covered newborns be screened using the automated auditory brainstem response (ABR) method and/or the automated evoked otoacoustic emissions (EOAE) method.

Results must be reported to the child's primary care provider in a timely manner.

If the birthing hospital has the appropriate equipment, the screening must be done at the hospital. When this occurs, the screening is covered as a part of the inpatient stay.

If the hospital is not equipped for ABR or EOAE, the child's physician, CNM, or NP must refer the newborn to a Medicaid enrolled hearing and speech center for screening prior to one month of age.

4.3.B. LOCAL HEALTH DEPARTMENT SCREENINGS

The primary care provider or Head Start agency (with approval from the child's primary care provider) may refer preschool-aged children to the local health department (LHD) for objective hearing screening. The results of the screening must be reported to the child's primary care provider. The results must also be shared with the Head Start agency if that agency was the referral source.

MDCH monitors the number of MHP and SHP referrals reported by LHDs, and may initiate charge-backs to the plans.

4.4 Care of Abused Children

Medicaid covers physician services related to the diagnosis and treatment of suspected abused or neglected children. When the physician has reasonable cause to suspect that a child may have been abused or neglected, he must immediately contact the appropriate Protective Services Unit of the local FIA office to report his suspicions.

Medicaid covers the inpatient stay of an abused or neglected child when, upon admission, the attending physician determines that the child requires further assessment and treatment which is best provided on an inpatient basis.

Physicians cannot admit a child to the hospital for the sole purpose of custodial or protective care.

4.5 Childbirth/Parenting Education

Medicaid covers childbirth/parenting education for pregnant women when referred in writing by the prenatal care provider and provided by qualified educators in a Medicare certified outpatient hospital or by a certified Maternal Support Service (MSS) program provider.

This service is not covered if rendered by the prenatal care provider in the office setting.

4.6 Communicable Disease Treatment

Medicaid covers the diagnosis and treatment of communicable diseases, including tuberculosis (TB), hepatitis, meningitis, and enteric disease. Cases of communicable disease must be reported to the LHD. Providers may obtain additional information regarding communicable disease prevention and control from the LHD.

4.7 Diabetes Patient Education

Medicaid covers diabetes self-management education when ordered by a physician and provided by diabetes educators (e.g., nurse, dietitian) in a Medicaid enrolled outpatient hospital or a LHD which has been certified by Community Public Health (CPH).

This service is not covered if rendered by a physician in the office setting, rendered by a nonenrolled provider, or rendered by a non-CPH certified provider.

4.8 Diagnostic Tests

Medicaid covers tests to diagnose a disease or a medical condition. Diagnostic testing must be directly related to the presenting condition of the beneficiary.

4.9 Family Planning

Medicaid covers family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis). A visit for family planning typically includes a complete physical examination, including a pelvic examination.

Separately identifiable services provided in addition to the examination are covered separately. Counseling for family planning services, including sterilization, is covered as a part of the family planning visit.

Medicaid covers contraceptives including:

- Oral contraceptives (must be prescribed by a physician and dispensed by an enrolled pharmacy or Family Planning Clinic)
- Diaphragms
- Intrauterine devices
- Condoms (available from a pharmacy without a prescription, or from a family planning clinic)
- Foams, gels, sponges (must be prescribed by a physician and dispensed by a pharmacy or family planning clinic.)

4.10 Foot Care, Routine

Medicaid covers these services when provided by a physician or podiatrist and when the beneficiary manifests signs and symptoms from a specific systemic disease of sufficient severity that care by a nonprofessional would be hazardous. The medical necessity for these services must be documented in the beneficiary's medical record and the beneficiary must be receiving regular care from a physician for the systemic disease.

4.11 Fracture Care

Medicaid covers medically necessary fracture care. Coverage includes the initial traction, cast application and removal, and routine follow-up care. Additional reductions are independent procedures not included in the original treatment and are covered separately.

Fracture care includes the insertion and removal of necessary wires, pins, etc. If the wire, pins, etc., are the types that are not normally removed but the removal is medically necessary, Medicaid also covers such removal. Documentation of the need must be included on the claim.

Coverage also includes subsequent recasting required during the course of fracture treatment (i.e., following initial cast application). Medicaid covers cast removal as a separate service only when performed by a physician who was not involved in the fracture care and who is not reapplying another cast.

4.12 Immunizations (Vaccines and Toxoids)

Vaccines and toxoids (immunizations) are covered when given according to Advisory Committee on Immunization Practices (ACIP) recommendations. For Medicaid children under the age of 19 years old, the Vaccine for Children (VFC) Program provides covered vaccines at no cost to the provider. In addition, Michigan offers a similar program for Medicaid adults age 19 years and older called the Michigan Vaccine Replacement Program (MI-VRP). Td, MMR, and Hepatitis B for adults are available from the LHD at no cost to the provider. Any LHD in the state can be contacted for specifics about the VFC and MI-VRP programs, what vaccines are available, and instructions on enrolling and obtaining vaccines. Medicaid does not cover vaccine costs for any product that is available free for Medicaid enrollees.

An administration fee is covered separately for vaccines and toxoids given to Medicaid beneficiaries whether the vaccine is free or not, and without regard to other services provided on the same day. The administration fee is set for each immunization.

For vaccines and toxoids available free under the VFC program, Federal statutes limit the amount a provider can charge for the administration of the vaccine. Providers cannot charge more for services provided to Medicaid beneficiaries than for services provided to their general patient population. For example, if the charge for administering a vaccine to a private pay patient is $5.00, then the charge for vaccine administration to the Medicaid patient cannot exceed $5.00.

MDCH encourages providers to immunize all Medicaid beneficiaries according to the accepted immunization schedule. For Medicaid beneficiaries enrolled in a MHP, the health plan must ensure that the Medicaid beneficiaries receive complete and timely immunizations. When a provider contracts with a health plan to provide primary care (which includes immunizations), then the provider must immunize the beneficiaries assigned to him by the plan. MHPs must not refer beneficiaries to a LHD for immunizations.

If a beneficiary is in a nursing facility, the facility is responsible for appropriately immunizing the residents. Coverage of the immunizations is included in the payment made to the facility.

4.13 Injectable Drugs and Biologicals

Medicaid covers injectable drugs and biologicals administered by a physician in the office or clinic setting and the beneficiary's home. The drug must be Federal Drug Administration (FDA) approved and reasonable and necessary according to accepted standards of medical practice for the diagnosis or treatment of the illness or injury of the beneficiary.

An injectable drug is covered if the drug is:

- Specific and effective treatment for the condition for which it is being given.
- Given for the treatment of a particular documented diagnosis, illness, or condition (e.g., vitamin injections which are not specific replacement therapy for a documented deficiency or disease and are given simply for the general good and welfare of the patient).
- Administered by the recommended or accepted administration method for the condition being treated.
- Administered according to the recommended dosing schedule and amount for the condition being treated.

Medicaid covers the injectable drug and the administration of the drug. If another covered service is provided at the same time, the administration of the drug is considered a part of that service and is not covered separately. Fee screens for the cost of the drug are established at 95 percent of the average wholesale price (AWP). Drug fee screens are updated quarterly.

For any injections given by the physician in the office, clinic setting, or the beneficiary's home, the injectable drug is considered a physician service rather than a pharmacy benefit. The physician must not send the beneficiary to a pharmacy to obtain an injectable drug or to have the pharmacy bill directly to MDCH for injectable drugs under the pharmacy benefit if the physician is administering the drug in the office, clinic, or beneficiary's home. If a pharmacy sells injectable drug products to a physician, the pharmacy must obtain payment directly from the purchasing physician.

4.14 LABORATORY

Medicaid covers medically necessary laboratory tests needed to diagnose or treat a specific condition, illness, or injury. Medicaid also covers screenings such as Pap smears, PSA, TB, etc. A physician, podiatrist, dentist, or CNM must order laboratory services according to their scope of practice.

The ordering physician or CNM must document required laboratory testing in the beneficiary's medical chart regardless of where the tests are performed. The ordering physician is held responsible if he orders excessive or unnecessary laboratory tests regardless of who actually renders the services. He may be subject to any corrective action related to these services, including recovery of funds.

Ordering or rendering of "profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition is considered random screening and is not covered. Multiple laboratory tests carried out as a part of the initial evaluation of the beneficiary, when the results of the history and physical examination do not suggest the need for the tests, are considered screening and are not covered.

4.14.A. MEDICAL NECESSITY

The documentation of medical necessity must include a description of the beneficiary's symptomatology and other findings that have led the physician to order the test(s). An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity.

4.14.B. REFERRED SERVICES

If a physician refers a beneficiary to an outside laboratory (independent lab, hospital lab, clinic lab, or physician office lab) for testing, the physician must indicate his Medicaid ID Number on the referral.

A physician cannot refer a beneficiary to an outside laboratory where he or an immediate family member has a financial interest. Noncompliance may result in corrective action by MDCH or other agencies.

Physician laboratory services are covered when performed by the physician or by his employees under his direct supervision. Coverage for laboratory services includes the collection of the specimen(s), the analysis, and the report(s). MDCH performs pre- and/or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. Questionable ordering patterns may result in a pre-payment review of each laboratory procedure billed or other corrective measures as a result of that provider's orders.

A beneficiary cannot be charged for any covered laboratory procedure, including those that are determined to be not medically necessary, or for those laboratory procedures which exceed the laboratory daily reimbursement limit.

MDCH limits laboratory payments when rendered by the same provider, for the same beneficiary, on a single date of service. Coverage is limited to only those laboratory procedures which do not exceed the daily reimbursement limits specified in the following table.

Provider Description	Daily Limit
Practitioner, Nurse Midwife	$50.00
Podiatrist	$50.00
Family Planning Clinic	$50.00
Medical Clinic	$50.00
Independent Laboratory	$125.00
Outpatient Hospital	$75.00

4.14.C. Laboratory Tests Exempt from Daily Limit

The following selected laboratory services identified by CPT/HCPCS procedure codes are exempt from the daily dollar limit.

- Limited Pathology Consultation
- Comprehensive Pathology Consultation
- Bone Marrow Procedures
- Cytopathology
- Cytogenetics
- Electron Microscopy

If coverage limits are exceeded, the billing health care provider must request an exception to the daily limit by submitting documentation of medical necessity for each laboratory procedure. All services provided on that date of service are manually reviewed for medical necessity and payment is determined accordingly.

When it is anticipated that Medicaid payments for testing ordered from an outside laboratory will exceed the coverage limit, the ordering practitioner must forward medical necessity documentation to the servicing laboratory for submission with the laboratory billing.

4.14.D. Children's Special Health Care Services Coverage

The coverages defined in this section and the daily reimbursement limits do not apply to beneficiaries with only Children's Special Health Care Services (CSHCS) eligibility. The

coverage limits do apply to beneficiaries with dual Medicaid and CSHCS eligibility if the laboratory procedures are not related to the crippling diagnosis.

Blood Handling	MDCH reimburses for blood handling only under the following circumstances: ▪ A beneficiary may be referred to a laboratory, clinic, or outpatient hospital for the sole purpose of drawing, packaging, and mailing a blood sample to MDCH for blood lead analysis. In this instance, the laboratory, clinic, or outpatient hospital may bill for blood handling. The State provides lead-free vacutainers for the analysis. Requests for vacutainers and the samples for analysis should be sent to MDCH Blood Lead Laboratory. (Refer to the Directory Appendix for contact information.) ▪ A beneficiary occasionally requires blood tests that are not performed in conjunction with other reimbursable services. Whenever possible, the beneficiary should be sent to the laboratory that will be performing the test(s). If this is not practical (i.e., the laboratory is not a local facility) and the sole purpose of a visit is to draw, package, and mail the sample to a laboratory, the blood handling may be covered. An office visit or other service code is not covered on the same date of service (DOS) as the blood handling service.
Hematology Studies	A practitioner's order for a complete blood count (CBC) with white blood cell (WBC) differential includes the RBC and WBC count, Hgb, Hct, MCH, MCHC, MCV, RBC morphology, platelet estimate, and WBC differential only. Additional hematology testing must have specific practitioner orders. The ordering practitioner is responsible for documenting medical necessity and recording the order in the beneficiary's medical record.
Microbiology Studies	Gram, fluorescent/acid fast stain procedures are included in the coverage for microbiology procedures when performed on the same DOS for the same beneficiary.
Pap Smear	Coverage for obtaining the cervical smear is included as a part of the pelvic examination. A pathologist must perform interpretation of the smear. The pathology report must include the printed or typewritten name of the pathologist and his handwritten signature. More than one Papanicolaou test within a 12-month period is covered only when determined medically necessary by the attending practitioner.
Pathology Consultations	Pathology consultations performed by a hematologist/pathologist for the review of abnormal laboratory test results are covered by Medicaid if: ▪ The abnormality relates to the beneficiary's medical condition and corresponding medical care (i.e., a peripheral blood smear review must be necessary for the specific beneficiary's care). ▪ The referring physician orders the review and records the order in the beneficiary's medical record. (Standing consultation orders from a physician to a laboratory are not covered by Medicaid.) ▪ A detailed report is sent to the referring physician. The report prepared from the study performed by the hematologist/pathologist must include: ▪ Identification of the laboratory where the review was performed. ▪ Name of the referring physician.

	▪ Beneficiary's name. ▪ Date of review. ▪ Identification of material examined. ▪ Comments and descriptions of normal and abnormal findings. ▪ Descriptions detailed enough to support a clinical impression or diagnosis. ▪ Clinical impression or diagnosis presented in relation to the suspected disease, disease process, or state of altered physiology. ▪ Recommendations for investigation or therapy, if any. ▪ The typewritten or printed hematologist/pathologist's name and his handwritten signature. This information must be retained in the beneficiary's medical records.
Pregnancy Related Lab Services	For routine pregnancy testing, Medicaid covers the serum or urine HCG qualitative method. The obstetric profile is covered when ordered by the attending practitioner as an all-inclusive panel of tests for required prenatal laboratory services. The individual tests of the OB Profile are: ▪ ABO typing ▪ CBC with WBC differential ▪ Hepatitis B surface antigen ▪ RBC antibody detection ▪ Rh (D) typing ▪ Rubella antibody ▪ Syphilis testing HIV testing and Urinalysis are covered separately when determined to be medically necessary and are ordered by the practitioner.
Practitioner Laboratory Procedures	Clinics and office-based laboratories must be registered as required by the Clinical Laboratory Improvement Act (CLIA). Medicaid only covers the procedures contained in the CLIA Certificate of Waiver Testing list for Certificate of Waiver practitioners. Coverage includes only the procedures contained in the CLIA Certificate of Registration Testing list for Certificate of Registration practitioners. Medicaid covers the procedures identified in the CLIA Physician Performed Microscopy list for appropriately certified physicians. Laboratory tests covered for CNMs and podiatrists who have the appropriate CLIA certification are identified in the appropriate database on the MDCH website.

4.15 MYCOTIC NAILS, DEBRIDEMENT

Medicaid covers debridement of mycotic nails once in a 60-day period when provided during or following any appropriate course of medical treatment for the causative fungal infection. Documentation in the beneficiary's medical record must support clinical evidence of the mycosis, identification of the toenail(s) affected, and evidence that the mycosis is likely to result in significant medical complications if appropriate antifungal treatment is not rendered.

The debridement of mycotic nails is covered for beneficiaries in the nursing facility only on the written order of the attending physician (MD or DO). The order must be patient-specific and not for routine care only.

4.16 NERVE BLOCKS

Nerve blocks are covered as a surgical procedure when performed for diagnostic or therapeutic purposes. As a surgical procedure, a complete description of the services rendered must be documented in the beneficiary's medical record. When used as anesthesia for another procedure, the anesthesia guidelines apply. Nerve blocks are not separately covered when used as a local anesthetic for another surgical procedure.

A nerve block is the injecting of a local anesthetic or neurolytic agent around a nerve to produce a block of that specific nerve. It is not injecting a painful area under the skin or a trigger point, or an injection into the general muscle mass of subcutaneous tissue that does not follow the anatomy of a specific nerve, to produce temporary relief of pain in that area.

Nerve blocks are payable in the hospital or office setting as appropriate. No more than three nerve blocks to the same area are covered within a six-month period without documentation of medical necessity. Documentation must include the diagnosis or condition, the management/treatment plan, specific nerve(s) affected, indications, and expected benefits. A medical visit is not covered separately on the same day unless documentation is supplied to justify the separate services.

4.17 OXYGEN

Medicaid covers oxygen and the equipment necessary for the administration of oxygen therapy.

A pharmacy or a medical supplier may provide gaseous cylinder oxygen. Portable cylinder oxygen is allowable if the cylinder can be refilled and if the flow rate is adjustable.

Only a medical supplier may provide concentrators, liquid oxygen, and oxygen tents, and PA is required.

All oxygen and equipment requires a physician's prescription and a CMN. The initial prescription is valid for six months. The first follow-up prescription is valid for six months, and each subsequent prescription is valid for one year.

The written prescription for oxygen must include all of the following:

- The date the oxygen was prescribed;
- The beneficiary's diagnosis(es);
- The flow rate (liters per minute);
- The number of hours to be used per day;
- Duration of need;
- Delivery system to be used; and
- PO2 level or oxygen saturation.

(Refer to the Medical Supplier Chapter of this manual for additional information and specific PA requirements.)

4.18 Substitute and Locum Tenens Physicians

Medicaid covers substitute physicians or locum tenens physicians and allows payment to be made to the beneficiary's attending physician for these services. Federal statutes and CMS requirements determine parameters for these arrangements.

Medicaid coverage under the beneficiary's attending physician for the services of a substitute physician can only occur under the following substitute physician billing arrangements:

- An informal reciprocal arrangement for a period not to exceed 14 days; or
- A locum tenens or temporary arrangement for 90 continuous days in the case of a per diem or other fee-for-time compensation.

Coverage for services provided by a substitute physician under either a reciprocal billing or a locum tenens arrangement must follow Medicaid policy for the service(s) rendered. Documentation in the beneficiary's medical record must identify the physician actually providing the service.

4.19 Supplies in the Office Setting

Medicaid separately covers a limited number of supplies used in the office setting. RVU-based payment to practitioners includes payment for the office overhead expense associated with the service. In most cases, the overhead includes the supplies used or provided by the practitioner in connection with the service. Providers must not require beneficiaries to buy a supply item in advance from a pharmacy or other supplier that is necessary to use in providing the service. If a beneficiary needs supplies to use in the home, providers should write a prescription that the beneficiary can take to a pharmacy or medical supplier to be filled. Medicaid does not cover take-home supplies for the office setting. Any surgical dressings applied by a physician in the office or other nonfacility setting are not covered separately.

In keeping with the RVU-based fee schedule, casting and splinting supplies are covered separately in the office setting when used with the fracture and dislocation or casting, splinting or strapping procedure codes listed in the musculoskeletal surgery section of the CPT coding manual. An allowance for these supplies is not included in these treatment codes. Cast/splint supplies are not covered without the appropriate fracture/dislocation codes.

The following supplies are covered separately when provided in the office setting:

- Implantable external access device.
- Levonorgestrel implant (is payable in addition to the insertion procedure on the same day).
- Progestasert IUD or copper IUD (is payable in addition to the insertion of the device on the same day).
- Levulan PDT.

(Refer to the physician's database on the MDCH website for specific supplies which are covered separately.)

4.20 VISION SERVICES

Medicaid covers medically necessary services for the diagnosis and treatment of complaints or symptoms of an eye disease or injury. An eye exam or service is considered routine and subject to vision benefit co-payments and limitations if provided solely for any of the following diagnoses:

- Ametropia
- Anisometropia
- Astigmatism
- Emmetropia
- Hypermetropia
- Hyperopia
- Myopia
- "No pathology"
- Presbyopia
- Refractive error

(Refer to the Vision Chapter of this manual for co-pay requirements.)

A routine examination is covered once every two years. The exam includes history, visual acuity determination, external exam of the eye, binocular measure, ophthalmoscopy with or without tonometry, with plotting of visual fields, with or without biomicroscopy (slit lamp), and with or without refraction. Exceptions to this frequency require documentation of medical necessity, including the visual acuities from both examinations. It is not sufficient to say "two or more line reduction in visual acuity" or "acuity of 20/50 or less with spectacles."

Ophthalmologists and optometrists must use the Vision Services Approval/Order form (DCH-0893) for hardware orders and PA requests.

If an ophthalmologist wishes to obtain the ordered hardware and dispense the items to Medicaid beneficiaries, he must also enroll with the MDCH as an optical company.

When a provider fills out a DCH-0893 to request PA or as an order for hardware, the CPT/HCPCS coding/modifier structure must be used as well as the ICD-9-CM diagnosis coding (to the highest specificity).

When requesting PA, the provider may mail or fax the DCH-0893 to the MDCH Vision Contract Manager. (Refer to the Directory Appendix for contact information.)

4.21 ORTHOPTIC SERVICES

Medicaid covers orthoptic services as detailed in this section. Evaluations for beneficiaries having manifest strabismus are covered regardless of the beneficiary's age.

PA is not required for evaluations for beneficiaries age 16 and under if the diagnosis is esotropia, exotropia, heterotropia, or strabismus. For beneficiaries age 16 and under with a diagnosis other than the above, and for all beneficiaries age 17 or older, PA is required.

A strabismus or amblyopia evaluation is covered once every six months and includes, but is not limited to:

- Case history
- Visual acuities
- Determination of objective angle of squint (direction, magnitude, and frequency) and determination of subjective angle of squint
- Diplopia fields (affected muscles)
- Assessment of foveal fixation and macular integrity
- Assessment of retinal correspondence
- Assessment of sensory fusion (suppression, steropsis), accommodative status
- Vergences (convergence excess/insufficiency, divergence excess/insufficiency)
- Assessment of cosmesis
- Diagnosis
- Treatment
- Programming
- Prognosis

When requesting PA, the physician must indicate the specific diagnosis and the beneficiary's best-corrected visual acuity of each eye. After the request is approved, the physician performs the evaluation. Following the evaluation, the physician must submit a new PA request for treatment and/or any necessary aids.

Treatment for all eye muscle problems related to orthoptics, except eye muscle surgery for beneficiaries under age 21, requires PA.

An enrolled dispensing ophthalmologist or optometrist must provide aids.

The following documentation must accompany the authorization request:

- Description of beneficiary's visual status
- Magnitude and direction of the subjective and objective angle of strabismus at distance and near fixation
- Laterality of strabismus
- Frequency of strabismus
- Refractive error of each eye
- Visual acuity, each eye, aided

- Correspondency
- Degree of fusion
- History of strabismus, including duration, any prior treatment (dates and nature), and any surgery (dates and nature)
- Other relevant information
- A detailed treatment plan to include identification of the procedures and equipment to be employed, frequency of office visits, home training, aids, and prognosis.

Orthoptic treatment may be authorized for a period not to exceed three months, including up to 12 visits.

If continued treatment is necessary beyond the period that was authorized, a new request for PA must be submitted. The following documentation must accompany the request:

- The documentation requirements as listed under the Special Authorization Instructions for Treatment.
- A report of the results of the previous treatment(s).
- The progress of the case and the indication for further treatment.

4.22 WEIGHT REDUCTION

Medicaid covers treatment of obesity when done for the purpose of controlling life-endangering complications, such as hypertension and diabetes. If conservative measures to control weight and manage the complications have failed, other weight reduction efforts may be approved. The physician must obtain PA for this service. Medicaid does not cover treatment specifically for obesity or weight reduction and maintenance alone.

The request for PA must include the medical history, past and current treatment and results, complications encountered, all weight control methods that have been tried and have failed, and expected benefits or prognosis for the method being requested. If surgical intervention is desired, a psychiatric evaluation of the beneficiary's willingness/ability to alter his lifestyle following surgical intervention must be included.

If the request is approved, the physician receives an authorization letter for the service. A copy of the letter must be supplied to any other provider, such as a hospital, that is involved in providing care to the beneficiary.

4.23 TUBERCULOSIS TESTING

Medicaid covers TB testing according to the guidelines of the AAP, which is based on risk. A risk assessment is completed at each visit. Coverage for the TB test includes any return visit to read the results of the TB test.

For assistance in determining high risk, providers may contact the MDCH, Communicable Disease and Immunization Division, or the AAP. (Refer to the Directory Appendix for contact information.)

SECTION 5 - GENERAL PRACTICE - SPECIAL CONSIDERATIONS

5.1 APHERESIS, THERAPEUTIC

Therapeutic apheresis is covered for the following indications.

- Plasma exchange for acquired myasthenia gravis.
- Leukapheresis in the treatment of leukemia.
- Plasmapheresis in the treatment of primary macroglobulinemia (Waldenstrom).
- Treatment of hyperglobulinemias, including (but not limited to) multiple myelomas, cryoglobulinemia and hyperviscosity syndromes.
- Plasmapheresis or plasma exchange as a treatment of last resort for thrombotic thrombocytopenic purpura (TTP).
- Plasmapheresis or plasma exchange as a treatment of last resort for life-threatening rheumatoid vasculitis.
- Plasma perfusion of charcoal filters for treatment of pruritis of cholestatic liver disease.
- Plasma exchange in the treatment of life-threatening forms of Goodpasture's Syndrome.
- Plasma exchange in the treatment of life-threatening forms of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage.
- Treatment of chronic relapsing polyneuropathy for patients with severe or life-threatening symptoms, or failed to respond to conventional therapy.
- Apheresis in the treatment of life-threatening scleroderma and polymyositis, when the patient is unresponsive to conventional therapy.
- Apheresis for the treatment of Guillain-Barre Syndrome, and
- Apheresis as a treatment of last resort for life-threatening Systemic Lupus Erythematosous (SLE) when conventional therapy has failed to prevent clinical deterioration.

Coverage is limited to the following settings:

- In a hospital setting (either inpatient or outpatient). Nonphysician services furnished to hospital patients are covered as hospital services. When covered services are provided to hospital patients by an outside provider/supplier, the hospital is responsible for paying the provider/supplier for the services.
- In a nonhospital setting, such as a physician directed clinic, when all of the following conditions are met:
  - A physician is present to perform medical services and to respond to medical emergencies at all times during patient care hours.
  - Each patient is under the care of a physician.
  - All nonphysician services are furnished under the personal supervision of a physician.

When the physician provides direct supervision of the procedure or personally performs any services, professional services are covered as therapeutic apheresis (plasma and/or cell exchange).

5.2 CHEMOTHERAPY ADMINISTRATION

Medicaid covers the services of a physician who administers antineoplastic chemotherapy to beneficiaries with a cancer diagnosis in the office setting and in the beneficiary's home. The chemotherapy drugs administered by the physician are covered separately.

Administration of other drugs for diagnoses other than cancer is covered under therapeutic, diagnostic, or prophylactic injection/infusion services.

Chemotherapy administration by push and by infusion techniques is covered on the same day; however, only one push administration is covered on a single day.

Physicians must personally administer the drug or be present when a qualified employee of the physician administers the drug. If chemotherapy is administered without face-to-face contact between the physician and the beneficiary, the services are covered if furnished in the physician's office by a qualified employee under the physician's supervision and the medical record reflects the physician's active participation in and management of the course of treatment.

In the hospital setting, chemotherapy administration is only covered when the physician personally administers the drug.

Refilling and maintenance of an implantable pump or reservoir is covered. Chemotherapy administration by IV push, infusion, or intra-arterial technique is not covered in addition to refilling the implantable pump or reservoir. Flushing of a vascular port prior to chemotherapy is included in the administration and is not covered separately. If a special visit is made to the physician's office only for port flushing, the service is covered under the appropriate E/M code.

Hydration therapy intravenous (IV) infusion is covered as a part of the chemotherapy IV infusion service when administered simultaneously. Hydration therapy is covered separately when administered sequentially or as separate procedures. The distinct procedural service modifier should be reported with the hydration therapy code when performed sequentially.

Supplies necessary to administer chemotherapy in the office setting are included in the overhead expense portion of the administration services and are not covered separately. (Refer to the Medicaid practitioner databases on the MDCH website for a listing of covered chemotherapy drugs.)

5.3 HEMODIALYSIS AND PERITONEAL DIALYSIS

Medicaid covers physician services required to manage care of beneficiaries with end-stage renal disease (ESRD) who are receiving ongoing dialysis in an outpatient facility or at home.

Most physician services are covered through a monthly capitation payment (MCP) to the managing physician. The MCP covers ESRD related physician services in all settings necessary to manage the beneficiary's dialysis care, except declotting of shunts, dialysis training, and nonrenal-related medical services.

Self-dialysis training services provided by the physician are covered.

5.4 HOME HEALTH CARE

Medicaid covers home health care subject to the requirements in this section.

Home Health services include intermittent nursing care, home health aide services, and physical therapy provided in the beneficiary's home by a Medicaid enrolled Home Health Agency (HHA). The service must be reasonable and necessary for the treatment of a specific illness, injury, or disability, and must be consistent with the nature and severity of the beneficiary's condition, particular medical need and accepted standards of medical practice. Limited services to ensure stability of beneficiaries with an established disability or frail condition, or to prevent an illness, injury or disability for women and newborns during the postpartum period are covered.

Home health is intended for beneficiaries whose conditions require intermittent rather than continuous medical/nursing care. In special instances, intensive nursing care in the home may be approved if MDCH determines that home care is appropriate and is a cost-effective alternative to institutional care.

5.4.A. PHYSICIAN ORDER FOR CARE

The beneficiary's physician must order covered home health services as part of a written plan of care (POC), and must review the POC every 60 days for continuing need. A HHA should not provide home care prior to the date of the physician's order for the care. The agency must maintain a patient plan of treatment form which must be signed and dated by the physician, or a narrative summary of the POC which must have the physician's signed and dated order attached. The HHA is responsible for obtaining necessary authorization from MDCH for special or extended care which may be provided.

Home health services are not to replace the services of a physician and are not covered solely for the lack of transportation or as a convenience to the beneficiary. Home health services may be appropriate when leaving the home is medically contraindicated or special transportation or effort is required.

5.4.B. MEDICAL SUPPLIES AND EQUIPMENT

Medical supplies, durable medical equipment, orthotic and prosthetic appliances, shoe supplies, and oxygen are covered for beneficiaries receiving services from an enrolled HHA. The physician (MD, DO, DPM) must prescribe these items. (Refer to the Home Health and the Medical Supplier Chapters of this manual for specific information concerning which equipment/supplies are covered for the medical supplier and which are covered for the HHA.)

5.4.C. PERSONAL CARE

If beneficiaries are not in need of nursing care or physical therapy, but have a need for nonspecialized, unskilled personal care or chore services, such services are available through the FIA Home Help Program. The local county FIA office should be contacted for information.

5.5 Hospice Services

Medicaid covers hospice services which include palliative and supportive services to meet physical, psychological, social, and spiritual needs of terminally ill beneficiaries and their families in the home, adult foster care facility, home for the aged, nursing facility, or an inpatient hospice setting.

To enroll in hospice, the beneficiary must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the referring physician and the hospice medical director must certify the life expectancy. (Refer to the Hospice Chapter of this manual for specific requirements related to the provision of hospice services.)

If the physician is not familiar with Medicaid-enrolled hospices in his area, hospice names, addresses, and telephone numbers may be obtained from MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

5.6 Implantable Infusion Pumps

Medicaid covers the refill and reprogramming of implantable infusion pumps by physicians in the physician's office. The refill kit and the electronic analysis of the pump are covered as a part of the refill and reprogramming procedure. Injectable drugs used during this procedure are covered separately in the physician's office.

5.7 Pediatric Multichannel Recordings

Multichannel recording is covered for a child under age 21 when provided in the inpatient or outpatient hospital setting by qualified personnel and interpreted by a physician. Multichannel recordings are not covered in the beneficiary's home.

A pediatric multichannel recording is a continuous and simultaneous recording of at least four channels that may include ECG, thoracic impedance, airflow measurements, oxygen saturation, esophageal pH, or strain gauge measurements. Other additional recording parameters may be included. A multichannel recording does not have to include an electroencephalogram (EEG). When an EEG is performed in addition to the four or more channels, it is covered separately. Payment for the multichannel recording is the same regardless of the number of channels or the length of time required. Use of a video camera is not separately covered.

Two multichannel recordings may be covered in one year for the same beneficiary. If more than two are medically justified for CSHCS beneficiaries, the physician must obtain PA from CSHCS. A copy of the PA approval letter must be attached to the claim form to be reimbursed. Physicians are responsible for providing a copy of the PA approval letter to the hospital.

A multichannel recording is covered as a professional service to the physician and as a technical service to the hospital. The professional service includes the interpretation with written report, and the scanning and scoring.

SECTION 6 - EVALUATION AND MANAGEMENT SERVICES

Medicaid covers medically necessary evaluation and management (E/M) services provided by a physician or other practitioner authorized by the State. Providers should refer to the CPT explanations, coding conventions, and definitions for E/M services.

Most E/M services are covered once per day for the same beneficiary. In these cases, only one office or outpatient visit is covered on a single day for the same beneficiary unless the visits were for unrelated reasons and at different times of the day (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).

Coverage of an E/M service includes related activities such as coordination of care, telephone calls, writing prescriptions, completing insurance forms, review and explanation of diagnostic test reports to the beneficiary.

6.1 PREVENTIVE MEDICINE SERVICES

One preventive medicine E/M service is covered for all beneficiaries annually. For beneficiaries under the age of 21 years, EPSDT screening services are covered according to the AAP periodicity schedule and CMS requirements. (Refer to the EPSDT Section of this chapter for specific information.)

A preventive medicine E/M visit and another E/M visit on the same date are covered separately if, during the preventive visit, a problem or abnormality is detected which requires additional work which meets the key component requirements of a problem oriented E/M visit. When this occurs, the office/outpatient E/M procedure code is covered using the modifier for a separately identifiable service, and the preventive E/M visit is covered without using a modifier. (Refer to CPT guidelines for additional information.)

6.2 E/M VISITS IN RELATION TO GLOBAL SURGERY PACKAGE

An E/M service that results in the decision for surgery is covered separately when provided by the surgeon on the day before or the day of a procedure with a 90-day global period and the decision for surgery modifier is reported. This same E/M service provided the day before or the day of a procedure with a 0-day or 10-day global period is not covered separately.

An E/M service is not covered separately on the same day as a procedure with any global surgery period unless the beneficiary's condition requires a significant, separately identifiable E/M service that is above and beyond the pre- and post-operative care associated with the procedure or service performed.

If the surgeon performs E/M services during the post-operative global surgery period for a reason unrelated to the surgical procedure, report the appropriate modifier with the E/M service. All care provided during the inpatient stay in which the surgery is performed is compensated through the global surgery package and is not covered separately.

6.3 CONSULTATIONS

Medicaid covers consultations rendered by a physician whose opinion or advice is requested by another appropriate practitioner (e.g., physician, CNM, dentist) for the further evaluation and management of the patient. A consultation includes preparation of a report of findings that is provided to the referring provider for the referring provider's use in the treatment of the beneficiary. A consultant may initiate

diagnostic and/or therapeutic services. If the referring provider transfers complete responsibility for treatment either orally or in writing to the consultant at the time of the request for consultation, the receiving physician's services are covered as normal E/M services rather than as a consultation.

If the referring provider transfers responsibility for the beneficiary's care to the consultant after the consultation is completed, the consultant's service is covered as a consultation. After the consulting physician assumes responsibility for the beneficiary's care, subsequent visits are covered as established patient office visits or subsequent hospital care, depending on the setting.

A consultation is covered if one provider in a group practice requests a consultation from a physician of a different specialty in the same group practice as long as all of the requirements for use of the CPT/HCPCS consultation codes are met. A request for a consultation from the attending provider and the need for consultation must be documented in the beneficiary's medical record. In an inpatient setting, the request may be documented as part of a plan written in the requesting physician's progress notes, an order in the hospital record, or a specific written request for the consultation.

Medicaid covers second opinions for surgery. The second opinion is covered as a consultation as long as all requirements for a consultation are met.

Ancillary services provided to a beneficiary in a nursing facility must be ordered by the attending physician and are not covered as consultations unless a specific request for opinion and advice is documented. Requests for services by another physician are covered as the actual service provided (e.g., nursing facility visit or eye examination).

6.4 Initial Visits

Medicaid covers one new patient visit for a physician or a group practice for the same beneficiary, regardless of the type of new patient visit billed (e.g., office visit, clinic visit, long term care visit, home visit).

6.5 Observation Care

Medicaid covers physician services for beneficiaries admitted and discharged from observation status in the hospital setting for a stay less than 24 hours. Coverage is based on CPT coding conventions to report observation stays occurring on a single date and observation stays which start on one date and end on the subsequent date. It is expected that the beneficiary would be discharged from the hospital at the end of observation care. The medical record must include the following documentation:

- The length of time of the observation stay.
- The physician was present and personally performed the services.
- The physician wrote the observation admission and/or discharge notes.

For outpatient surgical procedures, the global surgery rules apply. The surgeon is responsible for all post-operative care in the hospital and observation care is not covered separately.

Observation care for psychiatric reasons must be authorized by the PIHP/CMHSP. The PIHP/CMHSP is responsible for coverage of authorized psychiatric observation care services.

SECTION 7 - EMERGENCY SERVICES

Medicaid covers all medically necessary emergency services. Federal statutes prohibit PA for coverage of emergency services. Emergency services include covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and the services are necessary to evaluate or stabilize an emergency medical condition. All professional services must be identified as either an emergency or not an emergency.

7.1 SCREENING EXAM AND STABILIZATION IN THE EMERGENCY DEPARTMENT

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

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

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

Professional services for the medical screening and stabilization in the ED are covered separately from the facility fees.

7.2 TREATMENT OF EMERGENCY MEDICAL CONDITION IN THE EMERGENCY DEPARTMENT

PA is not required for the treatment of emergency medical conditions.

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

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

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

7.3 NONEMERGENCY MEDICAL CONDITIONS IN THE EMERGENCY DEPARTMENT

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

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

- FFS Medicaid beneficiaries with private health insurance must follow the rules of the private health insurance. Private insurers frequently require that the primary care provider perform the follow-up care.
- MHP enrollees must be referred to their primary care provider for treatment, or the MHP can be contacted to request authorization to provide the treatment. If the MHP fails to respond within one hour to the request to provide additional services beyond those required for stabilization, the request for authorization is deemed approved.

7.4 Psychiatric Emergency Services in the Emergency Department

Screening and stabilization of a psychiatric emergency does not require PA. These services are covered in the same manner as other emergency services provided in the ED detailed above. If it is determined that the beneficiary requires post-stabilization psychiatric services, the PIHP/CMHSP must be contacted for PA. The need for PA from the PIHP/CMHSP includes, but is not limited to, inpatient psychiatric admission, psychiatric partial hospitalization, and specialty mental health services.

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

7.5 Physician Emergency Department Two-Tiered E/M Rate

Physician services provided in the ED are covered as individual services. Critical care services are covered according to the CPT/HCPCS definitions and coding conventions for critical care. If critical care is required for a beneficiary in the ED, then only the critical care codes are covered. ED E/M or visit codes are not covered on the same day as critical care for the same provider.

When a beneficiary is seen in the ED, the appropriate level of ED E/M service is covered unless another E/M service is more appropriate (e.g., observation care, initial inpatient hospital care, or critical care). The ED E/M service which includes the medical screening exam is covered without regard to whether the medical screening results in the medical condition being deemed an emergency or not. The results of the medical screening examination, along with any medically necessary appropriate diagnostic services, determine if further treatment must be provided. If the attending physician determines that an emergency medical condition does exist, all subsequent medically appropriate services to stabilize the patient must be provided and are covered in addition to the ED E/M service. CPT/HCPCS coding conventions and Medicaid guidelines must be followed.

The medical record must support the need for the type and extent of diagnostic services performed based on the presenting symptoms of the beneficiary. The ED physician's review of x-rays and EKGs performed on the beneficiary are covered as a part of the E/M service. Professional component services are covered only for the physician who prepares a complete, written report of the findings for the medical record. If a specialist in the field prepares this, then the ED physician's review of the findings does not meet the conditions for separate coverage of the service.

The ED E/M services provided by the attending physician, regardless of the level of the service, are covered using a two-tiered rate based on whether the beneficiary was released or admitted. If the beneficiary was released from the ED, a single rate is used as the fee screen. If the beneficiary was admitted to the hospital or transferred to another hospital from the ED, a higher single rate is used as the fee screen.

Additional services will continue to be covered separately. Annually, when these physician rates are re-based using the current RVUs (relative value units), historic utilization, and funds appropriated by the Legislature, the ED E/M fee screens are adjusted accordingly.

Counties that administer their own Adult Benefit Waiver I (indigent care) program may have different coverage policies for physician ED services. Physicians rendering care to these beneficiaries must contact the entity administering the ABW County Health Plan for information on their coverage policies and rates.

7.6 URGENT CARE SETTINGS

Physician services rendered in urgent care centers or similar settings that are not part of a licensed hospital are covered. Coverage is based on the appropriate office or other outpatient services E/M procedure codes. Coverage for any additional professional services rendered in these settings follows CPT guidelines.

SECTION 8 - MATERNITY CARE AND DELIVERY SERVICES

Medicaid covers maternity care and delivery services. The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care. These services are included in the global obstetric package. The global obstetric package is covered when one physician or physician group practice provides the obstetric care to a beneficiary. The global obstetric package is covered as long as the provider or group has provided seven or more antepartum visits, the delivery, and the postpartum care. If less than seven antepartum visits are provided, report the global package with the modifier for reduced services and indicate the number of antepartum visits on the claim.

8.1 ANTEPARTUM CARE

Includes the initial and any subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Typically, if a beneficiary enrolls in the first trimester and delivers at term, she has about 13 antepartum visits. This varies depending on the actual start of antepartum care and the delivery date. If the total number of antepartum visits exceeds 13 due to a high-risk condition, the additional visits are covered when using the appropriate E/M codes with the diagnosis for the high-risk condition.

8.2 DELIVERY

Includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, delivery, and all post-delivery in-hospital care. All hospital visits within 24 hours of delivery are generally considered part of the global package. If the beneficiary is admitted more than 24 hours before delivery and stays more than 24 hours, then hospital care rendered prior to the day of delivery is covered separately as an E/M code. Medical problems complicating labor and delivery management that require additional resources are also covered separately.

8.3 POSTPARTUM

Includes all the visits following a delivery, both in the hospital and in the office. Services provided by physicians within the same group practice are considered as provided by the primary physician responsible for the beneficiary's overall obstetrical care.

8.4 OBSTETRICAL PACKAGE VS. COMPONENTS

If the same physician or group practice does not provide all of the obstetric care, Medicaid covers the portion of the care provided by each provider. Postpartum care is covered separately if provided by a different physician or group than the one providing the delivery services.

Services that are not included in the global package include:

- Maternal or fetal echography or fetal echography procedures.
- Fetal biophysical profile.
- Chorionic villus sampling, any method.
- Fetal contraction stress test.

- Fetal nonstress test.
- Hospital and observation care visits for premature labor (prior to 36 weeks gestation).

8.5 High-Risk Pregnancy

High-risk pregnancies are those with complicating conditions that are life-threatening to either the mother or fetus and, therefore, require more services than those provided in a routine pregnancy. When high-risk pregnancies require more visits than described for routine obstetrical care and more laboratory data than normally required, the additional services are covered in addition to the global obstetric package. If beneficiary visits are required due to conditions unrelated to the pregnancy, they are also covered in addition to the global obstetric package. Medicaid follows CPT guidelines for reporting high-risk pregnancy services.

8.6 Multiple Gestation

In the case of multiple gestation, Medicaid covers the services provided. Payment follows the multiple procedure rules. Providers must use a diagnosis code representing multiple gestation.

8.7 OB Enhanced Payments

MDCH provides an enhanced payment for each Medicaid delivery performed. This additional reimbursement is added to the fee reimbursed under FFS for the global maternity and delivery procedure codes. The maternity case rate paid to MHPs is also enhanced.

8.8 Maternity Outpatient Medical Services Program

Under the Maternity Outpatient Medical Services (MOMS) program, pregnant women can enroll and receive pregnancy related care early in the pregnancy.

Targeted Population	Women who are pregnant or recently pregnant (within 60 days following the month the pregnancy ended), who apply for medical coverage for their pregnancy at a LHD, Federally Qualified Health Center (FQHC), or FIA, and meet one or more of the following criteria: ▪ Women with incomes at or below 185 percent of the federal poverty level. ▪ Women who are covered by the Medicaid Emergency Services Only (ESO) program. Frequently, individuals determined eligible for MOMS may subsequently become eligible for Medicaid. MOMS eligibility is terminated on the effective date of full Medicaid coverage. Medicaid covers all services available under the MOMS program. (This does not include Medicaid ESO.)
Period of Coverage	Once the woman is enrolled into MOMS, outpatient pregnancy-related services and the provider's professional fee for labor and delivery are covered from the date of conception through 60 days after the pregnancy ends, regardless of the reason (live birth, miscarriage, or stillborn).

Covered Services	Coverage includes inpatient hospital services related to an inpatient delivery. No other inpatient hospital services are covered. Coverage includes the following outpatient pregnancy-related services during the prenatal and postpartum period: ▪ Prenatal care ▪ Pharmaceuticals and prescription vitamins ▪ Laboratory services ▪ Labor and delivery, both professional fees and inpatient hospitalization ▪ Postpartum care through 60 days after the pregnancy ends ▪ Radiology and ultrasound ▪ Maternal Support Services (MSS) until delivery ▪ Childbirth education ▪ Outpatient hospital care ▪ Other pregnancy-related services with PA
Private Insurance	Private insurance coverage, if any exists for pregnancy related care, must be billed first. MOMS is the secondary payer of services if private insurance coverage exists. (Reimbursement for services is specified in the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual.) This would include following the rules of any private commercial managed care contract. Services to the infant are not covered at any time under this program. The infant's family/primary caregiver is encouraged to apply promptly for Medicaid coverage for the infant. Policies and procedures are parallel to Medicaid FFS beneficiaries.
Guarantee of Payment Letter	MDCH has developed a process whereby providers are assured payment for services provided to pregnant women. If it is determined that the woman appears to qualify for MOMS or Medicaid, a Guarantee of Payment Letter (DCH-1164) will be issued to the pregnant woman to enable her to obtain care immediately and not have to wait for her identification card.

8.9 MATERNAL AND INFANT SUPPORT SERVICES

Maternal and Infant Support Services (MSS/ISS) are preventive health services that are delivered by an agency, which must be certified by MDCH. MSS and ISS services include:

- Psychosocial and nutritional assessment.
- Plan of care development.
- Professional intervention services of a multidisciplinary team consisting of a qualified:
  - Social worker;
  - Nutritionist;
  - Nurse; and
  - Infant mental health specialist (if available).

- Arranging transportation as needed for health, substance abuse treatment, support services, and/or pregnancy-related appointments.
- Referral to community services (e.g., mental health, substance abuse).
- Coordination with medical care providers.
- Childbirth classes or parenting education classes.

Services consist of social work, nutrition, nursing services (including health education), counseling/social casework, and beneficiary advocacy services.

Infant mental health specialists should be involved with ISS cases, if available in the geographic area. If not available, the provider must consider carefully how to provide this service.

8.9.A. MATERNAL SUPPORT SERVICES

MSS referrals are encouraged given the presence of any of the following conditions which are likely to adversely affect the pregnancy:

- Homeless or dangerous living/home situation.
- Negative or ambivalent feelings about the pregnancy.
- Mother under age 18 and has no family support.
- Need for assistance to care for herself and the infant.
- Mother with cognitive, emotional or mental impairment.
- Nutrition problem.
- Abuse of alcohol or drugs, or smoking.
- Need for transportation to keep medical appointments.
- Need for childbirth education classes.

Only those pregnant women that meet the above risk criteria should be enrolled in MSS. Medicaid eligibility by itself is not a qualifying condition for enrollment in MSS.

8.9.B. INFANT SUPPORT SERVICES

ISS referrals are encouraged if the presence of any one of the following conditions exists with the mother or infant:

- Abuse of alcohol or drugs (especially use of cocaine), or smoking.
- Mother is under 18 years of age and has no family support.
- Family history of child abuse/neglect.
- Failure to thrive.
- Low birth weight (less than 2500 grams).
- Mother with cognitive, emotional or mental impairment.

- Homeless or dangerous living/home situation.
- Any other condition that may place the infant at risk for death, illness or significant impairment when indicated by a physician.

(Refer to the Maternal & Infant Support Services [MSS/ISS] Chapter of this manual for additional information.)

SECTION 9 - PHARMACY

Refer to the Pharmacy Chapter of this manual for additional information.

SECTION 10 - RADIOLOGY, RADIATION THERAPY AND NUCLEAR MEDICINE

10.1 RADIOLOGY SERVICES

Medically necessary radiological services are covered when ordered by a physician to diagnose or treat a specific condition based on the beneficiary's signs, symptoms, and past history as documented in the medical record. Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging (MRI) services, diagnostic ultrasound, and other imaging procedures. Medical need for all services must be documented in the medical record and are subject to post-payment review.

10.1.A. GLOBAL/COMPONENT SERVICES

Medicaid covers global physician services in nonhospital settings or the professional component only in any setting. The technical component is only covered when provided and billed by a hospital.

When a physician reports a global procedure, the physician is responsible for the overall performance and quality of the test. The physician must either personally perform the test or it must be performed under the physician's supervision and direction. The physician must personally interpret the results and complete the written report. While some radiology procedures and diagnostic tests may not require the presence of the supervising physician on the premises, other procedures dictate that the physician be present and may even need to be directly involved in the performance of the procedure.

Interpretation of radiology services are covered for any physician trained in the interpretation of the study. The provider who interprets the study must be the one who evaluates the study and prepares and signs the written report for the medical record. Review of results and explanation to the beneficiary are part of the attending physician's E/M service and are not considered as interpretation of the study.

10.1.B. MULTIPLE SERVICES ON SAME DAY

Medicaid covers bilateral x-rays when medically necessary. Bilateral services are studies done on the same body area, once on the right side and once on the left side. Comparison films obtained for routine purposes are not covered. Providers should use a bilateral code when available. The Medicaid Practitioner Database indicates all diagnostic procedures that are covered as bilateral services. Medicaid also covers multiple studies of both areas if reported with the appropriate modifier. Examples would include bilateral wrist studies done before and after fracture care on both wrists the same day for the same patient or doing films to assess a patient's response to medical care, such as multiple chest films to monitor the cardiopulmonary status of a critically ill patient.

Contiguous Areas	Studies of contiguous areas, such as the wrist and hand, lumbosacral spine and pelvis, ankle and foot, are covered on the same day when medically necessary to visualize each space. The medical record must support the need for individual studies. If cervical, lumbosacral and thoracic views are performed, an entire spine study should be reported.

Screening Mammography	Screening mammography is covered according to the American Cancer Society guidelines. Women age 40 and older should have annual breast cancer screening consisting of a clinical breast examination and a mammogram.
Transrectal or Prostate Ultrasound	Transrectal or prostate ultrasound is covered when the patient is considered at high risk for prostate cancer. It is also covered for pathologic indications that include evaluation of prostatic nodule(s) or abnormalities of the seminal vesicles, staging of prostatic cancer, and monitoring of response to therapy for prostatic cancer.
CT, MRI, PET Scans	For CT, MRI and PET scans to be covered, all conditions of Certificate of Need (CON) must be met. These services are subject to standards for provision of the service that include specific staff and designation of who is qualified to interpret the results. Flat films and CT or MRI studies of the same area are covered on the same day when medically indicated. The provider is responsible for using the most appropriate diagnostic test(s) according to current standards of practice. A CT and a myleogram may be covered on the same day; however, an MRI and a myleogram are not covered separately if done on the same day. Coverage of a CT of the spine is limited to one level per day and coverage of an MRI is limited to two levels of the spine on the same day. Providers should be directing the study at the area of the suspected problem. CT and MRI scans may be done with or without contrast media or both. When a scan is done without contrast followed by another with contrast, only the full service is covered. The global RVUs for CT and MRI contrast scans include allowance for high osmolar contrast media, and the RVUs for global MRIs include allowance for paramagnetic contrast media. In certain instances, the use of low osmolar contrast media (LOCM) is separately covered. In the case of intra-arterial and intravenous radiological procedures, LOCM is covered separately for nonhospital patients with one or more of the following: ▪ A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting; ▪ A history of asthma or allergy; ▪ Significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension; ▪ Generalized severe debilitation; or ▪ Sickle cell disease. If the patient does not meet any of these criteria, the contrast media is considered bundled into the global service and is not covered separately. When high dose contrast technique is used with MRI, the global service is covered for the procedure designated without contrast, then with contrast. The third MRI (again with contrast) is not covered separately. The contrast material used in the second MRI procedure is not covered separately; however, the contrast material for the third MRI procedure is covered separately.

Obstetrical Ultrasound	Obstetrical ultrasound studies are covered in addition to the global obstetrical package. More than two studies are covered only for high-risk conditions such as bleeding, placental abnormalities, fetal post-maturity, etc. The need for the additional studies, including the change in clinical symptoms, must be documented. Pelvic ultrasounds are not covered to diagnose pregnancy or vaginal infections. The use of ultrasound studies for routine fetal age determination in or preparatory for pregnancy termination procedures is considered part of the termination procedure and is not covered separately.

10.2 RADIATION THERAPY

Medicaid covers medically necessary radiation therapy services provided to beneficiaries. CPT/HCPCS guidelines for radiation therapy services are followed.

Following the Medicare guidelines, many services are bundled into the treatment management codes and are not covered separately when the diagnosis is related to the weekly treatment diagnosis and the services are provided by the radiation oncologists or in conjunction with the therapy. The following services are included in the weekly treatment management service:

- Anesthesia
- Care of infected skin
- Checking treatment charts
- Continuing-care patient evaluation and examination
- Final medical examination
- Nutritional counseling
- Pain management
- Medical prescription
- Review and revision of the treatment plan
- Routine medical management of related problems
- Special care of ostomy
- Verification of dosage
- Written reports, progress notes
- Follow-up examination and care 90 days after the last treatment

Medicaid separately covers services furnished by a radiation physicist only when provided to a nonhospital beneficiary in a freestanding facility.

Professional services provided to hospital patients are covered only when personally performed by a physician.

Global physician services are only covered if provided in a freestanding, nonhospital setting.

10.3 NUCLEAR MEDICINE

Medicaid covers medically necessary nuclear medicine procedures. Providers are responsible for complying with Nuclear Regulatory Commission (NRC) requirements. Only professional services rendered to hospital patients are covered for the practitioner.

Medicaid covers global services when provided in a freestanding, nonhospital setting. Radionuclides used in the procedures are covered separately.

When specific nuclear medicine diagnostic procedures are performed, multiple procedure coverage rules apply. Generation and interpretation of automated data is covered as a part of the primary procedure.

SECTION 11 - HOSPITAL INPATIENT PHYSICIAN SERVICES

Medicaid covers physician services to hospital inpatients that are medically necessary and follow the requirements in this section. Medicaid does not cover physician services related to inappropriate or unnecessary inpatient admissions. This includes elective admissions and readmissions, all transfers that are not authorized through the Prior Authorization and Certification Evaluation Review (PACER) system, and admissions or readmissions which have been inappropriately identified as emergent. This also includes selected ambulatory surgeries inappropriately performed on an inpatient basis or any other inpatient admission determined to have not been medically necessary.

If Medicaid does not cover the services of the physician or hospital, the physician or hospital must not bill the beneficiary, a member of the beneficiary's family, or other beneficiary representative.

11.1 ADMISSION

All inpatient admissions must be medically necessary and appropriate, and all services must relate to a specific diagnosed condition. Elective admissions, readmissions, and transfers for surgical and medical inpatient hospital services must be authorized through the Admissions and Certification Review Contractor (ACRC). The physician should refer to the PACER subsection of this section for specific requirements.

Medicaid does not cover inpatient hospital admissions for the sole purpose of:

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

Any accommodation or ancillary services provided during nonallowable admissions or parts of stays are not covered. Physicians may not bill the beneficiary for any surgical/medical charges since the admission was unnecessary.

11.2 Prior Authorization and Certification Evaluation Review (PACER)

Elective admissions, all readmissions within 15 days of discharge, and all transfers for surgical or medical inpatient hospital services to and from any hospital enrolled in the Medicaid program require authorization through the ACRC. This includes transfers between a medical/surgical unit and an enrolled distinct part rehabilitation unit of the same hospital. All cases are screened using the Medicaid approved Severity of Illness/Intensity of Services (SI/IS) criteria sets and the clinical judgment of the review coordinator. An ACRC physician makes all adverse decisions.

If an admission, readmission, transfer, or continued stay is not approved, Medicaid does not cover the hospital or physician services rendered.

The ACRC completes the admission, readmission, or transfer review through the Pre-admission and Certification Evaluation Review (PACER) system and assigns a PACER number.

The attending/admitting physician or representative is responsible for obtaining the PACER number before admitting, readmitting, or transferring the beneficiary with exceptions as noted below. (Refer to the Directory Appendix for PACER authorization contact information.)

Physicians are asked to provide the procedure code when a surgical admission/readmission is requested. If the ACRC does not authorize the admission/readmission/transfer, the physician can request reconsideration. This request must be made within three working days of the denial.

Authorization for the hospital admission does not remove the need for PA for specific services. Any PA required for the service must be obtained before the ACRC authorization is requested.

The following do not require a PACER number:

- Emergent admissions. (Hospital services billed as emergent are reviewed on a post-payment sample basis.)
- Transfers to distinct-part psychiatric units or freestanding psychiatric hospitals. (Authorization must be requested through the local PIHP/CMHSP.)
- Obstetrical beneficiaries admitted for any delivery.
- Newborns admitted following delivery except for all transfers. Transfers include any of the following situations:
  - Transfer from one inpatient hospital to another.
  - Transfer from one unit of an inpatient hospital to another unit of the same hospital (i.e., distinct part rehabilitation unit) which has a separate Medicaid ID number.

  Newborns who are transferred following delivery require a PACER number. The ACRC must authorize the initial and subsequent transfers of the newborn.
- CSHCS beneficiaries. (Authorization is required if the admission is not related to the qualifying CSHCS diagnosis.)
- Medicaid beneficiaries enrolled in a MHP.
- CSHCS beneficiaries enrolled in a SHP.

- When a beneficiary is admitted to a hospital that is not enrolled with the Michigan Medicaid Program.
- When a beneficiary becomes Medicaid eligible after the admission, readmission, transfer, or certification review period.

Physicians are responsible for providing the PACER number to the admitting hospital. If an urgent or emergent readmission to the same hospital as the original admission occurs, the PACER number for the readmission must be made by the next working day following the readmission.

(Refer to the Hospital Chapter of this manual for additional information concerning the ACRC and PACER processes.)

11.3 VENTILATION MANAGEMENT

Ventilation management provided in the inpatient hospital setting is covered separately unless an E/M service is provided on the same day.

11.4 CRITICAL CARE

Medicaid covers critical care consistent with the CPT/HCPCS definitions and guidelines. Each day that critical care is provided, the medical record must support the level of service provided. The actual time spent with the patient delivering critical care services must be documented in the medical record.

11.5 RESPIRATORY CARE

Medicaid covers respiratory care as a separate service in the inpatient hospital setting for the anesthesiologist/physician who initiates respiratory care by setting up the respirator, placing the beneficiary on the respirator, and providing daily supervision of the beneficiary for the respiratory care alone.

11.6 STANDBY SERVICES

Medicaid does not cover the services of a standby surgeon, anesthesiologist or surgical team. Only direct beneficiary care is covered. Physician standby services are covered as a part of the hospital services.

SECTION 12 - SURGERY - GENERAL

Medicaid covers medically necessary surgical procedures.

12.1 GLOBAL SURGERY

Coverage for the global surgery package includes related services that are furnished by the physician who performs the surgery or by members of the same group with the same specialty. Medicaid policy is based on CMS guidelines for Medicare services for the global surgery package.

Global periods are identified on the Medicaid Physician Database. The payment rules for global surgery apply to global periods of 000 (only services on the day of the procedure are included), 010 (10-day global period), 090 (90-day global period), and YYY (global period determined on case-by-case basis). Codes with 000 and 010 global periods include endoscopies and minor procedures. Codes with a 090 global period include major surgeries. Codes with an YYY are individually priced and MDCH determines the global period.

12.1.A. SERVICES INCLUDED IN THE GLOBAL SURGERY PACKAGE

- Pre-operative visits beginning with the day before the surgery for major surgeries and the day of the surgery for minor surgeries.
- Intra-operative services that are a usual and necessary part of a surgical procedure.
- Complications following surgery. This includes all additional medical or surgical services required of the surgeon during the post-operative period due to complications that do not require return to the operating room. The surgeon's visits to a patient in an intensive care or critical care unit are also included.
- Follow-up visits within the post-operative period related to recovery from the surgery.
- Post-surgical pain management by the surgeon.
- Supplies for certain services furnished in a physician's office.
- Miscellaneous services and items such as dressing changes, local incisional care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes.

12.1.B. SERVICES NOT INCLUDED IN THE GLOBAL SURGERY PACKAGE

- The surgeon's initial consultation or evaluation of the problem to determine the need for surgery.
- The office or hospital visit to decide upon surgery if it occurs on the day before or the day of a major surgery.
- Other physicians' services, except when the surgeon and the other physician(s) agree on the transfer of care (The transfer of care agreement may be in the form of a letter or an annotation in the discharge summary, hospital records, or ambulatory surgical center records).

- Visits unrelated to the diagnosis for which the surgical procedure was performed.
- Treatment of the underlying condition or an added course of treatment that is not part of the normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiology procedures.
- Clearly distinct surgical procedures that are not repeat procedures, or treatment for complications during the post-operative period. A new post-operative period begins with the subsequent procedure.
- Staged procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples include procedures to diagnose and treat epilepsy in succession within 90 days of each other.
- Laser eye surgeries (and all other services whose CPT/HCPCS description includes one or more sessions) performed in a series over a period of weeks or months are not considered staged procedures. All sessions during the post-operative period of the first session are covered as a part of the global package.
- Chemotherapy and/or radiation therapy following cancer surgery.
- Treatment for post-operative complications that requires a return to the operating room. For this purpose, an operating room is a place of service specially equipped and staffed for the sole purpose of performing surgical procedures, including a cardiac catheterization suite, a laser suite, and an endoscopy suite. Not included is a patient's room, a minor treatment room, a recovery room, or intensive care unit unless the patient's condition is so critical there is insufficient time for transportation to an operating room.
- A second, more extensive procedure when a less extensive procedure fails.
- A therapeutic service that is required during the post-operative period of a diagnostic service. Example: A D&C followed by a therapeutic hysterectomy performed during the D&C's global period.
- Immunosuppressive therapy for organ transplants.
- Critical care services unrelated to the surgery when a seriously injured or burned patient is critically ill and requires constant attendance of the physician.
- Visits that are a significant, separately identifiable service on the same day as a minor surgery or endoscopy. For example, a visit for a full evaluation of a lump in the breast on the same day as a removal of a lesion on the back.
- When a beneficiary is returned to the operating room for treatment of complications, only the intra-operative portion of the service is covered.

12.2 Partial Global Package

Services of physicians furnishing less than the full global surgery package are covered. Modifiers are used to identify the portion of the global surgery package that is covered separately when performed by different physicians under certain circumstances. Only procedures with 10- or 90-day global periods are eligible for partial global surgery package coverage.

Surgeons should use the modifier for surgical care only when another physician provides all or part of the outpatient post-operative care. MDCH assumes that the surgeon is responsible for pre-operative, intra-operative and inpatient hospital post-operative care at a minimum. The modifier for post-operative management only is used when a second physician provides all or part of the post-operative care after hospital discharge in the global package. Surgeons must transfer care to the second physician, and both must keep a copy of the written transfer agreement in the beneficiary's medical record.

12.3 Bilateral Surgery

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The descriptions for some procedure codes include the terms "bilateral" or "unilateral or bilateral." The RVUs for these codes reflect the work involved if done bilaterally as the description states. Other procedure code descriptions do not include bilateral but may be performed bilaterally. The bilateral procedure modifier is used with these procedure codes.

The Medicaid Practitioner Database includes an indicator for those procedures that the bilateral procedure modifier can be used with. Reimbursement for a bilateral procedure reported appropriately with this modifier is based on the lower of the amount billed or 150 percent of the fee screen for the procedure.

12.4 Multiple Surgical Procedures

Multiple surgeries are separate procedures performed by a physician on the same beneficiary during the same operative session or on the same day for which separate coverage may be allowed. Co-surgeons, surgical teams, or assistants at surgery may participate in performing multiple surgeries on the same beneficiary on the same day.

When the same physician performs multiple surgical procedures during one operative session, all services are covered separately. MDCH follows CMS multiple surgery guidelines for coverage of the procedures. If an integral procedure (one that is part of a larger surgery and is necessary to perform the larger surgery) is performed, it is covered as a part of the larger procedure. If two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases), the procedures are covered separately.

Multiple surgery reimbursement policy applies to procedures performed during the same operative session or on the same day by the same physician or physicians of the same specialty in the same group practice. Medicaid reimburses up to 100 percent of the fee screen for the most complex surgical procedure and up to 50 percent of the fee screens for the second through the fifth surgical procedures. If more than five multiple procedures are performed, an operative report must be provided with the claim.

12.5 Multiple Endoscopy Procedures

Multiple endoscopy procedures are reimbursed based on the full fee for the highest paid service, plus the difference between the next highest and the base endoscopy. When related endoscopies are performed on the same day as other endoscopies or other surgical procedures, the standard multiple surgery rules apply. The multiple surgery rules consider the coverage for the related endoscopies as one service, and any other unrelated endoscopy or procedure as another service.

12.6 Multiple Surgeons

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same beneficiary during the same operative session. This may be required due to the complex nature of the procedures or the beneficiary's condition. The Medicaid Practitioner Database (located on the MDCH website) includes multiple surgeon indicators on allowable procedures.

12.7 Co-Surgeons

Two surgeons who work together as primary surgeons performing distinct parts of a total service are considered co-surgeons. The medical record must contain sufficient documentation supporting the medical necessity for co-surgeons. Report the modifier indicating two surgeons for the services furnished by each co-surgeon. The primary procedure is reimbursed at the full screen times 62.5 percent. Second and subsequent services are paid at 50 percent of the full-allowed amount times 62.5 percent.

12.8 Team Surgeons

Three or more surgeons who work together as primary surgeons to perform a specific procedure are considered team surgeons. Sufficient documentation must be submitted with the claim to establish that a team was medically necessary. If two or more surgeons are of the same specialty, the reason each was needed must be documented also. Report the surgical team modifier when billing for services rendered by each team surgeon. Each surgeon's dictated operative report must be included with the claims. Reimbursement is based on individual consideration.

12.9 Assistant at Surgery/Assistant Surgeon

Medicaid covers assistant at surgery services for designated surgical procedures. Assistant at surgery services must be considered reasonable and necessary for the surgery performed. An assistant at surgery actively assists the primary surgeon during the surgical procedure. Coverage for assistant at surgery services is not allowed when co-surgeons or team surgeons are utilized.

Medicaid does not cover assistant surgeon services in a teaching hospital setting unless a qualified resident is not available. The medical record must document the circumstances causing the unavailability of a qualified resident. The surgical procedure is reported with appropriate modifier identifying use of an assistant surgeon.

Medicaid covers assistant at surgery services performed by a second physician, a physician's assistant, or a nurse practitioner (NP). Physician's assistant and NP services as assistant at surgery must be under the delegation and supervision of the physician employing the physician's assistant or NP, or a physician employed by the same group practice that employs the physician's assistant or NP. If the physician's assistant and/or NP are employees of the hospital, their services are covered as a part of the hospital charges.

12.10 Surgeons Performing Distinctly Different Unrelated Procedures

If two or more physicians each perform distinctly different, unrelated surgeries on the beneficiary on the same day, the payment adjustment rules for multiple surgeries or co-surgeons do not apply. In such cases, the multiple procedures modifier should not be used unless one of the surgeons individually performs multiple surgeries.

12.11 Destruction of Lesions

Medicaid covers destruction of lesions by methods such as electrocautery, cryocautery, laser, and surgery.

Coverage of the surgical destruction of lesions that involve more extensive procedures is limited to the hospital setting. Less extensive procedures are covered in the office setting. (Refer to the Medicaid Practitioner Database to determine which procedures require a hospital setting for coverage and which procedures are covered in the office setting.) If a repeat procedure to the same lesion is necessary, it is covered as an office visit.

Chemocautery or chemical destruction of any lesion, such as the use of a nitrate stick or podophyllin, is covered as a part of the office visit.

12.12 Vision Procedures and Care

Ophthalmologists may transfer post-operative care associated with cataract removal or insertion of intraocular lens prosthesis to an optometrist. In this case, the ophthalmologist who performs eye surgery but does not provide the post-surgical care must report the surgical care only modifier with the surgery procedure code. This includes the pre-operative care, the surgery, and any in-hospital post-operative care. Post-operative care after hospital discharge is covered separately for the provider that the care was transferred to using the surgery code with the post-operative management only modifier.

Surgical procedure descriptions that include the phrase "one or more sessions" include all sessions. These procedures include the 90-day global period during which the procedure(s) can be completed in one or more session(s). These procedures include trabeculoplasty by laser surgery, iridotomy/iridectomy by laser or photocoagulation, repair of retinal detachment, destruction of retinal or choroid lesions. The code description in CPT identifies when one or more sessions are included. Separate coverage for a second or subsequent session of the same procedure during the global period of the initial service is limited to cases where the modifier reported with the procedure code indicates that services were performed on different eyes.

SECTION 13 - SURGERY - SPECIAL CONSIDERATIONS

13.1 ABORTIONS

Medicaid only covers an abortion performed by a physician and related hospital charges (e.g., room, supplies) when it has been determined medically necessary to save the life of the mother or the pregnancy is the result of rape or incest. Medicaid funding is not available for any elective therapeutic abortion or service related to the performance of such abortion unless one of these criteria has been met.

Physicians must certify on a completed Certification for Induced Abortion form (MSA-4240) that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest.

The physician who completes the MSA-4240 must also ensure completion of the Recipient Verification of Coverage form (MSA-1550) and is responsible for providing copies of the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) that would submit claims for services related to the abortion.

A copy of the MSA-4240 completed by the physician and an MSA-1550 must accompany all claims except those for ectopic pregnancies or spontaneous, incomplete or threatened abortions.

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

(Refer to the Forms Appendix for copies of the MSA-4240 and MSA-1550.) The forms are also available on the MDCH website. (Refer to the Directory Appendix for contact information.)

13.2 COSMETIC SURGERY

Medicaid only covers cosmetic surgery if PA has been obtained. The physician may request PA if any of the following exist:

- The condition interferes with employment.
- It causes significant disability or psychological trauma (as documented by psychiatric evaluation).
- It is a component of a program of reconstructive surgery for congenital deformity or trauma.
- It contributes to a major health problem.

The physician must identify the specific reasons any of the above criteria are met in the PA request.

Physicians should refer to the General Information for Providers Chapter for specific information for obtaining authorization.

13.3 HYSTERECTOMY

Hysterectomies are covered only if the beneficiary has been informed orally, prior to surgery, that a hysterectomy will render her permanently incapable of reproducing. The beneficiary or her representative must sign a written acknowledgment of receipt of that information. The Acknowledgment of Receipt of Hysterectomy Information (MSA-2218) serves as the written acknowledgment.

All items on the MSA-2218 must be completed and the form must be signed by the beneficiary (or representative) and the physician (MD or DO).

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

13.3.A. EXCEPTIONS

The MSA-2218 is not required in the following situations:

- The beneficiary was already sterile before the hysterectomy.
- The beneficiary requires a hysterectomy because of a life-threatening emergency situation. It was not possible for the physician to inform the beneficiary in advance that the surgery would make her permanently incapable of reproducing.
- The hysterectomy (as covered according to Medicaid policy) was performed during a period of retroactive eligibility.

13.3.B. ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION (MSA-2218)

Providers may use the following option or continue to attach a copy of the MSA-2218 to the claim without going through this pre-approval process. The MSA-2218 form is available on the MDCH website.

To encourage paperless billing and reduce administrative burden, MDCH allows for submission of the MSA-2218 via fax. Federal regulations require that this form be submitted to Medicaid before reimbursement can be made for any hysterectomy procedure. This process can eliminate submitting paper attachments for hysterectomy claims and pre-confirms the acceptability of the completed acknowledgement form, as well as reduces costly claim rejections.

13.3.C. PROCEDURE FOR ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION (MSA-2218) APPROVAL

- The provider who obtains the required Acknowledgement completes a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed acknowledgement form to the Medicaid Payments Division, Hysterectomy Acknowledgement Form Approval. (Refer to the Directory Appendix for contact information.) Do not fax invoices.

- The form is reviewed within five working days, and a notice of errors or acceptance is returned to the provider. When notified that the acknowledgement form has been accepted and is on file, inform the other providers via a copy of the response. All invoices related to the service may be submitted without attachments.
- If there is no response within five working days:
  - Confirm that the fax is working.
  - Be sure that the cover sheet included the necessary information for Medicaid staff to respond to the provider.
  - Resend the information if necessary.

13.4 ORGAN TRANSPLANTS

Medicaid covers organ transplants and related services if all requirements for these services are met. PA is required for all beneficiary, donor, and potential donor services related to all organ transplants except cornea and kidney transplants. If transplantation of additional organ(s) is to occur during the same operative session as a cornea or kidney transplant, PA is required.

Prior to surgery, the beneficiary must be evaluated at an accepted transplant center approved by the Office of Medical Affairs (OMA) to determine if he is a good transplant candidate. The attending physician must obtain the PA for this evaluation. If the beneficiary is accepted as a transplant candidate, the PA for the evaluation also covers the transplant and related services.

Authorization Instructions	If Medicare eligibility is denied, the denial notice must be attached to the PA request. If the Medicare application is still pending, this should be indicated on the PA request. Once a final determination is made, MDCH must be notified. The donor must exhaust all possible insurance sources before Medicaid is billed for the services. A copy of the letter of authorization for the evaluation for transplant that was sent to the attending physician from the OMA must be submitted with the claim.
Transportation and Lodging	Transportation and lodging expenses associated with the evaluation and the transplant are covered for the beneficiary and one accompanying individual (e.g., spouse, parent, guardian). The beneficiary's local FIA office should be contacted to make travel arrangements if the beneficiary has only Medicaid coverage or they are dually eligible for CSHCS and Medicaid. If the beneficiary only has CSHCS coverage, he must contact the CSHCS office in the LHD of the county where he resides to make travel arrangements. The mode of transportation should be that deemed medically necessary for the beneficiary by the attending physician.
Donor Searches	Charges for donor searches which do not result in an organ acquisition and transplant are covered as an outpatient service by the hospital and not covered for the physician.

13.5 STERILIZATION

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

Sterilizations are only covered if all of the following are met:

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

The only exception is in the case of premature delivery or emergency abdominal surgery. If the premature delivery or emergency abdominal surgery occurred before the 30-day waiting period is over, at least 72 hours must have passed between the time of obtaining informed consent and the sterilization procedure.

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

13.5.A. INFORMED CONSENT PROCESS

The following procedures must be included in the process of informed consent:

- The beneficiary must be advised that the sterilization will not be performed for at least 30 days after the informed consent to sterilization is signed, except in cases of emergency abdominal surgery or premature delivery.
- The person who obtains informed consent must offer to answer any questions the beneficiary may have concerning the procedure.
- Suitable arrangements must be made to ensure that information is effectively communicated to the deaf, blind, or otherwise handicapped.

- An interpreter must be provided if the beneficiary does not understand the language used on the informed consent form or the language used by the person obtaining informed consent.
- The beneficiary is permitted to have a witness of his choice present when informed consent is obtained.
- At the time of the informed consent, a copy of the consent form must be given to the beneficiary.

All of the following sterilization information and advice must be presented orally to the beneficiary both at the time the beneficiary signs the informed consent form and again by the physician performing the sterilization shortly before the procedure (e.g., during the pre-operative examination):

- Advice that the beneficiary is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the beneficiary might be otherwise entitled.
- A description of available alternative methods of family planning and birth control.
- Advice that the sterilization procedure is considered to be irreversible.
- A thorough explanation of the specific sterilization procedure to be performed.
- A full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
- A full description of the benefits or advantages that may be expected as a result of the sterilization.

The beneficiary, the person who obtained the consent, and the interpreter (if required) must sign the informed consent form not less than 30 days nor more than 180 days prior to the sterilization. The physician performing the sterilization must also sign and date the informed consent form after the sterilization has been performed.

No additional reimbursement is allowed for the examination or the sterilization explanation.

If the procedure occurs in a place other than that in which the consent form is signed (e.g., forms were signed in the physician's office, but the procedure will be rendered in the hospital), the person obtaining consent must send a copy of the completed form to the place of surgery. The second provider (e.g., hospital) is responsible for acquiring the physician's statement (if not previously documented) and for photocopying the signed form and supplying copies to any other Medicaid provider who is billing as a participant in the sterilization.

A copy of the completed MSA-1959 is required for coverage of charges related to a sterilization procedure. This form may be faxed or attached to the claim form.

13.5.B. Consent Form for Sterilization (MSA-1959)

Providers may use the following option or continue to attach a copy of the MSA-1959 to the claim without going through this pre-approval process. The MSA-1959 form is available on the MDCH website.

To encourage paperless billing and reduce administrative burden, MDCH allows for submission of MSA-1959 forms via fax. Federal regulations require that this form be submitted to MDCH before reimbursement can be made for any sterilization procedure. This process can eliminate submitting paper attachments for sterilization claims, and pre-confirms the acceptability of the completed consent form.

13.5.C. Procedure for Consent Form for Sterilization (MSA-1959) Approval

- The provider who obtains the required Consent and completed MSA-1959 completes a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed consent form to the Medicaid Payments Division, Sterilization Consent Form Approval. (Refer to the Directory Appendix for contact information.) Do not fax invoices.
- The form is reviewed within five working days, and a notice of errors or acceptance is returned to the provider. When notified that the consent form has been accepted and is on file, inform the other providers via a copy of the response. All invoices related to the service may be submitted without attachments.
- Providers may then submit claims (either electronic or hard copy) to Medicaid. The remarks section or appropriate electronic segment must include the statement "Consent on File."
- When sterilization claims are received with this information in the remarks section, consent form edit requirements are forced if the submitted invoice matches the consent form on file.
- If there is no response within five working days:
  - Confirm that the fax is working.
  - Be sure that the cover sheet included the necessary information for Medicaid staff to respond to the provider.
  - Resend the information if necessary.

13.5.D. Reversal of Sterilization

Services to reverse a previous sterilization are not covered by Medicaid.

SECTION 14 - DURABLE MEDICAL EQUIPMENT / ORTHOTICS / PROSTHETICS

Refer to the Medical Supplier Chapter of this manual for additional information.

SECTION 15 - PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES

15.1 PSYCHIATRIC SERVICES

Medicaid covers psychiatric services for diagnostic or active treatment purposes. Psychiatric services are covered by the local PIHP/CMHSP for services included under the capitation payments to the PIHPs/CMHSPs, and a limited outpatient benefit is covered for beneficiaries enrolled in MHPs. Services to beneficiaries not included in the capitation payments to the PIHPs/CMHSPs and not enrolled in Medicaid Health Plans are covered through FFS Medicaid. FFS limits outpatient visit coverage to a maximum of ten psychiatric visits in 12 months. Under FFS, only those psychiatric services personally rendered by a physician (MD or DO) are covered. Those services performed by other staff (e.g., psychologists, social workers, NPs, physician's assistants) are not covered. (Refer to the Medicaid Practitioner Database for specific services that are covered.)

Services provided to beneficiaries enrolled in MHPs must be authorized by the individual MHP. (Refer to the Medicaid Health Plans [MHPs] Chapter of this manual for additional information.)

(Refer to the Mental Health/Substance Abuse Chapter of this manual for services covered by the PIHPs/CMHSPs and authorization requirements.)

Psychological Testing	Medicaid covers psychological testing that is reasonable and necessary for diagnosing the beneficiary's mental or developmental status and strengths and needs. If a beneficiary requires psychological testing more than once per year, documentation of medical necessity must be maintained in the medical record. Psychological testing must be ordered by a physician (MD or DO) and must be performed by a psychologist who is fully licensed, limited-licensed, or temporary limited-licensed. This order must be kept in the beneficiary's clinical record. Supervision of limited-licensed and temporary limited-licensed psychologists must comply with the requirements of Michigan Public Act 368 of 1978, as amended. Psychological testing under FFS is only covered under the physician's provider ID number. The physician's provider ID number reported for coverage must be the ordering physician, the physician employing the psychologist, or a physician employed by the group which also employs the psychologist. The physician ordering psychological testing must examine the beneficiary. The physician employing the psychologist or employed by the same group that employs the psychologist does not need to examine the beneficiary in order to bill for the psychological testing unless that physician orders the psychological testing.
Inpatient Psychiatric Admissions	Inpatient stays in a psychiatric unit of a general hospital are covered for beneficiaries of any age. Inpatient treatment, including related psychiatric visits, in a freestanding psychiatric hospital, both private and state owned, is limited to eligible beneficiaries under age 21, and age 65 and older. If the beneficiary was an inpatient immediately prior to attaining age 21, he would be eligible to continue as an inpatient until age 22. If the beneficiary is discharged at some time following his 21st birthday, coverage terminates on the discharge date. All psychiatric admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Mental Health/Substance Abuse Chapter of this manual for specific coverages and authorization requirements.)

Psychiatric Partial Hospitalization	Psychiatric coverage includes partial hospitalization on a day-care or night-care plan for all beneficiaries, regardless of age. To be eligible for partial hospitalization, the beneficiary must be receiving active psychiatric treatment provided under the direction of a psychiatrist. All partial hospitalization admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Mental Health/Substance Abuse Chapter of this manual for specific coverages and authorization requirements.)

15.2 SUBSTANCE ABUSE SERVICES

Medicaid covers acute care detoxification in the inpatient hospital for FFS beneficiaries and through the MHPs for beneficiaries enrolled in Medicaid Health Plans.

Acute Care Detoxification	Admission to the acute care setting for a diagnosis of substance abuse must meet at least one of the following criteria as reflected in the physician's orders and patient care plans: ▪ Vital signs, extreme and unstable. Uncontrolled hypertension, extreme and unstable. ▪ Delirium tremens, (e.g., confusion, hallucinations, seizures) or a documented history of delirium tremens requiring treatment. ▪ Convulsions or multiple convulsions within the last 72 hours. ▪ Unconsciousness. ▪ Occurrence of substance abuse with pregnancy and monitoring the fetus is vital to the continued health of the fetus. ▪ Insulin dependent diabetes complicated by diabetic ketoacidosis. ▪ Suspected diagnosis of closed head injury based on trauma injury. ▪ Congestive heart disease or ischemic heart disease, or significant arrhythmia as examples of active symptomatic heart disease. ▪ Suicidal ideation and gestures necessitating suicidal precautions as part of treatment. ▪ Blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse. ▪ Blood alcohol level 400 mg/dl with diagnosis of alcohol dependence. ▪ Active presentation of psychotic symptoms reflecting an urgent condition.
Other Substance Abuse Services	Medicaid covers other substance abuse services provided to beneficiaries. These services are covered under capitation payments to the PIHPs/CMHSPs. (Refer to the Mental Health/Substance Abuse Chapter of this manual for coverage details and authorization requirements.)

SECTION 16 - PRIVATE DUTY NURSING

Refer to the Private Duty Nursing Chapter of this manual for additional information.

SECTION 17 - OCCUPATIONAL THERAPY

Medicaid covers medically necessary occupational therapy (OT) services that meet the requirements of this section. Evaluations must be ordered and a physician must prescribe therapy.

17.1 PRESCRIPTION REQUIREMENTS

For Medicaid or CSHCS coverage of OT, a physician's prescription must include:

- Name of the beneficiary;
- Therapy prescribed; and
- Diagnosis(es) or medical condition(s).

If therapy is not initiated within 30 days after the prescription date, a new prescription is required.

17.2 COVERAGE CONDITIONS

Services are covered as OT when provided by:

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

For CSHCS beneficiaries	OT must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the physician who is overseeing the care of the beneficiary. Functional progress must be demonstrated and documented.
For beneficiaries 21 years of age and older	OT is covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations, or participation restrictions.
For beneficiaries under age 21	OT must be medically necessary, reasonable, and required to: ▪ Return the beneficiary to the functional level prior to illness or disability; ▪ Return the beneficiary to a functional level that is appropriate to a stable medical status; and ▪ Prevent a reduction in medical or functional status had the therapy not been provided.

Therapy must require the skills, knowledge, and education of an OT. Interventions that could be expected to be provided by another practitioner (e.g., teacher, registered nurse, licensed physical therapist), family member, or caregiver are not covered as occupational therapy.

OT services may be covered for one or more of the following reasons:

- Therapeutic use of occupations;
- Adaptation of environments and processes to enhance functional performance in occupations;
- Graded tasks (performance components) in activities as prerequisites to engagement in occupations;
- Design, fabrication, application, or training in the use of assisted technology or orthotic devices; or
- Skilled services that are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers.

Occupational evaluations and therapy are covered when provided by a Medicaid-enrolled home health agency (HHA) in the home setting when:

- There is a need for adaptation of procedures, equipment, appliance, or prosthesis in the home setting identified by the OT;
- Services will prevent undue exposure to infection and stress for the beneficiary, as identified by the physician or treating nurse;
- The OTR, physician, or treating nurse documents problems with access to an outpatient facility, or coordination or continuity of services;
- Therapy must be initiated within 30 days of the prescription date. A new prescription is required if therapy is not initiated within 30 days of the original prescription; or
- OT may be provided up to a maximum of 24 times within the first 60 consecutive calendar days in the home setting without prior approval.

Some areas of therapy (e.g., dysphagia, assistive technology, hand therapy) may appropriately be addressed by more than one discipline (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. Duplication of service (i.e., where two disciplines are working on similar areas/goals) is not covered. It is the OTR's responsibility to communicate with other therapists and coordinate services. Documentation should include a report of this coordination.

School-aged beneficiaries may be eligible to receive OT through multiple sources. Educational OT is provided by the school system and is not covered by Medicaid. Educational OT includes coordination for handwriting, increasing attention span, identifying colors and numbers.

Evaluations	Evaluations are covered for the same medical diagnosis twice per year with a physician's order. If an evaluation is needed more frequently, prior approval is required. The occupational therapy evaluation must be completed by an OTR and must include: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis (e.g., medical diagnosis of cerebral palsy with contractures being treated). ▪ OT provided previously, including facility/site, dates, duration, and summary of change. ▪ Current therapy being provided to the beneficiary in this or other settings. ▪ Medical history as it relates to the current course of therapy. ▪ The beneficiary's current functional status (functional baseline). ▪ The standardized and other evaluation tools used to establish the baseline and to document progress. ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function. ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension).
Treatment Plan	The treatment plan consists of: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's life goals. ▪ Long-term goals that identify specific functional maximum reasonable achievement which serve as indicators for discharge from therapy. ▪ Anticipated frequency and duration of treatment required to meet short-term and long-term goals. ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational). ▪ Signature of physician verifying acceptance of the treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring physician.
Initiation of Services	Therapy may be initiated upon completion of the assessment and development of a treatment plan that is reasonable and medically necessary as documented in the beneficiary's record. For the initial 60-day treatment period, up to 24 OT services may be provided in the home setting. For the outpatient hospital setting, up to 36 OT services may be provided in the initial 90-day treatment period.

Requirements for Continued Active Therapy	To request PA to continue therapy beyond the initial 60 or 90 days, the OTR must complete an Occupational/Physical Therapy - Speech Pathology Prior Approval - Request/Authorization (MSA-115). The OTR may request up to 90 consecutive calendar days of continued active therapy in the outpatient hospital setting or up to 60 consecutive calendar days in the home setting. Requests to continue active therapy must be accompanied by: ▪ A treatment summary of the previous period of OT, including measurable progress on each short-term and long-term goal. This should include the treating OT's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. ▪ A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy. ▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ A copy of the prescription must be provided with each request. The prescription must be hand-signed by the referring physician and dated within 30 days prior to initiation of the continued service. ▪ A discharge plan. Requests for PA may be mailed or faxed to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.) After processing, MDCH returns a copy of the PA. This copy should be retained in the beneficiary's medical record.
Maintenance/Monitoring Services	In some cases, the beneficiary does not require active treatment, but the skills of an OTR are required for training or monitoring of maintenance programs that are being carried out by family and/or caregivers or continued follow-up for the fit and function of orthotic or prosthetic devices. PA is not required for these types of services for up to four times per 60-day period in the home or 90-day period in the outpatient hospital settings. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required. PA requests for continued maintenance/monitoring may ask approval for up to 90 consecutive calendar days in the outpatient setting and up to 60 consecutive calendar days in the home setting. The OT must complete an MSA-115 which must include: ▪ A service summary, including a description of the skilled services being provided. This should include the treating OT's analysis of the rate of progress and justification for any change in the treatment plan. Documentation must relate to the period immediately prior to that time period for which prior approval is being requested. ▪ A comprehensive description or copy of the maintenance/activity plan.

	▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ The anticipated frequency and duration of continued maintenance/monitoring. ▪ A discharge plan. Requests for PA may be mailed or faxed to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.) The copy of the MSA-115 returned to the provider should be retained in the beneficiary's medical record.

17.3 DISCHARGE SUMMARY

When the beneficiary is discharged from therapy services, a discharge summary must be on file with the OTR for identifying completion of services and status at discharge. The discharge summary includes:

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

SECTION 18 - PHYSICAL THERAPY

Medicaid covers medically necessary physical therapy (PT) services that meet the requirements of this section. A physician must order the evaluations and prescribe the therapy.

18.1 PRESCRIPTION REQUIREMENTS

For Medicaid or CSHCS coverage, a physician's prescription must include:

- Name of the beneficiary;
- Therapy prescribed; and
- Diagnosis(es) or medical condition(s).

If the therapy is not initiated within 30 days after the prescription date, a new prescription is required.

PT is covered in the following settings:

- Physician's office (provided by or under the direct supervision of the physician);
- Home (provided by a HHA); and
- Outpatient hospital.

18.2 COVERAGE CONDITIONS

Services are covered as PT when provided by:

- A Michigan-licensed physical therapist (LPT).
- A certified physical therapy aide (CPTA) under the supervision of an LPT. The LPT supervises and monitors the CPTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the appropriately licensed supervising LPT.
- A physician or under the physician's direct supervision, when provided in the physician's office.

For CSHCS beneficiaries	PT must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the physician who is overseeing the care of the beneficiary. Functional progress must be demonstrated and documented.
For beneficiaries 21 years of age and older	PT is covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations, or participation restrictions.
For beneficiaries under age 21	PT must be medically necessary, reasonable, and necessary to: ▪ Return the beneficiary to the functional level prior to illness or disability; or ▪ Return the beneficiary to a functional level that is appropriate to a stable medical status within a reasonable amount of time.

PT requires the skills, knowledge, and education of an LPT. Interventions that could be expected to be provided by another practitioner (e.g., teacher, registered nurse, registered occupational therapist), family member, or caregiver are not covered as PT.

Therapy services are covered for one or more of the following reasons:

- Therapy can be expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills.
- The service is diagnostic.
- Therapy is for a condition that is temporary in nature and creates decreased mobility.
- Skilled services are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers. Routine provision of the maintenance/prevention program is not reimbursable as therapy.

PT evaluations and therapy are covered when provided by a Medicaid-enrolled HHA in the home setting when:

- Services will prevent undue exposure to infection and stress for the beneficiary, as identified by the physician or treating nurse.
- Documented problems of access to an outpatient facility, coordination of services, or continuity of services, as identified by an LPT, physician, or treating nurse.
- PT does not require concurrent skilled nursing care but must be provided through a Medicaid-enrolled HHA.

If therapy is not initiated within 30 days after the prescription date, a new prescription is required.

PT may be provided up to a maximum of 24 times within the first 60 consecutive calendar days in the home setting without prior approval.

Some areas of therapy (e.g., dysphagia, assistive technology, hand therapy) may appropriately be addressed by more than one discipline (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. Duplication of service (i.e., where two disciplines are working on similar areas/goals) is not covered. It is the LPT's responsibility to communicate with other therapists and coordinate services. Documentation should include a report of this coordination.

School-aged beneficiaries may be eligible to receive PT through multiple sources. Educational physical therapy is provided by the school system and is not covered by Medicaid. Examples of educational PT include strengthening to play school sports, etc.

Evaluations	Evaluations are covered for the same medical diagnosis twice per year with a physician's order. If an evaluation is needed more frequently, PA is required. The PT evaluation must be completed by an LPT. It must include: ▪ The treatment diagnosis and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with gait being treated).

	▪ PT provided previously, including facility/site, dates, duration, and summary of change. ▪ Current therapy being provided to the beneficiary in this or other settings. ▪ Medical history as it relates to the current course of therapy. ▪ The beneficiary's current functional status (i.e., functional baseline). ▪ The standardized and other evaluation tools used to establish the baseline and to document progress. ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function. ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension).
Treatment Plan	The PT treatment plan consists of: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function and/or mobility. ▪ Long-term goals that identify specific functional maximum reasonable achievement which serve as indicators for discharge from therapy. ▪ Anticipated frequency and duration of treatment required to meet short-term and long-term goals. ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational). ▪ Signature of physician verifying acceptance of the treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring physician.
Initiation of Services	Therapy may be initiated upon completion of an evaluation and development of a treatment plan that is reasonable and medically necessary as documented in the beneficiary's medical record. PT may be provided up to a maximum of 24 times in the initial 60-day period in the home setting, or up to 36 times in the initial 90-day period in the outpatient hospital setting, or up to 20 times during a 75-day time period in the physician's office.
Requirements for Continued Active Therapy	To request approval to continue therapy beyond the initial 60 or 90 days, the LPT must complete an Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization (MSA-115). The LPT may request up to 90 consecutive calendar days of continued active therapy in the outpatient hospital setting or up to 60 consecutive calendar days in the home setting. PA is not required for continuation of physical therapy provided in the physician's office. Requests for PA may be mailed or faxed to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

	After processing, MDCH returns a copy of the PA. This copy should be retained in the beneficiary's medical record. Requests to continue active therapy must be accompanied by: ▪ A treatment summary of the previous period of PT, including measurable progress on each short-term and long-term goal. This should include the treating LPT's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. ▪ A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy. ▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ A copy of the prescription, hand-signed by the referring physician and dated within 30 days prior to initiation of continued service (must be provided for each request). ▪ A discharge plan.
Maintenance/Monitoring Services	In some cases, the beneficiary does not require active treatment, but the skills of an LPT are required for training or monitoring of maintenance programs that are being carried out by family and/or caregivers. PA is not required for these types of services for up to four times per 60-day period in the home setting or 90 days in the outpatient hospital setting. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required. Requests for PA may be mailed or faxed to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.) PA requests for continued maintenance/monitoring may ask approval for up to 90 consecutive calendar days in the outpatient setting and up to 60 consecutive calendar days in the home setting. The LPT must complete an MSA-115, which must include: ▪ A service summary, including a description of the skilled services currently being provided. This should include the treating LPT's analysis of the rate of progress and justification for any change in the treatment plan. ▪ A comprehensive description or copy of the maintenance/activity plan. A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.

	▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ A discharge plan. The copy of the MSA-115 returned to the provider should be retained in the beneficiary's medical record

18.3 DISCHARGE SUMMARY

When the beneficiary is discharged from PT, a discharge summary must be on file with the LPT for identifying the completion of services and the status at discharge. The discharge summary includes:

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

SECTION 19 - SPEECH AND LANGUAGE THERAPY

Medicaid covers medically necessary speech and language therapy services that meet the requirements of this section. A physician must order the evaluations and prescribe the therapy.

19.1 PRESCRIPTION REQUIREMENTS

For Medicaid or CSHCS coverage, a prescription for therapy must include:

- Name of the beneficiary;
- Therapy prescribed; and
- Diagnosis(es) or medical condition(s).

If therapy is not initiated within 30 days of the prescription date, a new prescription is required.

Speech therapy may be provided in the following settings:

- Hearing and speech center;
- Home (only for CSHCS beneficiaries) when provided by a HHA (see exceptions below); and
- Outpatient hospital.

19.2 COVERAGE CONDITIONS

Services are covered as speech-language therapy when provided by:

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

Exceptions: Speech evaluations and therapy are covered in the home setting for CSHCS beneficiaries when:

- There is a need for adaptation of procedures or equipment in the home setting as identified by an SLP.
- Services will prevent undue exposure to infection and stress for a child at risk, as identified by the physician or treating nurse.
- Documented problems of access to an outpatient hospital, coordination of services, or continuity of service is identified by an SLP, OTR, LPT, physician, or treating nurse.

- PA is obtained (this includes therapy for the initial 60 consecutive calendar days, continued active treatment, and maintenance/monitoring services).
- Speech-language evaluations and therapy services do not require concurrent skilled nursing care; however, treatment always requires PA and must be provided through a Medicaid-enrolled HHA.
- Therapy may be requested for up to 60 consecutive calendar days in the home setting.

For CSHCS beneficiaries who are not enrolled in Medicaid: Speech therapy must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the physician who is overseeing the care of the beneficiary.

For Medicaid beneficiaries who are not enrolled with CSHCS and who are under 21 years of age: Speech therapy must be obtained from a Medicaid enrolled hearing and speech center.

For Medicaid beneficiaries 21 years of age and older: Speech therapy may be provided by an outpatient hospital or a hearing and speech center.

For all beneficiaries: Speech therapy must relate to a medical diagnosis. Coverage is limited to services for:

- Articulation
- Language
- Rhythm
- Swallowing
- Training in the use of an augmentative communication device
- Training in the use of an oral-pharyngeal prosthesis
- Voice

For Medicaid beneficiaries who are receiving specialty mental health services through a PIHP/CMHSP, palliative therapy may be provided through the PIHP/CMHSP.

Therapy must be reasonable, medically necessary, and expected to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy would be when the treatment is required due to a recent change in the beneficiary's medical or functional status affecting speech and the beneficiary would experience a reduction in medical or functional status were the therapy not provided.

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

Some areas of service (e.g., dysphagia, assistive technology) may appropriately be addressed by more than one discipline (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. Duplication of service (i.e., where two disciplines are working on similar areas/goals) is not covered. It is the treating therapist's responsibility to communicate with other practitioners and coordinate services. Documentation should include a report of this coordination.

School-aged beneficiaries may be eligible to receive speech-language therapy through multiple sources. Educational speech is provided by the school system, and is not covered by Medicaid or CSHCS. Examples of educational speech include enhancing vocabulary, improving sentence structure, improving reading, increasing attention span, identifying colors and numbers.

Evaluations	Are covered for the same diagnosis twice per year with a physician's prescription. If an evaluation is needed more frequently, PA is required. The speech-language evaluation must be completed by an SLP and must include: ▪ The disorder and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with dysphagia as the speech disorder being treated). ▪ Speech therapy provided previously, including facility/site, dates, duration, and summary of measurable change. ▪ Current rehabilitation services being provided to the beneficiary in this or other settings. ▪ Medical history as it relates to the current course of therapy. ▪ The beneficiary's current functional communication status (functional baseline). ▪ The standardized and other evaluation tools used to establish the baseline and to document progress. ▪ Assessment of the beneficiary's functional communication skill level, which must be measurable. ▪ Medical, physical, intellectual deficits that could interfere with the beneficiary's improvement in therapy. Evaluations may include, but are not limited to: ▪ Articulation - standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication, and a medical diagnosis. ▪ Language - standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es). ▪ Rhythm - standardized tests that measure receptive and expressive language, mental age, oral motor skills, measurable assessment of dysfluency, current means of communication, and a medical diagnosis.

	▪ Swallowing - copy of the videofluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment, and a standardized cognitive assessment. ▪ Voice - copy of the physician's medical assessment of the beneficiary's voice mechanism and the medical diagnosis.
Treatment Plan	The speech-language therapy treatment plan consists of: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's communication needs. ▪ Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from speech-language therapy services. ▪ Anticipated frequency and duration of treatment required to meet short-term and long-term goals. ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational). ▪ Signature of physician verifying acceptance of stated treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring physician.
Initiation of Services	Therapy may be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without prior approval. For this initial period, speech therapy may be provided up to a maximum of 36 times during the 90 consecutive calendar days in the hearing and speech center or outpatient hospital. Speech therapy may be provided up to a maximum of 24 times during the 60 consecutive calendar days in the home.
Requirements for Continued Active Therapy for All Settings	To request approval to continue therapy beyond the initial 60 or 90 days (as applicable), the SLP must complete a PA request (the applicable form depending upon the setting). ▪ Special Services Prior Approval - Request/Authorization (MSA-1653-B) must be used for the hearing and speech center setting. ▪ Occupational/Physical Therapy - Speech Pathology Prior Approval - Request/Authorization (MSA-115) must be used for the outpatient hospital setting and services requested through a HHA for CSHCS. The SLP may request up to 90 consecutive calendar days of continued active therapy in the hearing and speech center or outpatient hospital settings or up to 60 consecutive calendar days for the CSHCS beneficiary receiving therapy in the home setting. Requests for PA may be mailed or faxed to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

	After processing, MDCH returns a copy of the PA. This copy should be retained in the beneficiary's medical record. Requests to continue active treatment must be accompanied by: ▪ A treatment summary of the previous period of service, including measurable progress on each short-term and long-term goal. This should include the treating SLP's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes. ▪ A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy. ▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ The anticipated frequency and duration of maintenance/monitoring. ▪ A discharge plan. ▪ A copy of the prescription, hand-signed by the referring physician and dated within 30 days prior to initiation of continued service (must be provided for each request).
Maintenance / Monitoring Services	In some cases, the beneficiary does not require active treatment, but the skills of an SLP are required for training or monitoring of maintenance programs that are being carried out by family and/or caregivers. In the outpatient hospital or hearing and speech center, these types of service may be provided without prior approval for up to four times per 90-day period. For the home setting, these types of services require prior approval for a 60-day period. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required. Requests for PA may be mailed or faxed to the Prior Authorization Division. (Refer to the Directory Appendix for contact information.) After processing, MDCH returns a copy of the prior approval. This copy should be retained in the beneficiary's medical record. Continued maintenance/monitoring requires prior approval in all settings. The SLP must complete the prior approval request which must include: ▪ A service summary, including a description of the current skilled services being provided. This should include the treating SLP's analysis of the rate of progress and justification for any change in treatment plan. It can cover up to three months. ▪ A comprehensive description or copy of the maintenance/activity plan.

	▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ The anticipated frequency and duration of continued maintenance/monitoring. ▪ A discharge plan.

19.3 DISCHARGE SUMMARY

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

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

SECTION 20 - CERTIFIED REGISTERED NURSE ANESTHETIST

Medicaid covers anesthesia services provided by a Medicaid enrolled Certified Registered Nurse Anesthetist (CRNA). CRNA services are covered for the CRNA or for the entity with which the CRNA has an employment or contract relationship that provides for payment to be made to the entity. CRNAs must comply with Michigan scope of practice licensing laws and regulations.

If a rural hospital elects reasonable cost reimbursement for CRNA services under Medicare, the CRNA costs are included in the facility payments to the hospital and are not covered separately by Medicaid.

For specific coverage parameters, see the Anesthesia Services Section of this chapter.

To enroll as a Medicaid provider, a CRNA must be currently licensed in Michigan as a nurse and certified by the State as a CRNA. Provider enrollment forms are available from the Medicaid Payments Division, Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

SECTION 21 - PHYSICIANS ASSISTANT

Medicaid covers services provided by a physician's assistant provided under the delegation and supervision of a physician licensed under part 170 or part 175 of Michigan Public Act 368 of 1978, as amended. The supervising physician must comply with the physician delegation and supervision requirements for utilizing physician's assistants specified in Public Act 368 of 1978, as amended, and any related rules promulgated by the State of Michigan or its Departments.

The physician's assistant may provide direct patient care under the delegation and supervision of a physician at the medical care site where the physician regularly sees patients. Records must demonstrate that the physician's assistant provided the services and that the licensed physician is regularly available and provides medical care to beneficiaries at the site on a routine basis. When the supervising physician is not physically present on the premises, he must be continuously available to the physician's assistant through direct communication such as telephone, radio, or telecommunication. This does not preclude licensed persons under the physician's delegation and supervision from making calls or going on rounds to private homes, public institutions, hospitals, or other health care facilities, as long as the care is a supplement to, and does not replace, the physician's personal services.

(Refer to the Surgery – General Section of this chapter for information on a physician's assistant functioning as an assistant at surgery.)

Medicaid only covers services performed by a physician's assistant under the delegating/supervising physician's provider identification number. The supervising physician is responsible for the services performed by the physician's assistant.

SECTION 22 - PODIATRIST

Medicaid covers the medically necessary services of a podiatrist. (Refer to the Medicaid Podiatrist Database on the MDCH website for specific covered services.)

Podiatrists should refer to the appropriate sections of this chapter for specific information related to the coverage of specific services.

22.1 CO-PAYMENT

A $2.00 co-payment is required for each separately covered visit for beneficiaries age 21 and older who are not residents in a nursing facility or are not receiving services covered by Medicare. If more than one separately covered service is rendered on the same day, such as an office visit and laboratory services, only one co-payment is required. If a procedure such as a surgery with a global period is rendered, only one co-payment is required.

22.2 CONSULTATIONS

Medicaid covers limited and intermediate level consultations if requested by a physician.

SECTION 23 - PHYSICAL THERAPIST

Medicaid only covers Medicare coinsurance and deductible amounts for services provided by enrolled physical therapists. A physician must order physical therapy services.

To qualify for coverage, services must be provided in the physical therapist's office. Services provided in the physician's office are covered under the physician, and services provided in a nursing facility setting are covered under the long term care provider. A licensed physical therapist (LPT) or a physical therapy assistant under the direct supervision of the physical therapist must provide services.

SECTION 24 - CERTIFIED NURSE MIDWIFE

Medicaid covers services provided by enrolled certified nurse midwives (CNMs). (Specific procedures covered for CNMs are listed in the Medicaid Certified Nurse-Midwife Database available on the MDCH website.)

CNM coverage includes the management of low risk and uncomplicated pregnancies and services to essentially normal women and newborns. Medically complicated pregnancies and services to beneficiaries with high-risk conditions MUST be referred to a physician. Services provided to high-risk women and women with medical complications are only covered under the delegation and supervision of a physician.

24.1 ENROLLMENT

The CNM must enroll with Medicaid by submitting a Medical Assistance Provider Enrollment Agreement (DCH-1625) and a copy of their license. A CNM must be able to demonstrate a safe mechanism for physician consultation, collaboration, and referral within an alliance agreement that includes mutually approved protocols.

24.2 FAMILY PLANNING

Medicaid covers family planning services provided by CNMs. (Refer to the Family Planning sub-section of this chapter for specific coverage information.) A CNM can only prescribe oral contraceptives under the delegation of a physician.

24.3 LABORATORY TESTS

Laboratory testing ordered by the CNM is covered and must be documented in the beneficiary's medical record by the ordering CNM regardless of where the tests are performed.

The following laboratory tests can be ordered by a CNM:

- Acetone and diacetic acid (ketone bodies), both qualitative and semi-quantitative
- Albumin, qualitative, semi-quantitative, and quantitative
- Antibody titer Rh system
- Blood typing, ABO, Rh(D), RBC antibody screening
- Blood count, RBC, WBC, hemoglobin, hematocrit, indices (MCV, MCH, MCHC)
- Culture, presumptive screening, for Neisseria, Gonorrhea, Candida, Hemophilus, or beta hemolytic Streptococci group A, etc.
- Culture, urine, definitive, with or without colony count
- Cytopathology, vaginal and/or cervical smears
- Glucose, qualitative, quantitative, timed specimen, tolerance
- Hemoglobin, electrophoretic separation, qualitative
- Hepatitis B test

- HIV detection
- Pregnancy test
- Quantitative sediment analysis and quantitative protein, 12- or 24-hour urine specimen
- Reticulocyte count, manual
- Routine prenatal laboratory services (OB profile)
- Rubella test, titer
- Syphilis test (VDRL, RPR, etc.), qualitative
- Sickle cell slide test
- TB skin test, tine
- Susceptibility (sensitivity) for aerobes
- Treponema antibodies, fluorescent, absorbed
- Complete urinalysis
- Wet mount, smear, tissue, direct microscopic examination

The following laboratory tests are covered when performed by the CNM:

- Complete urinalysis
- Direct microscopic examination of a smear, wet mount, and/or tissue for fungi
- Hematocrit
- Hemoglobin
- Pregnancy testing

These tests are not covered for the CNM if rendered by an outside laboratory.

24.4 MATERNITY CARE

Medicaid covers antepartum care, delivery, and postpartum care rendered by a CNM when provided in compliance with the specific coverage policies of this chapter.

Antepartum Care	Coverage for antepartum care includes all usual antepartum services provided prior to delivery and referral to Maternal Support Services (MSS) given the presence of psychosocial or nutritional factors that could adversely affect the pregnancy. If the provider initiated prenatal care within the first six months of pregnancy through the month of delivery, the appropriate antepartum care CPT code is covered. If the beneficiary is seen by several CNMs within a group or multiple CNMs supervised by the same physician or physician group, the antepartum care package is covered. (Refer to the Maternity Care and Delivery Services Section of this chapter for details on coverage of antepartum care and when individual E/M services are covered.)

	Enhanced coverage is available for CNM prenatal care services to women under 17 years of age or to women 35 years of age or older with their first pregnancy if these women are not medically at risk. (Refer to the Maternity Care and Delivery Services Section of this chapter for specific coverage information.) Enhanced coverage is also available for women with psychosocial or nutritional problems when confirmed by an enrolled MSS provider.
Delivery	Deliveries performed by a CNM are covered in a licensed setting only. Home deliveries and services associated with these deliveries are not covered. Coverage of the delivery includes monitoring, vaginal delivery, and resuscitation of the newborn infant when necessary.
Post-partum Care	Medicaid covers post-partum office visits following the delivery. Routine post-partum hospital care for the mother is covered as a part of the delivery. Routine care of the newborn in the hospital is covered for the provider who examines and provides the total hospital care of the newborn regardless of whether he performed the delivery. (Refer to the Services to Newborns sub-section in this chapter for additional coverage information.)

24.5 Office Visits

Visits not directly related to the antepartum care or follow up to a delivery, such as family planning visits, are covered under the appropriate office visit procedure code. (Refer to the Medicaid CNM Database on the MDCH website for a listing of office visit codes covered for CNMs.) (Refer to the Evaluation and Management (E/M) Services Section of this chapter for specific coverage information related to office visits.)

24.6 Pharmacy

Pharmaceuticals can only be ordered by a CNM under the delegation of a physician. The pharmaceutical must be provided by an enrolled pharmacy or, if appropriate, by an enrolled Family Planning Clinic (FPC).

SECTION 25 - NURSE PRACTITIONER

Medicaid covers the services of a nurse practitioner (NP) when provided pursuant to a current collaborative practice agreement with a physician. Evidence of consultation, as needed, between the NP and the physician is documented. Medicaid covers NP services only if the services would be covered if furnished by a physician. The services are not otherwise excluded from coverage, and the NP is legally authorized to perform the services under state law.

The services are subject to the limitations that apply to physician services. Certain services, such as long term care facility visits, consultations, and initial hospital care, may be restricted to physicians by program policy or federal and state statutes and are not covered for NPs. Professional services are only covered when the NP has personally performed the services.

Determination of the medical necessity and appropriateness of services is the responsibility of the NP/physician based on the terms of the agreement.

Services provided by NPs while a hospital employee are included in the hospital's charges and are not covered separately for the individual NP. Services that are covered for other enrolled providers, such as a home health agency, a long term care facility, a Family Planning Clinic (FPC), etc., are not separately covered for the NP. Services provided jointly by a NP and the supervising physician are covered for only one practitioner. Some services are only covered by Medicaid under the physician's ID number. (Refer to the appropriate section of this chapter for more information.)

NPs are not required to enroll in Medicaid. They may provide services to Medicaid beneficiaries under the employing physician's ID number.

Once enrolled, the NP may submit bills to MDCH directly if the beneficiary is in FFS Medicaid. For beneficiaries enrolled in a MHP, the NP must negotiate provider terms and payment arrangements with each individual MHP.

25.1 ENROLLMENT OF NURSE PRACTITIONER

In order for the NP to enroll, he must comply with all of the following:

- Meet state qualifications for nurse practitioners.
- Have an ambulatory based practice.
- Provide services according to the terms of a written collaborative practice agreement in place with a physician.
- Complete the appropriate enrollment forms and a Nurse Practitioner/Physician Agreement (DCH-1575).
- Attest to the type of nurse practice engaged in, such as pediatric, family, geriatric, adult, etc.
- If engaged in family or pediatric nurse practice, continue to provide proof of certification as a family nurse practitioner or a pediatric nurse practitioner by the appropriate accepted national credentialing body. (See Michigan Rule 338.10404 [3].)

25.2 COLLABORATIVE PRACTICE AGREEMENT

This is a formal document under which the NP and the physician deliver covered medical services. It is mutually developed or approved as satisfactory to both professionals involved and describes the kinds of services to be provided and any criteria for referral and consultation. This agreement must be available to MDCH upon request. Services must be delivered within each practitioner's scope of practice as allowed by federal regulations and state law. Services provided by the NP under the physician's delegation and supervision are also included.

The collaborative practice agreement must be reviewed at least annually and updated as necessary. The NP must notify MDCH if the agreement is dissolved so the NP's enrollment with Medicaid can be terminated. Medicaid only covers NP services provided within the provisions of the agreement.