50 State Medicaid Statute Survey

PART II
February 2011
Disclaimer

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Information contained in this report is current up to the date listed on the report. Note that the information is subject to change following action taken by a state’s legislature, state agencies, state medical boards, or other applicable state government agency or body. CTeL will make every effort to provide the most current information.

The views and opinions expressed in the forgoing publication are solely those of the author and do not necessarily represent the views and opinion of the Center for Telehealth & eHealth Law, its Board Directors, or its staff.

Methodology

This information in this report was compiled by contacting the Medicaid offices in all 50 states asking them:

1) If their state policy reimburses for Telehealth.
2) If their state policy reimburses for Telehomecare.

If the office responded in the affirmative, CTeL requested reimbursement documents to explain their state policy.

CTeL expresses appreciation to the State Medicaid offices for their cooperation.
Acknowledgements

Lydia Hall is a legislative assistant in the Government Relations and Regulatory Affairs practice group in the Washington, D.C. office of Drinker, Biddle & Reath. In her position as a legislative assistant, Lydia provides essential support for the practice group’s managers, directors and clients on a variety of health-related issues.

Originally from New England, Lydia graduated cum laude from Tufts University in 2008. During college, she held internships in the Washington offices of former Congressman Thomas Allen (D-ME) and the late Senator Edward Kennedy (D-MA). In her spare time, Lydia volunteers as a tutor for Horton’s Kids, a non-profit organization that works with at-risk youth in the Anacostia neighborhood.

Crystal LaMothe is a graduate from Stevenson University, and is currently pursuing a Master’s degree at Bowie State University in Maryland. Her diverse contributions to the health community include her serving as a volunteer with MedStar Washington Hospital Center; and working in-depth on projects for the Center for Telehealth & e-Health Law involving Medicare and Medicaid reimbursement, and White Papers.

Furthermore, Crystal’s prior encounters of remote communities within various Caribbean Islands has proven to be a driving force in her desire to see patrons within and across our borders gain access to telemedical services.

Chris Rieser is a legislative assistant in the Washington, D.C., office of Drinker Biddle & Reath. He has been with the firm since July of 2010. Chris works with a range of non-profit and for-profit health care clients providing both government relations and policy research services. He works on a variety of policy areas in the health care arena, including telehealth, medical devices, Medicare reimbursement and grassroots patient advocacy.

Chris graduated from the Georgetown Public Policy Institute with a Masters of Public Policy in May, 2010.
Welcome To CTeL

The Center for Telehealth & e-Health Law (CTeL) was founded in 1995 to overcome the legal and regulatory barriers to the utilization of telehealth and related e-health services. CTeL, formerly known as the Center for Telemedicine Law, was created under the vision and leadership of a number of individuals and organizations, including Dr. Yadin David, Bob Waters, the Mayo Foundation, the Cleveland Clinic, the Midwest Rural Telemedicine Consortium, and the Texas Children’s Hospital.

CTeL has established itself as a leader in the telehealth community and is known for its ability to compile and analyze complex legal, regulatory and public policy information. CTeL provides vital support to the community by providing critical analysis and information on legal and regulatory issues on topics such as reimbursement, licensure, telecommunications, FDA regulations, privacy, and accreditation.

For additional information about the Center for Telehealth & e-Health Law, please feel free to contact us at:

Center for Telehealth & e-Health Law
1500 K Street, NW
Suite 1100
Washington, DC 20005-3317
202.230.5090 | Fax 202.230.5300
info@ctel.org  |  www.ctel.org
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**Please Note:**
- The following ten states do not provide information regarding the coverage of telemedicine: Connecticut, Delaware, Iowa, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, Ohio, and Rhode Island.
- The District of Columbia does not provide information regarding the coverage of telemedicine.
KENTUCKY

Kentucky’s state Medicaid program does reimburse for wound care, tele-psychiatry and psychotherapy, end stage renal services, and family therapy or group psycho-therapy when services are provided through real-time telecommunications and conducted by a legally authorized representative for a medically necessary service.

In the area of tele-home care and remote monitoring services, Kentucky does not reimburse for telehealth
907 KAR 3:170. Telehealth consultation coverage and reimbursement.


STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.559(2), (7), 205.560

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.559 establishes the requirements regarding Medicaid reimbursement of telehealth providers and KRS 205.559(2) and (7) require the cabinet to promulgate an administrative regulation relating to telehealth consultations and reimbursement. This administrative regulation establishes the Department for Medicaid Services' coverage and reimbursement provisions relating to telehealth consultations in accordance with KRS 205.559.

Section 1. Definitions. (1) "Advanced registered nurse practitioner" or "ARNP" is defined by KRS 314.011(7).
(2) "Certified nutritionist" is defined by KRS 310.005(12).
(3) "Chiropractor" is defined by KRS 312.015(3).
(4) "Community mental health center" or "CMHC" means a facility that provides a comprehensive range of mental health services to Medicaid recipients of a designated area in accordance with KRS 210.370 to 210.485.
(5) "CPT code" means a code used for reporting procedures and services performed by physicians or other licensed medical professionals which is published annually by the American Medical Association in Current Procedural Terminology.
(6) "Department" means the Department for Medicaid Services or its designated agent.
(7) "Diabetes self-management education" means the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care.
(8) "Dietitian" is defined by KRS 310.005(3).
(9) "Encounter" means one (1) visit by a recipient to a telehealth spoke site where the recipient receives a telehealth consultation in real time, during the visit, from a provider at a telehealth hub site.
(10) "Federal financial participation" is defined in 42 C.F.R. 400.203.
(11) "GT modifier" means a modifier that identifies a telehealth consultation which is approved by the healthcare common procedure coding system (HCPCS).
(12) "Health care common procedure coding system" or "HCPCS" means a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).
(13) "Health care provider" means a Medicaid-enrolled provider, in accordance with 907 KAR 1:671 and 907 KAR 1:672, who is a:
(a) Licensed physician;
(b) Licensed advanced registered nurse practitioner;
(c) Certified physician assistant working under physician supervision;
(d) Licensed dentist or oral surgeon;
(e) Community mental health center;
(f) Psychologist with a license in accordance with KRS 319.010(5);
(g) Licensed clinical social worker;
(h) Chiropractor; or
(i) Licensed optometrist.
(14) "Hub site" means a telehealth site:
(a) Where the telehealth provider performs telehealth; and
(b) That is considered the place of service.
(15) "KenPAC" means the Kentucky Patient Access and Care System.
(16) "KenPAC PCM" means a Medicaid provider who is enrolled as a primary care case manager in the Kentucky Patient Access and Care System.
(17) "Legally-authorized representative" means a Medicaid recipient's parent or guardian if a recipient is a minor child, or a person with power of attorney for a recipient.
(18) "Licensed clinical social worker" means an individual meeting the licensure requirements established in KRS 335.100.
(19) "Licensed dietitian" is defined by KRS 310.005(11).
(20) "Licensed marriage and family therapist" is defined by KRS 335.300(2).
(21) "Licensed professional clinical counselor" is defined by KRS 335.500(3).
(22) "Medical necessity" or "medically necessary" means a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
(23) "Occupational therapist" is defined by KRS 319A.010(3).
(24) "Optometrist" means an individual licensed to practice optometry in accordance with KRS 320.210(2).
(25) "Physician" is defined by KRS 327.010(2).
(26) "Psychologist" is defined by KRS 311.550(12).
(27) "Physician assistant" is defined by KRS 311.840(3).
(28) "Psychiatric medical resident" means an individual who:
(a) Possesses a special faculty license in accordance with KRS 311.550(29); and
(b) Meets the qualifications for licensure requirements established in KRS 311.571(1) or (2); and
(c) Is a resident as defined by 42 C.F.R. 415.152.
(29) "Psychiatric registered nurse" means a registered nurse who:
(a) Has a master of science in nursing with a specialty in psychiatric or mental health nursing;
(b) Has a bachelor of science in nursing and at least one (1) year of experience in a mental health setting;
(c) Is a graduate of a three (3) year educational program and has at least two (2) years of experience in a mental health setting;
(d) Has an associate degree in nursing and at least three (3) years of experience in a mental health setting; or
(e) Has any level of education with American Nursing Association (ANA) certification as a psychiatric nurse.
(30) "Physician assistant" is defined by KRS 311.010(8).
(31) "Registered nurse" is defined by KRS 314.011(5).
(32) "Speech-language pathologist" is defined by KRS 334A.020(3).
(33) "Spoke site" means a telehealth site where the recipient receiving the telehealth consultation is located.
(34) "Telehealth consultation" is defined by KRS 205.510(15).
(35) "Telehealth provider" means a Medicaid-enrolled provider, in accordance with 907 KAR 1:671 and 907 KAR 1:672, performing a telehealth consultation at a hub site.

(36) "Telehealth site" means a hub site or spoke site that has been approved as part of a telehealth network established in accordance with KRS 194A.125.

(37) "Telepresenter" means an individual operating telehealth equipment at a spoke site to enable a recipient to receive a telehealth consultation.

(38) "Transmission cost" means the cost of the telephone line and related costs incurred during the time of the transmission of a telehealth consultation.

(39) "Two (2) way interactive video" means a type of advanced telecommunications technology that permits a real time telehealth consultation to take place between a recipient and a telepresenter at the spoke site and a telehealth provider at the hub site.

Section 2. Telehealth Coverage For Telehealth Not Provided in a Community Mental Health Center. (1) The department shall reimburse for the following telehealth consultations not provided via a community mental health center in accordance with the following provisions:

(a) Wound care with a CPT code of 97601 or 97602 provided by a physician or advanced registered nurse practitioner;
(b) A service, provided by a physician, chiropractor, optometrist, or ARNP, which has an evaluation and management code of 99201 through 99215;
(c) A service, provided by a physician, chiropractor, or ARNP, with an evaluation and management code of 99241 through 99255;
(d) A psychiatric diagnosis or evaluation interview with a CPT code of 90801 through 90802 if provided by:
   1. A psychiatrist;
   2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychologist if the psychologist also interacts with the recipient during the encounter;
   4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   6. A physician; or
   7. An ARNP;
(e) Outpatient individual psychotherapy with a CPT code of 90804 through 90809 if provided by:
   1. A psychiatrist;
   2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychologist if the psychologist also interacts with the recipient during the encounter;
   4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   6. A physician not to exceed four (4) encounters per recipient per year; or
   7. An ARNP not to exceed four (4) encounters per recipient per year;
(f) Outpatient individual interactive psychotherapy with a CPT code of 90810 through 90815 if provided by:
   1. A psychiatrist;
   2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychologist if the psychologist also interacts with the recipient during the encounter;
   4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   6. A physician not to exceed four (4) encounters per recipient per year; or
   7. An ARNP not to exceed four (4) encounters per recipient per year;
(g) Inpatient individual psychotherapy with a CPT code of 90816 through 90822 if provided by:
   1. A psychiatrist;
   2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the telehealth encounter;
   3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychologist if the psychologist also interacts with the recipient during the encounter;
   4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   6. A physician not to exceed four (4) encounters per recipient per year; or
   7. An ARNP not to exceed four (4) encounters per recipient per year;
(h) Inpatient individual interactive psychotherapy with a CPT code of 90823 through 90829 if provided by:
   1. A psychiatrist;
   2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychologist if the psychologist also interacts with the recipient during the encounter;
   4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
   6. A physician not to exceed four (4) encounters per recipient per year; or
   7. An ARNP not to exceed four (4) encounters per recipient per year;
(i) Other psychotherapy with a CPT code of 90845 through 90846 if provided by:
1. A psychiatrist;
2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician not to exceed four (4) encounters per recipient per year; or
7. An ARNP not to exceed four (4) encounters per recipient per year;
(j) Family therapy with a CPT code of 90847 if provided by:
1. A psychiatrist;
2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician not to exceed four (4) encounters per recipient per year; or
7. An ARNP not to exceed four (4) encounters per recipient per year;
(k) Family or group psychotherapy with a CPT code of 90849 through 90857 if provided by:
1. A psychiatrist;
2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician not to exceed four (4) encounters per recipient per year; or
7. An ARNP not to exceed four (4) encounters per recipient per year;
(l) Psychiatric medication management with a CPT code of 90862 if provided by:
1. A psychiatrist;
2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician not to exceed four (4) encounters per recipient per year; or
7. An ARNP not to exceed four (4) encounters per recipient per year;
(m) Interpretation of data to family or others with a CPT code of 90887 if provided by:
1. A psychiatrist;
2. A physician not to exceed four (4) encounters per recipient per year; or
3. An ARNP not to exceed four (4) encounters per recipient per year;
(n) A dialysis related service with a CPT code of 90918 through 90925 if provided by a physician or ARNP;
(o) Initial visit with a CPT code of 99304 through 99305 to a new or established patient in a nursing home if provided by a physician or ARNP;
(p) Subsequent visit with a CPT code of 99308 through 99310 to a patient in a nursing home if provided by a physician or ARNP;
(q) Discharge of a patient from a nursing home with a CPT code of 99315 if provided by a physician or ARNP;
(r) Speech therapy evaluation with a CPT code of 92056 if provided by a speech-language pathologist;
(s) Speech therapy treatment with a CPT code of 92057 if provided by a speech-language pathologist;
(t) Occupational therapy with a CPT code of 97003 if provided by an occupational therapist;
(u) Physical therapy with a CPT code of 97001 if provided by a physical therapist;
(v) Individual medical nutrition therapy with an HCPCS code of G0270 or a CPT code of 97802 through 97804 if provided by a licensed dietician or certified nutritionist;
(w) End stage renal disease services with an HCPCS code of G0308, G0309, G0311, G0314, G0315, G0317, or G0318 if provided by a physician or ARNP;
(x) Neurobehavioral status exam with a CPT code of 96116 if provided by:
1. A psychiatrist;
2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician not to exceed four (4) encounters per recipient per year; or
7. An ARNP not to exceed four (4) encounters per recipient per year;
(y) Patient diabetes self-management education regarding diabetes care planning including nutrition, exercise, medication, or blood glucose testing equipment:
1. If ordered by the physician, advanced registered nurse practitioner, or physician assistant who is managing the recipient’s diabetic condition;
2. If provided by a registered nurse or dietician; and
3. With a corresponding:
   a. HCPCS code of G0108 or G0109; or
   b. CPT code of 97802.
(2) The department shall not reimburse for a telehealth consultation if the consultation:
(a) Is not medically necessary; or
(b) requires a face-to-face contact with a recipient in accordance with 42 C.F.R. 447.371.
(3) A telehealth consultation shall require:
(a) The use of two (2) way interactive video;
(b) A referral by a health care provider;
(c) A referral by a recipient’s KenPAC PCCM if the comparable nontelehealth service requires a KenPAC PCCM referral; and
(d) A referral by a recipient’s lock-in provider if the recipient is locked-in pursuant to 42 C.F.R. 431.54 and 907 KAR 1:677.

Section 3. Coverage of Telehealth Provided by a Community Mental Health Center.
(1) The department shall reimburse for the following telehealth consultation provided via a community mental health center in accordance with the following provisions:
(a) A psychiatric diagnosis or evaluation interview with a CPT code of 90801 through 90802 if provided by:
   1. A psychiatrist;
   2. A physician;
   3. A psychologist with a license in accordance with KRS 319.010(5);
   4. A licensed marriage and family therapist;
   5. A licensed professional clinical counselor;
   6. A psychiatric medical resident;
   7. A psychiatric registered nurse;
   8. A licensed clinical social worker;
   9. An advanced registered nurse practitioner;
(b) Outpatient individual psychotherapy with a CPT code of 90804 through 90809 if provided by:
   1. A psychiatrist;
   2. A physician;
   3. A psychologist with a license in accordance with KRS 319.010(5);
   4. A licensed marriage and family therapist;
   5. A licensed professional clinical counselor;
   6. A psychiatric medical resident;
   7. A psychiatric registered nurse;
   8. A licensed clinical social worker;
   9. An advanced registered nurse practitioner;
(c) Outpatient individual interactive psychotherapy with a CPT code of 90810 through 90815 if provided by:
   1. A psychiatrist;
   2. A physician;
   3. A psychologist with a license in accordance with KRS 319.010(5);
   4. A licensed marriage and family therapist;
   5. A licensed professional clinical counselor;
   6. A psychiatric medical resident;
   7. A psychiatric registered nurse;
   8. A licensed clinical social worker;
   9. An advanced registered nurse practitioner;
(d) Inpatient individual psychotherapy with a CPT code of 90816 through 90822 if provided by:
   1. A psychiatrist;
   2. A physician;
   3. A psychologist with a license in accordance with KRS 319.010(5);
   4. A licensed marriage and family therapist;
   5. A licensed professional clinical counselor;
   6. A psychiatric medical resident;
   7. A psychiatric registered nurse;
   8. A licensed clinical social worker;
   9. An advanced registered nurse practitioner;
(e) Inpatient individual interactive psychotherapy with a CPT code of 90823 through 90829 if provided by:
   1. A psychiatrist;
   2. A physician;
   3. A psychologist with a license in accordance with KRS 319.010(5);
   4. A licensed marriage and family therapist;
   5. A licensed professional clinical counselor;
   6. A psychiatric medical resident;
   7. A psychiatric registered nurse;
   8. A licensed clinical social worker;
   9. An advanced registered nurse practitioner;
(f) Other psychotherapy with a CPT code of 90845 through 90846 if provided by:
   1. A psychiatrist;
   2. A physician;
   3. A psychologist with a license in accordance with KRS 319.010(5);
   4. A licensed marriage and family therapist;
   5. A licensed professional clinical counselor;
   6. A psychiatric medical resident;
   7. A psychiatric registered nurse;
   8. A licensed clinical social worker;
   9. An advanced registered nurse practitioner;
(g) Family therapy with a CPT code of 90847 if provided by:
   1. A psychiatrist;
   2. A physician;
   3. A psychologist with a license in accordance with KRS 319.010(5);
Section 7. Medical Records. (1) A request for a telehealth consultation from a health care provider and the medical necessity for the recipient is unable to provide informed consent and the recipient's legally-authorized representative is unavailable.

(3) The requirement to obtain informed consent before providing a telehealth consultation shall not apply to an emergency situation if the legally-authorized representative upon request.

(2) A copy of the signed informed consent shall be retained in the recipient's medical record and provided to the recipient or the recipient's legally-authorized representative upon request.

(f) The recipient shall have the right to object to the video taping of a telehealth consultation.

(e) The recipient shall have the right to exclude anyone from either site; and

(d) The dissemination, storage, or retention of an identifiable recipient image or other information from the telehealth consultation shall be performed in accordance with law establishing individual health care data confidentiality provisions;

(c) The recipient shall have access to medical information resulting from the telehealth consultation as provided by law;

(b) The recipient shall be informed of alternatives to the telehealth consultation that are available to the recipient;

(a) The recipient shall have the option to refuse the telehealth consultation at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of a Medicaid benefit to which the recipient is entitled;

Section 6. Informed Consent. (1) Before providing a telehealth consultation to a recipient, a health care provider shall document written informed consent from the recipient and shall ensure that the following written information is provided to the recipient in a format and manner that the recipient is able to understand:

(a) The recipient shall have the option to refuse the telehealth consultation at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of a Medicaid benefit to which the recipient is entitled;

(b) The recipient shall be informed of alternatives to the telehealth consultation that are available to the recipient;

(c) The recipient shall have access to medical information resulting from the telehealth consultation as provided by law;

(d) The dissemination, storage, or retention of an identifiable recipient image or other information from the telehealth consultation shall comply with 42 U.S.C. 1301 et seq., 45 C.F.R. Parts 160, 162, 164, KRS 205.566, 216.2927, and any other federal law or regulation or state law establishing individual health care data confidentiality provisions;

(e) The recipient shall have the right to be informed of the parties who will be present at the spoke site and the hub site during the telehealth consultation and shall have the right to exclude anyone from either site; and

(f) The recipient shall have the right to object to the video taping of a telehealth consultation.

(2) A copy of the signed informed consent shall be retained in the recipient's medical record and provided to the recipient or the recipient's legally-authorized representative upon request.

3. A psychologist with a license in accordance with KRS 319.010(5);

4. A licensed marriage and family therapist;

5. A psychiatric medical resident;

6. A psychiatric registered nurse;

7. A psychiatrist.

(b) If a CMHC, in accordance with 907 KAR 1:045; or

(c) If provided by an ARNP, an amount equal to the amount paid for a comparable in-person service in accordance with 907 KAR 3:010; or

(2) The department shall not reimburse for a telehealth consultation if the consultation:

(a) Is not medically necessary; or

(b) Requires a face-to-face contact with a recipient in accordance with 42 C.F.R. 447.371.

(3) A telehealth consultation shall require:

(a) The use of two (2) way interactive video;

(b) A referral by a health care provider;

(c) A referral by a recipient's lock-in provider if the recipient is locked-in pursuant to 42 C.F.R. 431.54 and 907 KAR 1:677.

Section 4. Reimbursement. (1) The department shall reimburse a telehealth provider for a telehealth consultation:

(a) Except for a telehealth consultation provided by an ARNP or CMHC, an amount equal to the amount paid for a comparable in-person service in accordance with 907 KAR 3:010;

(b) If a CMHC, in accordance with 907 KAR 1:045; or

(c) If provided by an ARNP, an amount equal to the amount paid for a comparable in-person service in accordance with 907 KAR 1:104.

(2) A telehealth provider shall bill for a telehealth consultation using the appropriate evaluation and management CPT or HCPCS codes specified in Section 2 or 3 of this administrative regulation along with the corresponding two (2) letter "GT" modifier.

(3) The department shall not require the presence of a health care provider requesting a telehealth consultation at the time of the telehealth consultation unless it is requested by a telehealth provider at the hub site.

(4) The department shall not reimburse for transmission costs.

Section 5. Confidentiality and Data Integrity. (1) A telehealth consultation shall be performed on a secure telecommunications line or utilize a method of encryption adequate to protect the confidentiality and integrity of the telehealth consultation information.

(2) Both a hub site and a spoke site shall use authentication and identification to ensure the confidentiality of a telehealth consultation.

(3) A provider of a telehealth consultation shall implement confidentiality protocols that include:

(a) Identifying personnel who have access to a telehealth transmission;

(b) Usage of unique passwords or identifiers for each employee or person with access to a telehealth transmission; and

(c) Preventing unauthorized access to a telehealth transmission.

(4) A provider’s protocols and guidelines shall be available for inspection by the department upon request.

Section 6. Informed Consent. (1) Before providing a telehealth consultation to a recipient, a health care provider shall document written informed consent from the recipient and shall ensure that the following written information is provided to the recipient in a format and manner that the recipient is able to understand:

(a) The recipient shall have the option to refuse the telehealth consultation at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of a Medicaid benefit to which the recipient is entitled;

(b) The recipient shall be informed of alternatives to the telehealth consultation that are available to the recipient;

(c) The recipient shall have access to medical information resulting from the telehealth consultation as provided by law;

(d) The dissemination, storage, or retention of an identifiable recipient image or other information from the telehealth consultation shall comply with 42 U.S.C. 1301 et seq., 45 C.F.R. Parts 160, 162, 164, KRS 205.566, 216.2927, and any other federal law or regulation or state law establishing individual health care data confidentiality provisions;

(e) The recipient shall have the right to be informed of the parties who will be present at the spoke site and the hub site during the telehealth consultation and shall have the right to exclude anyone from either site; and

(f) The recipient shall have the right to object to the video taping of a telehealth consultation.

(2) A copy of the signed informed consent shall be retained in the recipient's medical record and provided to the recipient or the recipient's legally-authorized representative upon request.

(3) The requirement to obtain informed consent before providing a telehealth consultation shall not apply to an emergency situation if the recipient is unable to provide informed consent and the recipient's legally-authorized representative is unavailable.

Section 7. Medical Records. (1) A request for a telehealth consultation from a health care provider and the medical necessity for the
telehealth consultation shall be documented in the recipient's medical record.

(2) A health care provider shall keep a complete medical record of a telehealth consultation provided to a recipient and follow applicable state and federal statutes and regulations for medical recordkeeping and confidentiality in accordance with KRS 194A.060, 422.317, 434.840 - 434.860, 42 C.F.R. 431.300 to 431.307, and 45 C.F.R. 164.530(j).

(3) A medical record of a telehealth consultation shall be maintained in compliance with 907 KAR 1:672 and 45 C.F.R. 164.530(j).

(4) Documentation of a telehealth consultation by the referring health care provider shall be included in the recipient's medical record and shall include:
   (a) The diagnosis and treatment plan resulting from the telehealth consultation and a progress note by the referring health care provider if present at the spoke site during the telehealth consultation;
   (b) The location of the hub site and spoke site;
   (c) A copy of the signed informed consent form; and
   (d) Documentation supporting the medical necessity of the telehealth consultation.

(5)(a) A telehealth provider's diagnosis and recommendations resulting from a telehealth consultation shall be documented in the recipient's medical record at the office of the health care provider who requested the telehealth consultation.

(b) A telehealth provider shall send a written report regarding a telehealth consultation within thirty (30) days of the consultation to the referring health care provider.

Section 8. Federal Financial Participation. A provision established in this administrative regulation shall be effective contingent upon the department's receipt of federal financial participation for the respective provision.

Section 9. Appeal Rights. (1) An appeal of a department determination regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

(2) An appeal of a department determination regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) A provider may appeal a department-written determination as to the application of this administrative regulation in accordance with 907 KAR 1:671. (28 Ky.R. 150; Am. 1430; eff. 12-19-2001; 30 Ky.R. 1861; 2055; eff. 3-18-2004; 32 Ky.R. 1934; 2279; eff. 7-7-2006; 35 Ky.R. 1923; 2456; 2757; eff. 7-6-2009.)
LOUISIANA

Louisiana’s state Medicaid program does reimburse for medical and behavioral telehealth services at 100% of the face-to-face reimbursement rate.

In the area of tele-home care and remote monitoring services, Louisiana does not reimburse for tele-health.
PROFESSIONAL SERVICES PROVIDER TRAINING

Fall 2007

LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency that establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, to administer certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by DHH. This includes payment of Medicaid claims; processing of certain financial transactions; utilization review of provider claim submissions and payments; processing of pre-certification and prior authorization requests; and assisting providers in understanding Medicaid policy and procedure and correctly filing claims to obtain reimbursement.

This training packet has been developed for presentation at the Fall 2007 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis of the workshops is on policy and procedures that affect Medicaid billing.

This packet does not present general Medicaid policy such as recipient eligibility and ID cards, and third party liability. The 2006 Basic Training packet may be obtained by downloading it from the Louisiana Medicaid website, www.lamedicaid.com.
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| 80 – Assistant Surgeon   |                                    |                              | MD’s = 20% of the full service physician fee on file.  
Certified Nurse Midwives = 80% of MD’s ‘Assistant Surgeon’ fee. |
| AS – First Assistant in Surgery: Qualified Phys. Assistant, Nurse Practitioner, or Clinical Nurse Specialist |                     |                              | 80% of MD’s ‘Assistant Surgeon’ fee      |
| AT – Acute Treatment     | Chiropractors use this modifier when reporting service 98940, 98941  |                              | Fee on file                            |
| GT – Telemedicine        | Services provided via interactive audio and video telecommunications system | Modifier should be appended to all services provided via telemedicine and be documented in the clinical record at both sites. | 100% of the fee on file |
| Q5 – Reciprocal Billing Arrangement | Services provided by a substitute physician on an occasional reciprocal basis not over a continuous period of longer than 60 days. Does not apply to substitution within the same group. | The regular physician submits the claim and receives payment for the substitute. The record must identify each service provided by the substitute. | 100% of the fee on file |
| Q6 – Locum Tenens        | Services provided by a substitute physician retained to take over a regular physician’s practice for reasons such as illness, pregnancy, vacation, or continuing education. The substitute is an independent contractor typically paid on a per diem or fee-for-time basis and does not provide services over a period of longer than 60 days. | The regular physician submits claims and receives payment for the substitute. The record must identify each service provided by the substitute. | 100% of the fee on file |
Telemedicine is generally described as the use of an interactive audio and video telecommunications system to permit real time communication between distant site health care practitioners and patients. Louisiana Medicaid requires that providers use the HIPAA compliant modifier to identify services provided via telemedicine.

Claim Submission

Medicaid covered services provided using telemedicine must be identified on claim submissions by appending the modifier “-GT” (via interactive audio and video telecommunications system) to the applicable procedure code. The recipient’s clinical record at both the originating and distant sites should reflect that the service was provided through the use of telemedicine.
RURAL HEALTH CLINICS
PROVIDER MANUAL

Chapter Forty of the Medicaid Services Manual

Issued December 1, 2010

State of Louisiana
Bureau of Health Services Financing
RURAL HEALTH CLINICS

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Medical/Behavioral Encounters

Medical/behavioral health services are reimbursed as encounters. Encounter visits must be billed on a CMS-1500 using encounter code T1015. The encounter reimbursement includes all services provided to the recipient on that date of service and any services on a subsequent day incident to the original encounter visit. In addition to the encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and total charges for each service provided on subsequent lines.

When behavioral health services are the only services provided during an encounter, and they are administered by a licensed clinical social worker or a clinical psychologist, the RHC provider identification number must be placed as both the billing and attending provider with the appropriate modifiers and detail line procedure codes on the claim.

A visit to pick up a prescription or a referral is not considered a billable encounter. Lab or x-ray services with no “face-to-face” encounter with a covered RHC provider do not constitute an RHC visit and will not be reimbursed separately as they are part of the original medical encounter which warranted these additional services.

If a covered service is provided via an interactive audio and video telecommunications system (telemedicine), it must be identified on the claims form by appending the Health Insurance Portability and Accountability Act (HIPAA) 1996 complaint modifier “GT” to the appropriate procedure code.

For obstetrical services, providers must bill the encounter code T1015 with modifier TH and all services performed on that date of service. When this modifier is used, the visit is not counted in the 12 office and other outpatient visit limit for recipients 21 years and older.

**NOTE:** Medical encounter services not covered through the Professional Services Program are not covered through the RHC Program.

Adjunct Services

RHC adjunct services should be billed with the T1015 encounter code, the appropriate detail procedure, along with the adjunct service procedure code. The adjunct service procedure code may not be submitted as the only “detail line” for the encounter. Providers should bill their usual and customary charges for payment of the adjunct procedure code.
Maine’s state Medicaid program provides for Medicaid reimbursement for telemedicine services. Maine’s Medicaid policy follows that of private insurance coverage in regards to telemedicine reimbursement. The current law is framed to permit “insurer approval of telemedicine networks.” It also “allows deductibles, copayments and coinsurance the same as for in-person health services and provides for coverage consistent with in-person health care services.” In regards to coverage for telemedicine services, state statute carefully defines telemedicine as “the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. ‘Telemedicine’ does not include the use of audio-only, telephone, facsimile machine, or e-mail.” Medicaid reimbursement also covers telepsychiatry and ER tele-consultations.

In the area of tele-home care and remote monitoring services, Maine does not provide reimbursements.
DATE:       July 30, 2010

TO:         Interested Parties

FROM:       Anthony Marple, Director, Office of MaineCare Services

SUBJECT:    Major Substantive Emergency Rule: Chapter 101, MaineCare Benefits Manual, Chapters II & III, Section 40, Home Health Services

This letter gives notice of an emergency rulemaking for MaineCare Benefits Manual, Chapters II and III, Section 40, Home Health Services. These are Major Substantive rules and will not be permanently adopted until approved by the Legislature. The Department is adopting through emergency rule-making, amendments to MaineCare Benefits Manual, Section 40, Chapters II and III, Home Health Services. In order to meet Center for Medicare and Medicaid Services certification requirements for HIPAA-compliant codes, the Department is adopting the Maine Integrated Health Management System (MIHMS) which will be effective September 1, 2010. Chapter II of the emergency rule-making directs providers to the new website addresses for CMS definitions related to billing and for the new billing instructions and billing codes for services and non routine medical supplies that will be utilized by MIHMS. The amendment redefines “unit of service” improving consistency and clarifying it related to the new HIPAA compliant codes in Chapter III. The amendment adds a new definition for “non routine medical supplies”, directs providers how to access the list of non routine medical supplies which can be reimbursed under Section 40 and creates a process for adding to this list. Chapter III of this emergency rule provides the new HIPAA-compliant codes and the associated units of service that must be used by Home Health Services providers to bill for services when MIHMS is implemented. Existing codes remain in effect until implementation of MIHMS.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at, http://www.maine.gov/dhhs/bms/rules/provider_rules_policies.htm or for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

If you have any questions regarding the policy, please contact your Provider Relations Specialist at 624-7539, option 8 or 1-800-321-5557 extension option 8 or TTY:(207)287-1828 or 1-800-606-0215
Notice of Agency
Emergency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: Chapter 101, MaineCare Benefits Manual, Chapters II and III, Section 40, Home Health Services.

ADOPTED RULE NUMBER:

CONCISE SUMMARY: This is emergency rulemaking. These are changes to major substantive rules and they will not be permanently adopted until they have been approved by the Legislature. The Department is adopting through emergency rule-making, amendments to MaineCare Benefits Manual, Section 40, Chapters II and III, Home Health Services. In order to meet Center for Medicare and Medicaid Services requirements for HIPAA-compliant codes, the Department is adopting the Maine Integrated Health Management System (MIHMS) which is expected to become operational in the near future. Chapter II of the emergency rule-making directs providers to the new website addresses for CMS definitions related to billing and for the new billing instructions and billing codes for services and non routine medical supplies that will be utilized by MIHMS. The amendment adds a new definition for “non routine medical supplies”, directs providers how to access the list of non routine medical supplies which can be reimbursed under Section 40 and creates a process for adding to this list. It redefines the unit of service, making it consistent with the services associated with the new HIPAA compliant codes. Chapter III of this emergency rule provides the new HIPAA-compliant codes and the associated units of service that must be used by Home Health Services providers to bill for services when MIHMS is implemented.

These rules are not expected to have an adverse impact on small businesses, municipalities or counties.


EFFECTIVE DATE: September 1, 2010

AGENCY CONTACT PERSON: Margaret Brown, Division of Policy
AGENCY NAME: MaineCare Services
Division of Policy
ADDRESS: 442 Civic Center Drive
11 State House Station
Augusta, Maine 04333-0011

TELEPHONE (207) 287-5505   FAX: (207) 287-9369
TTY: 1-800-606-0215 or 207-287-1828 (Deaf/Hard of Hearing)
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* Effective when the MaineCare claim system MIHMS is implemented.
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40.01 DEFINITIONS

40.01-1 Authorized Agent shall mean the organization authorized by the Department to perform functions pursuant to a contract or which are specified in a written agreement. The Authorized Agent will perform medical eligibility determinations and prior authorizations of services as required.

40.01-2 Certification Period shall mean the months, days, years, which identify the period covered by the physician’s plan of care. The “From” date for the initial certification must match the start of care date. The “To” date can be up to, but never exceed, two (2) calendar months and mathematically never exceed sixty-two (62) days. Recertifications shall follow the same length of time requirements.

40.01-3 Classification Period shall mean the period of time, designated by a start and end date established by the Department or its Authorized Agent, approved for coverage of home health services, in accordance with Section 40.08.

40.01-4 Contraindicated shall mean the member’s condition renders some particular line of treatment improper or undesirable.

40.01-5 Duration shall mean the length of time the services are to be rendered and may be expressed in days, weeks, or months. This must be specified on the physician certified plan of care.

40.01-6 Extensive Assistance means although the individual performed part of the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:

- Weight-bearing support three (3) or more times, or
- Full staff performance during part (but not all) of the last seven (7) days.

40.01-7 Frequency shall mean the number of visits per discipline to be rendered, stated in days, weeks, or months. This must be specified on the physician certified plan of care.

40.01-8 Functionally Significant Improvement is the demonstrable, measurable increase in the individual’s ability to perform specific tasks or motions that contribute to independence outside the therapeutic environment.

40.01-9 Home Health Agency (HHA) means a voluntary, public or private organization, or a part of such organization, that is certified under Title XVIII of the Social Security Act for reimbursement for the delivery of home health services.

40.01-10 Home Health Aide Services are those in-home services that are provided by a certified home health aide and which are delegated and supervised by a registered nurse. A certified home health aide must have satisfactorily completed a training program for certified nurse assistants, consistent with the rules and regulations of the
40.01 DEFINITIONS (cont.)

40.01-10 Home Health Aide Services (cont.)

Maine State Board of Nursing. Home health aides employed by a home health agency must also have completed an agency orientation as defined by the regulations Governing the Licensing and Functioning of Home Health Care Services.

40.01-11 Home Health Services are those skilled nursing and home health aide services, physical and occupational therapy services, speech-language pathology services, medical social services, and the provision of certain medical supplies, needed on a “part-time” or “intermittent” basis. Services are delivered by a Medicare certified home health agency to a member in his or her home or in other particular settings with limitations as described in Section 40.06. Services are delivered according to the orders of a licensed physician and an authorized plan of care.

In a nursing facility (NF) setting, only physical therapy, occupational therapy and/or speech-language pathology services may be delivered by a home health agency if the NF’s MaineCare reimbursement rate does not include these services.

40.01-12 Intermittent, in general, shall mean skilled nursing care needed on fewer than seven (7) days each week or less than eight (8) hours each day for periods of up to twenty-one (21) days (or longer in exceptional circumstances when the need for care is finite and predictable); but as defined in CMS Publication 11 “Medicare Home Health Agency Manual,” and the regulations issued pursuant thereto as are most currently in effect. This manual is available on line at http://www.cms.hhs.gov/Manuals/PBM/list.asp.

40.01-13 Medical Social Services are assessment, counseling, and assistance services that are needed by a member to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the member’s medical condition or to affect his or her rate of recovery. Services are provided by a social worker who is functioning within the scope of the license granted by the state or province in which the services are performed and who has had at least one (1) year of social work experience in a health care setting. Medical social services must be required in conjunction with a skilled nursing service, physical therapy, occupational therapy or speech-language pathology services.

A licensed social worker shall receive consultation in accordance with State of Maine Board of Social Work Registration and the Rules and Regulations of the Board of Social Work. The licensed social worker with more than two (2) years experience shall receive consultation from a licensed master social worker, a licensed clinical social worker, or a certified social worker on a quarterly basis.

** See Below

40.01-14 Non Routine Medical Supplies are supplies that are necessary for a particular procedure ordered by a physician to be provided by Home Health Services. Non Routine medical supplies meet the following criteria:

** Effective when the MaineCare claim system MIHMS is implemented.
**See Below** 40.01-14 **Non Routine Medical Supplies** (cont.)

A. The non routine medical supply must be medically necessary and reasonable for the Home Health Agency provider to use in performance of the specific service for the individual Member as ordered by the physician in the order for service.

B. The non routine medical supply must be an item that is consumable, in that its use is of limited duration and it will be discarded after use. The use of the supply is confined to the one member for the particular procedure ordered by the physician.

C. The non routine medical supply is appropriate for use in the member’s place of residence as defined in 40.02-3.

D. The covered non routine medical supply must be outside the scope of usual supplies generally utilized as part of the services the Home Health Agency provides. Examples of routine supplies include cotton swabs, alcohol wipes and latex gloves. Routine supplies are not separately reimbursed and are considered part of the rate for the Home Health Service.

40.01-15 **Nursing Services** are those services that are provided by a registered nurse (RN) and/or a licensed practical nurse, which holds a current license issued by the state or province in which services are performed.

40.01-16 **Occupational Therapy Services** are those restorative services provided in accordance with physician orders, by an Occupational Therapist Registered (OTR) or by a Certified Occupational Therapist Assistant (COTA) under the direct supervision of an OTR, licensed by the state or province in which services are provided and acting within the scope of that license.

40.01-17 **One-person Physical Assist** requires one (1) person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting. This does not include cueing.

40.01-18 **Part-time**, in general, shall mean less than eight (8) hours a day or twenty-eight (28) hours a week; but as defined in CMS Publication 11 “Medicare Home Health Agency Manual” and the regulations issued pursuant thereto as are most currently in effect. This manual is available online at [http://www.cms.hhs.gov/Manuals/PBM/list.asp](http://www.cms.hhs.gov/Manuals/PBM/list.asp).

40.01-19 **Physical Therapy Services** are those restorative services provided in accordance with physician orders, by a physical therapist or by a physical therapist assistant working under the direct supervision of a licensed physical therapist, licensed by the state or province in which services are provided and acting within the scope of that license.

** Effective when the MaineCare claim system MIHMS is implemented.
Major Substantive Rule

40.01-20 Psychiatric Nursing Services are services provided by a registered professional nurse that is licensed by the state or province in which services are provided and has met requirements for approval to practice as an advanced practice psychiatric nurse or is certified as a psychiatric and mental health nurse by the appropriate national accrediting body.

40.01-21 Rehabilitation Potential is the documented expectation by a physician of measurable, “functionally significant improvement” (defined in Section 40.01-8) in the member’s condition in a reasonable, predictable period of time as the result of the prescribed treatment plan. The physician documentation of rehabilitation potential must include the reasons used to support the physician expectation and must follow guidelines detailed in MaineCare Benefits Manual (MBM), Chapter II, Section 90, Physician Services.

40.01-22 Speech-Language Pathology Services are those restorative services which are furnished in accordance with physician orders by a speech-language pathologist or speech language pathology assistant licensed by the state or province in which services are provided, who is acting within the scope of that license, and services meet the conditions described in Chapter II, Section 109 of the MBM. Services may be delivered by a speech-language pathology assistant who is registered and supervised by a Board licensed speech-language pathologist, as provided by 32 M.R.S.A., Section 6003 (7-A).

40.01-23 Start of Care Date (SOC) shall mean the first billable visit. This date remains the same on subsequent plans of care until the member is discharged.

40.01-24 The Unit of Home Health Service is fifteen (15) minutes of personal contact in the member's place of residence made for the purpose of providing a covered service by a health worker on the staff of a home health agency or by others under contract or arrangement with the home health agency. If the Unit of service is described as a "visit", providers will be reimbursed for one fifteen minute Unit regardless of the length of the visit. When two (2) or more persons simultaneously provide separate and distinct types of services, each provider's service is billed separately.

40.01-25 Unstable Medical Condition exists when the member’s condition is fluctuating in an irregular way and/or is deteriorating and affects the member's ability to function independently. The fluctuations occur to such a degree that medical treatment and professional nursing observation, assessment and management are required at least three (3) times per week. An unstable medical condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record.

** Effective when the MaineCare claim system MIHMS is implemented.
Major Substantive Rule

40.02 ELIGIBILITY FOR CARE

40.02-1 General and Specific Requirements

An individual may be found eligible to receive services as set forth in this Section, if he or she meets both the General MaineCare Eligibility Requirements and the Home Health Services Medical Eligibility Requirements.

40.02-2 General MaineCare Eligibility Requirements. Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

40.02-3 Home Health Services Medical Eligibility Requirements. A member must meet the following requirements:

A. The medical condition of the member must be such that it can be safely and appropriately treated by the home health agency under a plan of care reviewed and signed by a physician every certification period; AND

B. The member must be in a place of residence and NOT in an institution that meets the definition of a hospital, nursing facility or ICF-MR except as allowed under Section 40.01-11 and Section 40.06; AND

C. Home health services shall not be provided if services are available and safely accessible to the member on an outpatient basis. The plan of treatment signed by both the physician and the home health agency must include a statement of the medical necessity for receiving services at home citing the specific reasons outpatient care is contraindicated (defined in 40.01-4) or not possible. The reasons must be listed and the likelihood of a bad outcome must be probable or definite as opposed to possible or rarely; AND

D. Observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness/injury where these indications are part of a longstanding pattern of the member’s condition and there is no significant change in health status; AND

E. The condition of the member must require skilled nursing care on a “part-time” (as defined in Section 40.01-18) or “intermittent” (as defined in Section 40.01-12) basis or otherwise no less than twice per month, or physical therapy services, or speech-language pathology services, or occupational therapy services as described below.

   1. intraarterial, intravenous, intramuscular or subcutaneous injection, or intravenous feeding, all for treatment of unstable conditions requiring medical or nursing intervention. Daily insulin injections for an individual whose diabetes is under control do not meet the requirements of this Section; or
2. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past thirty (30) days) or unstable condition; or

3. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within the past thirty (30) days) or unstable condition; or

4. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, second or third degree burns, open surgical sites, fistulas, tube sites and tumor erosions); or

5. administration of oxygen on a regular and continuing basis when the member's medical condition warrants professional nursing observation for a new or recent (within past thirty (30) days) condition; or

6. professional nursing assessment, observation and management of an unstable medical condition (see Section 40.01-25); or

7. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the member's medical record; or

8. care to manage conditions requiring a ventilator/ respirator (Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BiPAP) system or wearing an airway clearance system vest does not meet the requirements of this Section); or

9. direct assistance from a professional nurse is required for the safe management of an uncontrolled seizure disorder (i.e.: grandmal); or

10. assessment and management for a new or recent medical condition (within the past thirty (30) days); or

11. professional nursing care and monitoring for administration of treatments, procedures, or dressing changes, which involve prescription medications, according to physician orders, at least twice per month. Treatments include:
   a. administration of medication via a tube;
   b. tracheostomy care;
Major Substantive Rule

40.02 ELIGIBILITY FOR CARE (cont.)

40.02-3 Home Health Services Medical Eligibility Requirements. (cont.)

c. urinary catheter change;
d. urinary catheter irrigation;
e. barrier dressings for Stage 1 or 2 ulcers;
f. chest PT by RN;
g. oxygen therapy by RN;
h. other physician ordered treatments; or
i. teaching and training activities for patient and family;

or

12. professional nursing care for members receiving:
   a. radiation therapy;
   b. chemotherapy given intravenously or by injection; or
   c. hemodialysis or peritoneal dialysis;

or

13.a. physical therapy or occupational therapy services as part of a planned program that is designed, established and provided by, and requires the professional skills of a licensed or registered therapist. (Therapy services may be delivered by a qualified licensed or certified therapy assistant under the direction of a qualified professional therapist.) The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame. The need for maintenance or preventative therapy does not meet the requirements of this Section.

   b. in addition to the requirements in Section 40.02-3(E)(13)(a), members aged twenty-one (21) or older, seeking occupational or physical therapy services must have rehabilitation potential (defined in Section 40.01-21) documented by a physician;

or

14. speech-language pathology services as part of a planned program that is designed, established, and provided by and requires the professional skills of a licensed speech-language pathologist or speech-language pathology assistant supervised by a Board licensed speech-language pathologist.

Members age twenty-one (21) and over must be assessed by a physician. The physician must provide documentation that the member has experienced a significant decline in his or her ability to communicate orally, safely swallow, or masticate and has rehabilitation potential (defined in Section 40.01-21). The documentation of the
40.02-3  **Home Health Services Medical Eligibility Requirements.** (cont.)

Physician’s assessment must be signed by the physician and be part of the member’s record.

For continued eligibility beyond the initial certification period for members age twenty-one (21) and over, the home health agency must obtain a report completed by the speech-language pathologist documenting the member’s progress and prognosis for improved speech, mastication, or swallowing functioning. The report must be forwarded to the member’s physician for confirmation that rehabilitation potential still exists for the member. The report must be amended and signed by the physician to document the rehabilitation potential of the member. This report must be maintained in the member’s medical record.

40.02-4  **Medical Eligibility Requirements for Psychotropic Medication Services.** A member may receive in-home psychotropic medications if he or she meets ALL of the following requirements:

A. The member has a severe and disabling mental illness that meets the eligibility requirements set forth in Section 17.02, Community Support Services for persons with Severe and Disabling Mental Illness. A copy of the Department’s approved Section 17 assessment tool shall be completed pursuant to the requirements in Section 17.

The signed assessment shall be maintained in the member’s medical record. A copy of the signed assessment must be submitted to the Department along with the start of care form; AND

B. The member requires psychotropic medication administration or monitoring for psychotropic medication; AND

C. The member is not receiving psychotropic medication services under any other Sections of the MBM (except physician services are allowed); AND

D. Home health services shall not be provided if services are available and safely accessible to the member on an outpatient basis. The plan of treatment signed by both the physician and the home health agency must include a statement of the medical necessity for receiving services at home citing the specific reasons outpatient care is contraindicated (defined in 40.01-4) or not possible. The reasons must be listed and the likelihood of a bad outcome must be probable or definite as opposed to possible or rarely.
40.02 ELIGIBILITY FOR CARE (cont.)

40.02-5. Prior authorization (PA) requirements. The HHA must obtain prior authorization from the Department or its Authorized Agent for all members age twenty-one (21) and older in the following circumstances:

A. Home health nursing and aide services and medical social services must be prior authorized after the first two (2) consecutive certification periods (defined in 40.01-2). This subsection pertains to these particular home health services received after the enactment of legislation in 2004, which changed the prior authorization requirement from sixty (60) to one hundred-twenty (120) days. This subsection is no longer in effect after the implementation of Section 40.02-5 (B) below.

B. Effective January 20, 2006, all home health services must be prior authorized after the first two (2) consecutive certification periods (defined in 40.01-2) or

C. A member who qualifies under 40.02-4 and requires psychotropic medication administration or psychotropic medication monitoring as his/her only services, shall be exempt from prior authorization for these services. If the member requires any additional home health services, these shall require prior authorization prior to providing services. In this circumstance, the home health agency cannot authorize services for the first two (2) consecutive certification periods.

The Department or its Authorized Agent must determine if the member continues to meet the eligibility for care requirements in Section 40.02. Members receiving services under Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities are not eligible for reimbursement for services under this Section because these services are also covered under Section 19.

40.03 DURATION OF CARE

Each MaineCare member is eligible to receive as many covered services as are medically necessary as long as the member meets the eligibility requirements as set forth in Section 40.02, and services are provided in accordance with a valid, authorized certification period as required in Section 40.08-2, and there is a valid prior authorization when PA is required (see 40.02-5). The Department reserves the right to request additional information to evaluate medical necessity. Coverage will be denied if the services provided are not specified in the authorized plan of care.

Home health services shall be reduced, denied, or terminated by the Authorized Agent or the Department, as appropriate, if any of the following situations occur:

A. The member declines home health services;
Major Substantive Rule

40.03 **DURATION OF CARE** (cont.)

B. A significant change occurs in the member’s medical or functional status such that a plan of care can no longer be developed and implemented safely;

C. The member does not meet the medical eligibility criteria for home health services as set forth in Section 40.02-3, as determined by the Authorized Agent or the Department;

D. The member is not financially eligible to receive MaineCare benefits;

E. When the member’s most recent assessment, and the clinical judgment of the Authorized Agent, determine that the authorized plan of care must be changed or reduced to match the member’s needs as identified in the assessment, the plan of care shall be modified by the Authorized Agent, or the Department, to reflect the change in needs;

F. The member has provided fraudulent information in connection with obtaining services;

G. The Department, or the Authorized Agent, documents that the member, or other person living or visiting the member’s residence, harasses, threatens or endangers the safety of individuals delivering services;

40.04 **STANDARDS OF CARE**

**General Regulatory Compliance**

All home health agencies must meet the following standards to qualify for MaineCare reimbursement:

A. In order to qualify for reimbursement under this Section, a home health agency must have in effect a license pursuant to the Department’s Regulations Governing the Licensing and Functioning of Home Health Care Services, as are currently in effect. A home health agency must also comply with all requirements of Title XIX of the Social Security Act and the regulations issued pursuant thereto, as are most currently in effect. These standards are incorporated into this Section by reference as if set out fully herein. The home health agency must have in effect a current MaineCare provider agreement with the MaineCare program.

B. In order to qualify for reimbursement under this Section a home health agency must have in effect a current Medicare certification to participate pursuant to §1861(o) and 1891 of the Social Security Act and the regulations found at 42 CFR, Part 484, and regulations issued pursuant thereto as are most currently in effect. These standards are incorporated into this Section by reference as if set out fully herein.

40.05 **COVERED SERVICES**

A covered service is a service for which payment to a provider is permitted under this Section of the MaineCare Benefits Manual. In order to be reimbursed under this Section, covered services must be delivered under a timely and complete plan of care, signed and certified by a qualified physician. The plan of care must meet the requirements of Section 40.08. The CMS-485 must be completed for each member under this Section.
40.05 COVERED SERVICES (cont.)

A. Skilled Nursing Services. To be covered as skilled nursing services, the services must meet the following conditions:

1) require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, to be safe and effective, considering the inherent complexity of the service, the condition of the member and accepted standards of medical and nursing practice; and

2) be medically necessary to the treatment of the member’s illness or injury. Medical necessity of services is based on the condition of the member at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period; and

3) be required on an intermittent or part-time basis (as defined in Section 40.01-12 and 40.01-18). To meet the requirement for intermittent skilled nursing care, a member must have a medically predictable recurring need for skilled nursing service; and be ordered by the physician for the member and are included in the physician’s plan of care.

B. Home Health Aide Services. The services must be required in conjunction with a skilled nursing service as described in 40.05(A) or physical therapy or occupational therapy as described in 40.05(C). Home health aide services must be ordered by the physician and specified as to frequency and duration in the physician’s plan of care for the member. The services must be medically necessary to provide personal care to the member, to maintain health, or to facilitate treatment of the member’s illness. Covered services include, but are not limited to:

1) personal care services;

2) simple dressing changes that do not require the skills of a registered or licensed nurse;

3) assisting the member with self-administering medications that do not require the skills of a registered or licensed nurse; home health aides cannot administer medications;

4) assistance with activities that directly support skilled therapy services and are listed on the Maine State Board of Nursing approved nursing assistant skills checklist;

5) routine care of prosthetic and orthotic devices;

6) incidental services. When a home health aide visits a member to provide a health-related service, the home health aide may also perform some incidental services that do not meet the above definition (for example, light cleaning, preparing a meal, removing trash, or shopping). However, the purpose of the home health aide visit must not be solely to provide these incidental services.
C. Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services.

The Department may review at any time a member’s plan of care and other records to determine if therapy services are medically necessary and in accordance with the requirements of this Section. If the Department, or its Authorized Agent, determines that the therapy services are no longer medically necessary, the Department will not reimburse the HHA for continuing services. Therapy services are otherwise reimbursable only if all of the conditions set forth in this Section are met.

Physical therapy, occupational therapy and speech-language pathology services must meet the following criteria:

1) prescribed by a physician;

2) directly and specifically related to an active treatment regimen;

3) of such a level, complexity and sophistication that the judgment, knowledge, and skills of a licensed therapist are required;

4) performed by a licensed therapist or by a licensed therapist assistant under the supervision of a licensed or registered therapist, each operating within the scope of his or her license;

5) provided based on the physician’s assessment that the member has rehabilitation potential (defined in Section 40.01-21) and will improve significantly in a predictable period.

a. Once rehabilitation potential has been established for members aged twenty-one (21) or older, they are specifically eligible only for physical and occupational therapy in the following circumstances:

i. treatment following an acute hospital stay for a condition affecting range of motion, muscle strength, and physical functional abilities. Services must be initiated within sixty (60) days from the date of the physician’s certification of the member’s rehabilitation potential; and/or

ii. treatment after a surgical procedure performed for the purpose of improving physical function. Services must be initiated within sixty (60) days from the date of the physician’s certification of the member’s rehabilitation potential; and/or
Major Substantive Rule

40.05 COVERED SERVICES (cont.)

iii. treatment in those situations in which a physician has documented that the member has, in the preceding thirty (30) days, required extensive assistance (defined in Section 40.01-6) with at least one-person physical assist (defined in Section 40.01-17) in the performance of one (1) or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility;

iv. palliative care is limited to one (1) visit per year to design a plan of care and train the member or caretaker of the member to implement the plan or to reassess the plan of care;

6) considered under accepted standards of medical practice to be a specific and effective treatment for the member’s condition;

and

7) certified by the physician in a current certification period.

D. Medical Social Services. Medical social services that are provided by a qualified medical social worker may be covered as home health services when medical social services are required in conjunction with a skilled nursing service as described in 40.05(A) or physical therapy or occupational therapy as described in 40.05(C); AND when:

1) the services of these professionals are necessary to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the member’s medical condition or to affect his or her rate of recovery; and

2) the plan of care indicates how the services that are required necessitate the skills of a qualified medical social worker.

3) services may include: assessments of the social and emotional factors related to the member’s illness, need for care, response to treatment and adjustment to care; assessment of the relationship of the member’s medical and nursing requirements to the member’s home situation, financial resources, and availability of community resources; appropriate action to obtain available community resources to assist in resolving the member’s services to address general problems that do not clearly and directly impede treatment or recovery, as well as long-term social services, such as ongoing alcohol counseling, are not covered.

4) certified by the physician in a current certification period.
**Section 40 Covered Services (cont.)**

1) In order to carry out the physician ordered service for the Member, it may be necessary for the Home Health Services provider to obtain and utilize particular medical supplies that are required for performance of the ordered procedure. The Home Health Service provider can bill for these “non routine medical supplies”, as defined in Chapter II, Section 40.01-14, in addition to the per unit rate it is paid.

2) The Department or its designee will maintain a Home Health Services Supply List of non routine medical supplies covered under Chapter II. Only non routine medical supplies meeting the criteria contained in Section 40.01-14 and included on this list may be approved for reimbursement by the Department. The Department will make the list readily available to providers directly from the Department and electronically at the Provider Tab, “Portal Tools” section in the “Procedure Code Lookup” at: http://www.maine.gov/dhhs/oms.

3) All covered supplies must be billed in accordance with the billing instructions for Home Health Services providers. Non routine medical supplies covered under Section 40 must be billed at the lower of either the acquisition cost or the durable medical equipment price which can be found at: http://portalxw.bisoex.state.me.us/oms/proc/pub_proc.asp?cf=mm

4) Members or providers on behalf of Members may request coverage for an item not currently on the Home Health Services Supply List by sending a written request to the Division of Consumer Services, explaining how the item meets the criteria of Section 40.01-14. In order to add an item to the Home Health Services Supply List for reimbursement, the Department or its designee must be satisfied that the item meets the criteria for a “non routine medical supply” as defined by Section 40.01-14.

40.06 Limitations

Services delivered under this Section shall not duplicate any other services delivered to the member. Duplication includes, but is not limited to:

A. Services under this Section shall not be reimbursed for members who are receiving services under Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities, because nursing services and personal care services are provided under this Section.

**Effective when the MaineCare claim system MIHMS is implemented.**

B. Home health aide services shall not be reimbursed for members who are receiving services under Section 2, Adult Family Care Services, or Section 12, Consumer Directed Attendant Care Services, or Section 21 Home and Community-Based Waiver Services for the Mentally Retarded or Section 22, Home and Community-Based Waiver Services for the Physically Disabled. Personal care services are covered services under these Sections.

C. If the member resides in a Section 50, ICF-MR, a home health agency may provide services only if the facility’s MaineCare reimbursement rate, or the facility’s contract with the state agency, does not include these services. Home health aide services shall not be reimbursed in Section 97 (PNMI) and Section 50 (ICF-MR) settings because personal care services are a covered service under these Sections.
Major Substantive Rule

D. Nursing and home health aide services delivered to a member who is receiving Section 96, Private Duty Nursing (PDN) Services & Personal Care Services, shall count towards the member’s authorized PDN cap. Occupational therapy, physical therapy, and speech-language pathology services may be provided and do not count toward the member’s PDN cap.

E. Excluding members whose medical condition is “unstable” (as defined in Section 40.01-25), assessment and management services, as well as teaching and training services, are limited to two (2) certification periods or a maximum of one hundred twenty (120) days, per admission.

40.07 NON-COVERED SERVICES
The following services are not reimbursable by the MaineCare Program under this Section:

A. Parenting skills training.

B. Nursing services, physical therapy, and occupational therapy exercises that may be carried out by the member, or family member or friend who is trained, willing and able to safely perform the service after receiving instruction from the appropriate home health care professional.

C. Services provided by a personal care attendant.

D. Laboratory services as defined in Section 55 of this Manual.

E. Blood glucose monitoring, i.e. glucometer, if the member is stable and does not need teaching of diabetic management.
Major Substantive Rule

40.07 NON-COVERED SERVICES (cont.)

F. Routine foot care, unless the member suffers severe circulatory impairment, or metabolic, neurological, or systemic diseases where nonprofessional care may pose a threat to the member's condition.

G. Homemaking services (for example; vacuuming, laundry) and chore services, except when delivered as "incidental" services, as described in Section 40.05 (B).

H. RN supervisory visits made for the purpose of supervising home health aide services to the member.

I. Nursing evaluation visits, unless skilled observation and assessment by a licensed nurse would result in a change of the treatment of the member.

J. Visits made solely to remind the member to follow instructions.

K. Services that can be appropriately provided by other community resources, e.g., homemaker services, adult protective services, "Meals on Wheels".

L. Respite services.

M. Venipuncture if this is the sole skilled service provided during the visit.

N. Custodial care.

O. A monthly injection if this is the sole skilled nursing service provided during the visit.

P. Monthly catheter change, beyond the acute phase.

40.08 POLICIES AND PROCEDURES

40.08-1 Prior Authorization Requirement

For all services under this Section that require prior authorization (see Section 40.02-5), the Department or its Authorized Agent shall conduct the eligibility assessment and reassessment as required in order to approve a prior authorization request. Home health services will be authorized only if all requirements set forth in this Section are met. Prior authorization determines only medical necessity of the authorized service and does not establish or waive any other prerequisites for payment, such as member eligibility or coverage by other third party payor.

Submission of request. In order to receive reimbursement, a HHA must request an assessment and receive approval from the Authorized Agent before providing services after the first two (2) consecutive certification periods (defined in Section 40.01-2).
40.08 **POLICIES AND PROCEDURES** (cont)

A. The HHA shall submit prior authorization requests in accordance with procedures set forth by the Department.

B. Notice of Approval. For all approved prior authorization requests for home health services, the Authorized Agent will provide written notice to the HHA.

C. Notice of Denial or Modification and Right to Appeal. For all denied or reduced prior authorization requests, the Authorized Agent will notify both the member and the HHA of the denial or modification, reason, right to appeal, and appeal procedures (see Section 40.08-5).

D. The home health agency must notify the Department of a member’s start of care date for the initial certification period. The admit/discharge form must be submitted to the Department within fourteen (14) days of admission. If services continue into a consecutive certification period, the HHA must notify the Department with an updated CMS 485 no later than five (5) days after the start of this second certification period, and with any subsequent consecutive certification period. The home health agency must also submit documentation of rehabilitation potential as described in Section 40.02-3(E)(13b) and (14) for physical therapy, occupational therapy, and speech-language pathology services for initial and consecutive certification periods for members receiving these services.

E. When prior authorization is required, all home health services shall be prior authorized and covered for an approved classification period. It is the responsibility of the home health agency to submit a request for prior authorization when prior authorization is required. When prior authorization is required, the home health agency must submit the referral form. The beginning and end dates of the individual’s classification period correspond to the beginning and end dates for MaineCare coverage. In order for home health services coverage to continue uninterrupted, the home health agency must submit the Department’s authorized request form to the Authorized Agent five (5) calendar days prior to the end date of the current classification period

**40.08-2 Plan of Care Requirements**

In accordance with licensing requirements, all home health services must be provided under a plan of care established by the HHA, individually for each member.

A. Providers Qualified to Establish a Plan of Care.

1. The member’s physician must establish a written plan of care. The physician must recertify and sign the plan of care for each certification period (Section 40.01-2).
40.08 POLICIES AND PROCEDURES (cont.)

40.08-2 Plan of Care Requirements (cont.)

2. A HHA nurse or skilled therapist or social worker may establish an additional, discipline oriented plan of care, when appropriate. These plans of care may be incorporated into the physician’s plan of care or prepared separately, but do not substitute for the physician’s plan of care.

B. Content of the Plan of Care. The orders on the plan of care must specify the nature, frequency and duration of each service to be provided to the member and the type of professional who must provide it. The physician must sign the plan of care before the HHA submits its claim for those services to the Department for payment. The plan of care must contain:

1. all pertinent diagnoses, including the member’s mental status;

2. the types of services, supplies, and equipment ordered;

3. the frequency and duration of the visits for each discipline to be made. A discipline may be one (1) or more of the following: skilled nursing, physical therapy, speech-language pathology services, occupational therapy, medical social services, or home health aide;

4. the prognosis, rehabilitation potential, goals, functional limitations, permitted activities, nutritional requirements, medications, and treatments;

5. any safety measures to prevent injury;

6. the discharge plans;

7. any additional items the home health agency or physician chooses to include;

8. the member’s address and type of residence, whether private home or residential care facility, etc; and

9. identify any other community resources and services, as well as care management, care coordination, targeted case management or social work services.
Major Substantive Rule

40.08 POLICIES AND PROCEDURES (cont.)
40.08-2 Plan of Care Requirements (cont.)

C. Certification Period. Both the plan of care, required under Section 40.08-2 (A)(1), and the discipline-oriented plan of care, as provided for in 40.08-2 (A)(2), must be reviewed and signed by a physician for each certification period as defined in Section 40.01-2.

D. Verbal Orders.

1. Services that are provided from the beginning of the certification period and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician if:

   a. the clinical record contains a documented verbal order for the care before the services are furnished; and

   b. the services are included in a signed plan of care.

2. Any increase in the frequency of services or any addition of new services during a certification period must be authorized in advance by a physician with verbal or written orders. The Department will pay for care provided based on verbal orders only if they are followed by a written order signed by the physician before the Department is billed.

40.08-3 Awaiting Placement

A member who is currently receiving home health services under this Section and who no longer meets the eligibility criteria under this Section, but has been determined eligible, by the Department or its Authorized Agent, for any of the following in-home long term care services, Section 96, Private Duty Nursing & Personal Care Services, any Home and Community Benefit program, Section 43 Hospice Services, or Section 12, Consumer Directed Attendant Services, may be classified as “awaiting placement”. “Awaiting placement” status may be used, if necessary, until an appropriate service provider begins delivering services. Under awaiting placement status, members will be covered for services under this Section.

“Awaiting placement” classification is for a specified period of time approved by the Department or its Authorized Agent. For coverage to continue beyond the approved period, the HHA must submit a completed request form along with a current CMS 485, to the Authorized Agent at least five (5) calendar days prior to the end date of the member’s approved period. If upon review, the Department or its Authorized Agent determines the member is no longer eligible for any of the other in-home programs, continued coverage for home health services shall be denied.
Content of Records

There shall be a specific record for each member, which shall include, but not necessarily be limited to:

1. The member's name, address, and birth date;
2. The name of the attending physician;
3. The member's social and medical history and diagnosis;
4. The member's need for teaching and the member's ability to learn;
5. Community resources available to meet the needs of the member;
6. A personalized plan of care, which meets the requirements in Section 40.08-2;
7. Plans for coordination with other health care agencies for the delivery of services. For psychiatric nursing services, plans will include coordination with other mental health and social services agencies;
8. Discharge plan for the member;
9. Written progress notes and/or flow sheets including (at a minimum):
   a. Identification of the service provided, the date, and the provider;
   b. Progress toward the achievement of long and short-range goals;
   c. Signature of the service provider; and
   d. Date and full description of any unusual condition or unexpected event.
10. Entries are required for each date of service billed;
11. The plan of care signed and reviewed as necessary by the supervising physician;
12. Documentation of skilled nursing and home health aide hours. The HHA must maintain records, which show the entrance and exit times of each skilled nurse’s and each aide’s visits and total time spent in the home by each. Exclude travel time;
13. The signed CMS-485 must be retained and available upon request. Complete the form in its entirety. Do not leave any blank items. However, there are items where “not applicable” (N/A) is acceptable.
14. Documentation of rehabilitation potential as defined in this Section for members receiving physical therapy, occupational therapy and speech-language pathology services.

**Member Appeals**

See Chapter I of the MaineCare Benefits Manual for information regarding appeals. Members under age twenty-one (21) years shall submit a request for an appeal in accordance with Chapter I. An appeal by members who are age twenty-one (21) years and over regarding services under this Section must be requested in writing and mailed to:

Director  
Office of Elder Services  
c/o Hearings  
11 State House Station  
442 Civic Center Dr.  
Augusta, Maine 04333-0011

**Program Integrity**

All providers are subject to the Department’s Program Integrity activities. Refer to Chapter I, General Administrative Policies and Procedures for rules governing these functions.

**REIMBURSEMENT**

A. The amount of payment for services rendered shall be the lowest of the following:

1. The amount listed in Chapter III, Section 40, “Allowances for Home Health Services” of the MaineCare Benefits Manual; or

2. The lowest amount allowed by the Medicare carrier; or

3. The provider’s usual and customary charge.

B. In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from every other source that is available for payment of a rendered service prior to billing MaineCare.
40.09 **REIMBURSEMENT** (cont.)

C. The eligibility requirements and limits on home health services under this Section do not apply to members with Medicare coverage or other third party health insurance until the coverage for these home health services, (including occupational therapy, physical therapy and speech-language pathology services) by the other third party payor has been exhausted. MaineCare will cover the co-insurance and deductible in these cases.

40.10 **COPAYMENT**

A. A copayment will be charged to each MaineCare member for each day home health services are provided. The amount of the copayment shall not exceed $3.00 per day for services provided, according to the following schedule:

<table>
<thead>
<tr>
<th>MaineCare Payment for Service</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10.00 or less</td>
<td>$.50</td>
</tr>
<tr>
<td>$10.01 - 25.00</td>
<td>$1.00</td>
</tr>
<tr>
<td>$25.01 - 50.00</td>
<td>$2.00</td>
</tr>
<tr>
<td>$50.01 or more</td>
<td>$3.00</td>
</tr>
</tbody>
</table>

B. The member shall be responsible for copayments up to $30.00 per month whether the copayment has been paid or not. After the $30.00 cap has been reached the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.

C. No provider may deny services to a member for failure to pay a copayment. Providers must rely upon the member's representation that he or she does not have the cash available to pay the copayment. A member's inability to pay a copayment does not, however, relieve him/her of liability for a copayment.

D. Providers are responsible for documenting the amount of copayments charged to each member (regardless of whether the member has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous copayments.

Providers are subject to the Department’s copayment requirements. Refer to Chapter I, General Administrative Policies and Procedures for rules governing copayment requirements, exemptions and dispute resolution.

40.11 **CONFIDENTIALITY**

The disclosure of information regarding individuals participating in the MaineCare program is strictly limited to purposes directly connected with the administration of the MaineCare program. Providers shall maintain the confidentiality of information regarding these individuals in accordance with 42 CFR §431 et seq. and other applicable sections of state and federal law and regulation.
BILLING INSTRUCTIONS

A. Billing must be accomplished in accordance with the Department's billing requirements in "Billing Instructions for Home Health Agencies" that are available on the provider portal at www.maine.gov/dhhs/oms or by contacting MaineCare Services, Division of Customer Service, 11 State House Station, Augusta, ME 04330, or calling 1-800-321-5557.

B. In order to receive full MaineCare reimbursement for claims submitted for a service that is defined as an exemption in Chapter I, refer to the billing instructions distributed by the Department and to Chapter I, General Administrative Policies and Procedures.

C. All services provided on the same day shall be submitted on the same claim form for MaineCare reimbursement.

BILLING APPEALS FOR DUAL MAINECARE/MEDICARE MEMBERS

A. An agency document must be on file signed by the MaineCare member or guardian noting that services are denied Medicare coverage and all claims will be submitted to MaineCare.

B. The agency will obtain and keep on file a signed departmental “Authorization to Represent” form on all MaineCare members. This form will be provided by the Department. The agency will present this form to the Department or its designee when an Initial Determination and/or Reconsideration or Administrative Law Judge is requested.

C. The Department will find the home health agency liable for the cost of services following an adverse decision by Medicare in response to a Department appeal detailing a technical denial. Examples of a technical denial shall include but not be limited to:

1) Plan of Care not authorized by a physician.
2) Information not received.
3) No documentation for services billed.
4) Time Limit Reject.

** Effective when the MaineCare claim system MIHMS is implemented.
** See Below

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>MAXIMUM ALLO</th>
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<tbody>
<tr>
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</tbody>
</table>

** Effective when the MaineCare claims system MIHMS is implemented.
**Major Substantive Rules**

NEW REIMBURSEMENT CODES BELOW WILL BE EFFECTIVE UPON IMPLEMENTATION OF THE MIMHS

REIMBURSEMENT CODES WILL REMAIN IN EFFECT UNTIL THAT TIME

---

**REV CODE/ PROC CODE** | **DESCRIPTION** | **MAXIMUM ALLOWANCE PER UNIT**
--- | --- | ---
0551/ G0154TD | Services of skilled nurse in home health setting, each 15 minutes (RN) | $28.32
0559/ G0154TE | Services of skilled nurse in home health setting, each 15 minutes (LPN/LVN) | $19.82
0571/ G0156 | Services of home health aide in home health setting, each 15 minutes | $13.28
0431/ G0152 | Services of occupational therapist, in home health setting, each 15 minutes | $33.25
0431/ G0152TF | Services of occupational therapist, in home health setting, each 15 minutes | $23.28
0421/ G0151 | Services of physical therapist in home health setting, each 15 minutes | $31.29
0421/ G0151TF | Services of physical therapist in home health setting, each 15 minutes (physical therapy assistant) | $21.91
0441/ G0153 | Services of a speech and language pathologist in home health setting, each 15 minutes | $32.78

**Deleted:**

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**Effective when the MaineCare claims systems MIHMS is implemented.**
**NEW REIMBURSEMENT CODES BELOW WILL BE EFFECTIVE UPON IMPLEMENTATION OF THE MIMHS
REIMBURSEMENT CODES WILL REMAIN IN EFFECT UNTIL THAT TIME**

<table>
<thead>
<tr>
<th>Code on web</th>
<th>Services Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0441/G0153TF</td>
<td>Services of speech and language pathologist in home health setting, each 15 minutes (speech and language pathologist assistant)</td>
<td>$27.95</td>
</tr>
<tr>
<td>0561/G0155</td>
<td>Services of clinical social worker in home health setting, each 15 minutes</td>
<td>$28.32</td>
</tr>
<tr>
<td>0551/T1502</td>
<td>Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit</td>
<td>$28.32</td>
</tr>
<tr>
<td>0290</td>
<td>Non Routine Medical Supplies – General – To be billed with appropriate, allowable supplies code provided on OMS website</td>
<td>Lower of either Acquisition Cost or DME price</td>
</tr>
</tbody>
</table>

**Effective when the MaineCare claims systems MIHMS is implemented.**
<table>
<thead>
<tr>
<th>Service Code</th>
<th>Service Description</th>
<th>Report Type</th>
<th>Payment Basis</th>
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</thead>
<tbody>
<tr>
<td>S11</td>
<td>Registered Nurse Services</td>
<td>By Report</td>
<td>Per visit</td>
</tr>
<tr>
<td>S12</td>
<td>Licensed Practical Nurse Services</td>
<td>By Report</td>
<td>Per visit</td>
</tr>
<tr>
<td>S13</td>
<td>Home Health Aide Services</td>
<td>By Report</td>
<td>Per visit</td>
</tr>
<tr>
<td>S14</td>
<td>Licensed Occupational Therapist (OTR) Services</td>
<td>By Report</td>
<td>Per visit</td>
</tr>
<tr>
<td>S15</td>
<td>Certified Occupational Therapist Assistant (COTA) Services</td>
<td>By Report</td>
<td>Per visit</td>
</tr>
<tr>
<td>S16</td>
<td>Licensed Physical Therapist Services</td>
<td>By Report</td>
<td>Per visit</td>
</tr>
<tr>
<td>S17</td>
<td>Licensed Physical Therapist Assistant Services</td>
<td>By Report</td>
<td>Per visit</td>
</tr>
<tr>
<td>S18</td>
<td>Licensed Speech-Language Pathologist Services</td>
<td>By Report</td>
<td>Per visit</td>
</tr>
<tr>
<td>S19</td>
<td>Licensed Speech Pathologist Assistant Services</td>
<td>By Report</td>
<td>Per visit</td>
</tr>
<tr>
<td>S20</td>
<td>Medical Social Services</td>
<td>By Report</td>
<td>Per visit</td>
</tr>
<tr>
<td>S21</td>
<td>Routine Supplies Identify Supply in “Remarks”</td>
<td>By Report</td>
<td>Per visit</td>
</tr>
<tr>
<td>S22</td>
<td>RN – Psychotropic Medication Administration and Monitoring</td>
<td>By Report</td>
<td>Per visit</td>
</tr>
</tbody>
</table>
PUBLIC Law, Chapter 169

An Act To Provide for Insurance Coverage of Telemedicine Services

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §4316 is enacted to read:

§ 4316.  Coverage for telemedicine services

1. Definition. For the purposes of this section, "telemedicine," as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. "Telemedicine" does not include the use of audio-only telephone, facsimile machine or e-mail.

2. Coverage of telemedicine services. A carrier offering a health plan in this State may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health care provider. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health care services provided through in-person consultation. A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

Effective September 12, 2009

Related Pages

Search Bill Text Legislative Information
Bill Directory
Search Bill Status Session Information
119th Legislature Bills Maine Legislature
An Act To Provide for Insurance Coverage of Telemedicine Services

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §2765 is enacted to read:

§ 2765. Coverage for health care services provided through telemedicine

All individual health insurance policies, contracts and certificates must provide coverage for health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health care provider.

1. Definition. For the purposes of this section, "telemedicine," as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. "Telemedicine" does not include the use of audio-only telephone, facsimile machine or e-mail.

2. Telemedicine network. An insurer may limit coverage to those health care providers in a telemedicine network approved by the insurer.

3. Deductible, copayment and coinsurance. A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

4. Coverage consistency. Coverage for health care services under this section must be consistent with coverage for health care services provided through in-person consultation.

5. Rulemaking. The superintendent may adopt rules regarding coverage for health care services provided through telemedicine. Rules adopted pursuant to this subsection are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A.

Sec. 2. 24-A MRSA §2847-Q is enacted to read:

§ 2847-Q. Coverage for health care services provided through telemedicine

All group health insurance policies, contracts and certificates must provide coverage for health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health care provider.

1. Definition. For the purposes of this section, "telemedicine," as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. "Telemedicine" does not include audio-only telephone, facsimile machine or e-mail.
2. **Telemedicine network.** An insurer may limit coverage to those health care providers in a telemedicine network approved by the insurer.

3. **Deductible, copayment and coinsurance.** A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

4. **Coverage consistency.** Coverage for health care services under this section must be consistent with coverage for health care services provided through in-person consultation.

5. **Rulemaking.** The superintendent may adopt rules regarding coverage for health care services provided through telemedicine. Rules adopted pursuant to this subsection are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A.

Sec. 3. 24-A MRSA §4257 is enacted to read:

§ 4257. **Coverage for health care services provided through telemedicine**

All individual and group health maintenance organization policies, contracts and certificates must provide coverage for health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health care provider.

1. **Definition.** For the purposes of this section, "telemedicine," as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. "Telemedicine" does not include audio-only telephone, facsimile machine or e-mail.

2. **Telemedicine network.** An insurer may limit coverage to those health care providers in a telemedicine network approved by the insurer.

3. **Deductible, copayment and coinsurance.** A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

4. **Coverage consistency.** Coverage for health care services under this section must be consistent with payment for health care services provided through in-person consultation.

5. **Rulemaking.** The superintendent may adopt rules regarding coverage for health care services provided through telemedicine. Rules adopted pursuant to this subsection are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A.
Sec. 4. Application. The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2010. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

SUMMARY

This bill provides for coverage of health care services delivered through telemedicine. The bill allows for insurer approval of telemedicine networks, allows deductibles, copayments and coinsurance the same as for in-person health services and provides for coverage consistent with in-person health care services. The provisions of the bill apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2010.
Maine Revised Statutes

§3174-EE Title 22: HEALTH AND WELFARE

Subtitle 3: INCOME SUPPLEMENTATION

HEADING: PL 1973, C. 790, §1 (AMD)

Part 1: ADMINISTRATION

Chapter 855: AID TO NEEDY PERSONS HEADING: PL 1973, C. 790, §2 (NEW)

§3174-FF. MaineCare Basic

1. Established. The MaineCare Basic program is established to deliver medically necessary health care services to adult members of the MaineCare program.

   [ 2003, c. 673, Pt. MMM, §1 (NEW) .]

2. Rules. The department shall adopt rules to implement MaineCare Basic in accordance with this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

   [ 2003, c. 673, Pt. MMM, §1 (NEW) .]

3. Services. The rules adopted pursuant to subsection 2 must provide for access to medically necessary services as provided in the federally approved Medicaid state plan. Benefits for certain services are limited as follows.

   A. A member is eligible for speech therapy benefits if the member has been assessed to have rehabilitation potential or a demonstrated medical necessity for speech therapy to avoid a significant deterioration in the member's ability to communicate orally, safely swallow or masticate. In order for the member to be eligible for speech therapy benefits, a physician must document that the member has experienced a significant decline in ability to communicate orally, safely swallow or masticate or may reasonably suffer a significant deterioration in these functions if therapy is not provided. Speech therapy benefits must cover one initial evaluation of the member per provider per year and one reevaluation every 6 months per provider. Speech therapy benefits must cover outpatient therapy provided in the home, independent practitioners' offices and speech and hearing clinic sites. [2007, c. 71, §1 (RPR).]

   B. A member is eligible for rehabilitation services benefits for brain injury subject to levels of care determined by rule. [2003,
C. A member is eligible for psychological services benefits for individual and group counseling. Benefits for one or both types of counseling combined are limited to a total of 16 one-hour visits per year, except that the department may increase the maximum number of visits for psychological services to 24 visits in a 12-month period as long as any cost associated with this increase is offset by savings from managing the use of these services by methods that may include prior authorization. [2005, c. 680, §1 (AMD).]

D. A member is eligible for benefits for durable medical equipment, prosthetics and orthotics for one pair of shoes and one pair of inserts per year, medical supplies required to meet standard daily needs and power wheelchairs for a member who is nonambulatory and has a significant neuromuscular disease or disorder. [2003, c. 673, Pt. MMM, §1 (NEW).]

E. A member is eligible for occupational and physical therapy benefits provided by occupational and physical therapists licensed under Title 32 and who are acting within their scope of practice. Services of occupational and physical therapists may be provided in all outpatient settings, including the home. For services subject to this paragraph, the department may require a member to have that member's rehabilitation potential documented by a physician and may limit treatment to:

1. Treatment following an acute hospital stay for a condition affecting range of motion, muscle strength and physical functional abilities;

2. Treatment after a surgical procedure performed for the purpose of improving physical function; or

3. Treatment in those situations in which a physician has documented that the patient has in the preceding 30 days required extensive assistance in the performance of one or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility.

The department may limit occupational and physical therapy services benefits under this paragraph for palliative care and maintenance of function to one visit per year to design a plan of care and train the member or caretaker of the member to implement the plan or to reassess the plan of care. [2003, c. 673, Pt. MMM, §1 (NEW).]

F. A member is eligible for benefits for chiropractic services provided by a chiropractor licensed under Title 32. Benefits under this paragraph may be limited by the department by requiring a member to have that member's rehabilitation potential documented by a physician. Benefits may be limited to treatment as follows:
(1) Treatment for acute neuromuscular skeletal conditions affecting range of motion, muscle strength and physical functional abilities; or

(2) Treatment after a surgical procedure performed for the purpose of improving physical function. [2003, c. 673, Pt. MMM, §1 (NEW).]

G. A member is eligible for benefits under the private duty nursing and personal care program and waiver programs for the physically disabled or elderly as long as those benefits may be limited by reductions in units of service or by rate reductions. [2003, c. 673, Pt. MMM, §1 (NEW).]

H. A member who is eligible for benefits under section 3174-G, subsection 1, paragraph F is eligible for benefits under this section subject to the provisions of paragraphs A to G and to additional rules limiting benefits as specified in this paragraph.

(1) Benefits for inpatient hospital admissions are limited to 2 per year, except that more admissions may be approved through prior authorization by the department. This subparagraph does not limit inpatient hospital benefits for laboratory services, x-ray services, prenatal care and mental health diagnoses.

(2) Benefits for outpatient visits to a hospital are limited to 5 per year, except that more visits may be approved through prior authorization by the department. This subparagraph does not limit benefits for visits for laboratory services, x-ray services, prenatal care and mental health diagnoses.

(3) Benefits for brand-name prescription medications are limited to 5 medications dispensed during the same time period, except that benefits for additional brand-name medications may be approved through prior authorization by the department. In addition to the brand-name limitation, as compared to members who are eligible under other paragraphs of section 3174-G, subsection 1, prescription medication benefits for members who are eligible under paragraph F are limited by stricter prior authorization requirements, increased review of pharmacy use and a request for federal permission to waive freedom of choice.

(4) A member who is eligible for benefits under section 3174-G, subsection 1, paragraph F begins coverage on the date that the department determines that the member is eligible. [2003, c. 673, Pt. MMM, §1 (NEW).]

[ 2007, c. 71, §1 (AMD). ]

SECTION HISTORY
The Revisor's Office cannot provide legal advice or interpretation of Maine law to the public. If you need legal advice, please consult a qualified attorney.
Office of the Revisor of Statutes
7 State House Station
State House Room 108
Augusta, Maine 04333-0007
Michigan’s state Medicaid program does reimburse for the following telemedicine services: consultation, office visits, individual psychotherapy, pharmacological management, and end stage renal disease (ESRD) related services.

In the area of tele-home care and remote monitoring services, Michigan does not provide reimbursements.
Updates to the Medicaid Provider Manual


The January 2011 version of the Manual does not highlight changes made during the past year (2010). However, consistent with previous quarterly manual updates, tables attached to this bulletin describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Subsequent changes made for the April, July, and October 2011 versions of the manual will be highlighted within the text of the on-line manual.

Physicians/Practitioners and Medical Clinics Database

Effective January 1, 2011, MDCH will publish a subset of the Physicians/Practitioners and Medical Clinics Database codes and their fee screens. The new subset of codes is titled Physician-Administered Drugs and Biologicals.

Fee screens and coverage parameters are located on the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Correction to Bulletin MSA 10-20

Bulletin MSA 10-20; Registered Dental Hygienists as an Enrolled Medicaid Provider was issued on November 12, 2010. Affected providers (Dentists and Dental Clinics) should note the following correction. In the section titled "National Provider Identification (NPI) and Billing Information", first paragraph, the second sentence should read: "Effective for dates of service on and after January 1, 2011, the billing provider can submit claims for services with the RDH as the rendering/serving provider."
Patient Protection and ACA Compliance

On March 23, 2010, the Patient Protection and ACA was signed into law. While the Medical Services Administration (MSA) is currently in compliance with several sections of the ACA, MSA is reviewing the law and working with the Federal government to achieve compliance as new Federal guidance is issued. MSA will utilize the policy promulgation process as necessary to provide notification of required changes to the Medicaid Program.

Habilitation/Supports Waiver for Persons with Developmental Disabilities

Goods and Services (New Service Effective October 1, 2010)

The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by the HSW beneficiary using arrangements that support self-determination and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and services must increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and community living supports and other one-to-one support as described in the HSW or §1915(b)(3) Additional Service definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance.

A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS. Purchase of a warranty may be included when it is available for the item and is financially reasonable.

Goods and Services are available only to individuals participating in arrangements of self-determination whose individual budget is lodged with a fiscal intermediary.

This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.

Manual Maintenance

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

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of 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 phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2650.

Requests for the Michigan Medicaid Provider Manual on compact disc (CD) should contain the provider's name, National Provider Identifier (NPI) number, mailing address, and telephone number and be submitted:

By mail to: MDCH/Medicaid Program Policy Division, PO Box 30479, Lansing, MI 48909
By e-mail to: MSA-Forms@Michigan.gov
By fax to: 517-335-5136

Approved

Stephen Fitchen
Stephen Fitchen, Director
Medical Services Administration
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<th>CHAPTER</th>
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<td>3.3 Eligibility Verification for Dates of Service Over 12 Months Old</td>
<td>The 2nd sentence was revised to read: An exception is allowed for Hospital providers (Enrollment Type: FAC) to submit DOS older than 12 months for inpatient related services only to complete Medicare DSH audits. Providers must complete the DSH question under the &quot;Manage Provider Checklist&quot; page in the CHAMPS-PE Subsystem and receive approval from MDCH. The last sentence was revised to read: There may be a transaction fee charged to the requester for these DSH inquiries.</td>
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<td></td>
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<td>Billing &amp; Reimbursement for Institutional Providers</td>
<td>Section 5 - Hospital Claim Completion - Inpatient</td>
<td>The following was added at the end of the 1st paragraph: The MDCH website contains additional billing information (i.e., MDCH Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)</td>
<td>General information</td>
</tr>
<tr>
<td>5.1.A. Intensive Care</td>
<td>The paragraph was revised to read: Refer to the NUBC Manual for the specific cost center for a specific type of intensive care unit and the definitions and report the most appropriate revenue code. The MDCH website contains additional billing information (i.e., MDCH Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)</td>
<td>General update</td>
<td></td>
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<tr>
<td>5.3 Pre-Admission and Certification Evaluation Review</td>
<td>In the 4th paragraph, in the table under &quot;Readmission within 15 days to the Same Hospital (Related Admission)&quot;, the 1st bullet point was revised to read:</td>
<td>General update</td>
<td></td>
</tr>
<tr>
<td>5.6 Telemedicine</td>
<td>The 1st sentence was revised to read: To be reimbursed for the originating site facility fee, the hospital must bill the appropriate telemedicine NUBC revenue code with the appropriate telemedicine CPT/HCPCS procedure code and modifier.</td>
<td>Clarification</td>
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* Technical Updates/Clarifications are always highlighted in yellow in the online manual.
MEDICAID PROVIDER MANUAL OVERVIEW

SECTION 1 — INTRODUCTION

The following documents comprise the Michigan Medicaid Provider Manual, and address all health insurance programs administered by the Michigan Department of Community Health (MDCH). MDCH also issues periodic bulletins as changes are implemented to the policies and/or processes described in the manual. An inventory of these bulletins is maintained in the Supplemental Bulletin List located on the MDCH website. Bulletins are incorporated into the online version of the manual on a quarterly basis. (Refer to the Directory Appendix for website information.)

1.1 ORGANIZATION [CHANGES MADE 7/1/10]

The following table identifies each chapter and appendix in the manual, indicates what providers are affected, and provides a brief overview of each.

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<th>Chapter Content</th>
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<td>Medicaid Provider Manual Overview</td>
<td>All Providers</td>
<td>Brief discussion of the organization of the manual and effectively using the document.</td>
</tr>
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<td>General Information for Providers</td>
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</tr>
<tr>
<td>Coordination of Benefits</td>
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<td>Policies and information regarding coordination of benefits, Medicaid's payment liability, etc.</td>
</tr>
<tr>
<td>Billing &amp; Reimbursement for Dental Providers</td>
<td>Providers billing the ADA 2006 or 837 Dental claim formats.</td>
<td>Policies and instructions for billing dental services.</td>
</tr>
<tr>
<td>Billing &amp; Reimbursement for Institutional Providers</td>
<td>Providers billing the UB-04 or 837 Institutional claim formats.</td>
<td>Policies and instructions for billing institutional services.</td>
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# Billing & Reimbursement for Institutional Providers

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5.5 STERILIZATION

For coverage policy information, refer to the Hospital Chapter of this manual. Refer to the Forms Appendix of this manual for a copy of the Consent for Sterilization (MSA-1959/HHS-687), including completion instructions. If any field on the form is improperly completed, the claim is rejected.

The procedure for completion of the MSA-1959/HHS-687 form is:

- Complete 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 MSA-1959/HHS-687. Do not fax claims.
- Wait for a response. When notified that the MSA-1959/HHS-687 has been accepted and is on file, inform the other providers via a copy of the response.
- 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 needed for Medicaid staff to contact the provider. Resend the information if necessary.
- All providers may then submit claims (either electronic or paper copy) to Medicaid. The Remarks Section or Comment Record must include the statement "Consent on File."
- The information on the sterilization claim must match the information on the MSA-1959/HHS-687. If it does not, the claim is rejected.

This process is optional. Copies of the MSA-1959/HHS-687 may be attached to a claim without going through the pre-approval process. If choosing to include a paper copy of the MSA-1959/HHS-687, indicate "submitted attachment" in the Remarks Section.

5.6 TELEMEDICINE

To be reimbursed for the originating site facility fee, the hospital must bill revenue code 0780 with the appropriate telemedicine procedure code and modifier. Additional information about telemedicine services is contained in the Telemedicine Section of the Practitioner Chapter. Procedure code and modifier information is contained in the MDCH Telemedicine Services Database available on the MDCH website. (Refer to the Directory Appendix for website information.)

5.7 TRANSPLANTS

Heart, bone marrow, liver, lung, simultaneous pancreas/kidney and pancreas transplants are reimbursed at the hospital's Medicaid cost to charge ratio.
6.15 Observation Care Services

MDCH follows Medicare's observation care services coverage, claim submission, and reimbursement policies.

6.16 Radiation Treatments

MDCH follows Medicare's billing guidelines for repetitive billing on the same claim or separately by date of service. If reporting charges on a single claim, the provider must also report all charges for the radiation services (one episode of care) and supplies for the recurring radiation service on the same claim.

6.17 Self-Care Dialysis Training

Bill self-care dialysis training using the appropriate revenue code and HCPCS/CPT codes. Refer to the Wrap-Around Procedure Cost List on the MDCH website for CPT HCPCS codes. (Refer to the Directory Appendix for MDCH website information.)

If a beneficiary completes a course:

- Report HCPCS code 90989 (dialysis patient training, complete course).
- The quantity should be "1".

If a beneficiary does not complete a course:

- Report each session separately using HCPCS code 90993 (dialysis patient training, per session).
- The service date on the claim line must indicate the actual date that the session occurred.

A quantity of "1" must be entered, not to exceed a maximum of nine sessions per course.

6.18 Sterilization

Refer to the Hospital Claim Completion-Inpatient Section of this chapter for additional information related to sterilization.

6.19 Telemedicine

Information about telemedicine services is contained in the Telemedicine Section of the Practitioner Chapter. Procedure code and modifier information is contained in the MDCH Telemedicine Services Database available on the MDCH website. (Refer to the Directory Appendix for website information.)

6.20 Therapies (Occupational, Physical and Speech-Language) [Change made 4/1/10]

Dual-use therapy codes may be billed by both a physical therapist and an occupational therapist on the same date of service when both professionals provided covered therapy services on the same day under their corresponding treatment plans. The appropriate OPPS modifier must be reported if applicable.
Interim reimbursement is based on a percentage of charge. Final reimbursement is calculated during the respective period's cost settlement and is based on that period's audited cost to charge ratio.

Medicare/Medicaid – If Medicare is being billed for the nursing facility stay, neither the nursing facility nor a medical supplier can bill Medicaid for oxygen services (i.e., gas, equipment, supplies). Oxygen services are included in the Medicare payment to the facility under Medicare's Prospective Payment System.

- 0780 – Telemedicine – To be reimbursed for the originating site facility fee, the NF must bill revenue code 0780 with the appropriate telemedicine procedure code and modifier. Additional information about telemedicine services is contained in the Telemedicine Section of the Practitioner Chapter. Procedure code and modifier information is contained in the MDCH Telemedicine Services Database available on the MDCH website. (Refer to the Directory Appendix for website information.)
6.19 TELEMEDICINE

The Telemedicine Services Database provides procedure code and modifier information, and is available on the MDCH website. (Refer to the Directory Appendix for website information.)

6.19.A. ORIGINATING SITE

MDCH will reimburse the originating site provider the lesser of charge or the current Medicaid fee screen. Additional services provided at the originating site on the same date as the telemedicine service may be billed and reimbursed separately according to published policy.

6.19.B. DISTANT SITE

The modifier for interactive communication must be used in conjunction with the appropriate procedure code to identify the professional telemedicine services provided by the distant site provider.

6.20 VISION

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<th>Routine Eye Examination</th>
<th>A routine eye examination includes, but is not limited to:</th>
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<tbody>
<tr>
<td></td>
<td>- Case history</td>
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<tr>
<td></td>
<td>- Determination of visual acuity (each eye)</td>
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<td>- Ophthalmoscopy</td>
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<td>- Treatment program</td>
</tr>
<tr>
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<td>- Disposition</td>
</tr>
<tr>
<td></td>
<td>Ophthalmologists and optometrists must use appropriate CPT/HCPCS code(s) for the service</td>
</tr>
<tr>
<td>Nonroutine Eye Examination</td>
<td>Nonroutine eye examinations for the purpose of evaluation and treatment of chronic, acute, and/or sudden onset of abnormal ocular symptoms must be billed using the appropriate CPT/HCPCS codes.</td>
</tr>
<tr>
<td>Glaucoma Screening</td>
<td>Glaucoma screening must be billed with the appropriate CPT/HCPCS procedure codes. This screening entails a dilated eye examination, tonometry, and direct ophthalmoscopy or slit lamp examination. If this screening is provided as part of another billable service, separate reimbursement for this screening is not allowed. If the beneficiary presents with a visual or ocular complaint, the glaucoma screening procedure code should not be used. A procedure code that best describes the encounter should be selected from the E/M or General Ophthalmological codes.</td>
</tr>
</tbody>
</table>
FEDERALLY QUALIFIED HEALTH CENTERS

As required by Executive Order 2009-22, effective for dates of service on and after 07/01/2009, Chiropractic and Vision services (routine eye exams, eyeglasses, contact lenses and other vision supplies) are no longer payable for beneficiaries age 21 and older.

Per Public Act 187 of 2010, effective for dates of service on and after 10/01/2010, the following services have been reinstated for beneficiaries age 21 and older:

- Dental Services
- Low-vision Services (Low-vision Services include low-vision eyeglasses, contact lenses, optical devices, and other related low-vision supplies and services. Refer to the Vision Chapter for low-vision coverage and diagnosis code information.)
- Podiatry Services

Reinstated services reflect the level of services available in June 2009. Refer to specific chapters for additional information. (revised per bulletin MSA 10-47)

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SECTION 2 — BENEFITS

FQHC services subject to PPS reimbursement are FQHC services defined at Section 1861 (aa)(1)(A)-(C) of the Social Security Act.

2.1 PRIMARY CARE SERVICES

Primary care services are defined as:

- Those required under Section 330 of the Public Health Service Act.
- Medicaid-covered services provided in a place of service that is the FQHC’s office or clinic, patient’s home, Domiciliary Facility Nursing Home, Nursing Facility (NF), or Skilled Nursing Facility (SNF) by a provider type physician, medical clinic, podiatrist, dentist, CNP or CNM.
- Medicaid-covered inpatient hospital care (as specified in the MOA) is limited to the following procedures:
  - Initial inpatient consultations;
  - Follow-up inpatient consultations;
  - Initial hospital care;
  - Subsequent hospital care; and
  - Newborn care.
- Visits by a clinical psychologist or clinical social worker at the FQHC’s office or clinic, patient’s home, Domiciliary Facility Nursing Home, Nursing Facility, or Skilled Nursing Facility.
- Other ambulatory services, i.e., Medicaid transportation, Medicaid outreach, and Maternal Infant Health Program (MIHP) services.

2.2 TRANSPORTATION/OUTREACH

Outreach services and non-emergency transportation of the Medicaid beneficiary to and from the FQHC is covered. The cost of outreach and non-emergency transportation is part of the encounter rate. These services are not cost settled.

2.3 TELEMEDICINE

Telemedicine (also known as telehealth) is the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the beneficiary is performed via a real time interactive audio and video telecommunications system. This means that the beneficiary must be able to see and interact with the off-site practitioner at the time services are provided via telemedicine.

An FQHC can be an authorized originating site. Refer to the Billing & Reimbursement for Professionals Chapter for information regarding billing the originating site facility fee.

For additional information regarding telemedicine services, refer to the Telemedicine Section of the Practitioner Chapter.
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therapy" and "sometimes therapy") found on the CMS website. (Refer to the Directory Appendix for website information.) \(\textit{added 4/1/10}\)

3.30 Therapy, Speech-Language Pathology [Change Made 4/1/10]

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

Refer to the Outpatient Therapy Chapter of this manual for standards of coverage and service limitations for therapy provided in the outpatient hospital setting. The MDCH OPSS aligns as closely as possible with Medicare’s billing and coverage guidelines for "sometimes therapy" services that may be reimbursed as non-therapy services for hospital outpatients. Refer to the therapy codes and their respective designations used for therapy services (i.e., "always therapy" and "sometimes therapy") found on the CMS website. (Refer to the Directory Appendix for website information.) \(\textit{added 4/1/10}\)

3.31 Telemedicine

Telemedicine (also known as telehealth) is the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the beneficiary is performed via a real-time interactive audio and video telecommunications system. This means that the beneficiary must be able to see and interact with the off-site practitioner at the time services are provided via telemedicine.

A hospital can be an authorized originating site. Refer to the Billing & Reimbursement for Institutional Providers Chapter for information regarding billing the originating site facility fee.

For additional information regarding telemedicine services, refer to the Telemedicine Section of the Practitioner Chapter.

3.32 Weight Reduction

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

The request for PA must include:

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

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

Mail requests to Office of Medical Affairs (OMA). (Refer to the Directory Appendix for contact information.)
### 3.20 Speech, Hearing, and Language

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities provided by a speech-language pathologist or licensed audiologist to determine the beneficiary's need for services and to recommend a course of treatment. A speech-language pathology assistant may not complete evaluations.</td>
<td>Diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO). Therapy must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy is 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 must be skilled (i.e., requires the skills, knowledge, and education of a certified speech-language pathologist) to assess the beneficiary's speech/language function, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, registered occupational therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage. Services may be provided by a speech-language pathologist or licensed audiologist or by a speech pathology or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license). All documentation by the candidate must be reviewed and signed by the appropriately credentialed supervising speech-language pathologist or audiologist.</td>
</tr>
</tbody>
</table>

### 3.21 Substance Abuse

Refer to the Substance Abuse Services Section of this chapter for specific program requirements relating to substance abuse services.

### 3.22 Targeted Case Management

Refer to the Targeted Case Management Section of this chapter for specific program requirements.

### 3.23 Telemedicine

Telemedicine (also known as telehealth) is the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the beneficiary is performed via a real time interactive audio and video telecommunications system. This means that the beneficiary must be able to
see and interact with the off-site practitioner at the time services are provided via telemedicine. Practitioners must meet the provider qualifications for the covered service provided via telemedicine.

For additional information regarding telemedicine services, refer to the Telemedicine Section of the Practitioner Chapter.

3.24 TRANSPORTATION

PIHPs are responsible for transportation to and from the beneficiary's place of residence when provided so a beneficiary may participate in a state plan, HSW or additional/B3 service at an approved day program site or in a clubhouse psychosocial rehabilitation program. MHPs are responsible for assuring their enrollees' transportation to the primary health care services provided by the MHPs, and to (non-mental health) specialists and out-of-state medical providers. The DHS is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs; and to dental, substance abuse, and mental health services (except those noted above and in the HSW program described in the Habilitation/Supports Waiver for Persons with Developmental Disabilities Section of this chapter) for all Medicaid beneficiaries. (Refer to the local DHS or MHP for additional information, and to the Ambulance Chapter of this manual for information on medical emergency transportation.)

PIHP's payment for transportation should be authorized only after it is determined that it is not otherwise available (e.g., DHS, MHP, volunteer, family member), and for the least expensive available means suitable to the beneficiary's need.

3.25 TREATMENT PLANNING

Activities associated with the development and periodic review of the plan of service, including all aspects of the person-centered planning process, such as pre-meeting activities, and external facilitation of person-centered planning. This includes writing goals, objectives, and outcomes; designing strategies to achieve outcomes (identifying amount, scope, and duration) and ways to measure achievement relative to the outcome methodologies; attending person-centered planning meetings per invitation; and documentation. Monitoring of the individual plan of service including specific services, when not performed by the case manager or supports coordinator, is included in this coverage.

Case managers and supports coordinators perform these functions as part of the case management and supports coordination services; therefore, they should not report this activity as "Treatment Planning." Other mental health and health professionals who attend the beneficiary's person-centered planning should report the activity as "Treatment Planning."

For the Children's Waiver, the attendance of all clinicians and case managers during treatment planning is included in the monthly case management coverage.
4.3 ESSENTIAL ELEMENTS [CHANGES MADE 4/1/10]

| Team-Based Service Delivery | ACT is a team-based service that includes shared service delivery responsibility that provides consistent continuity of care. Case management services are interwoven with treatment and rehabilitative services, and are provided by all members of the team. ACT teams are expected to address co-occurring substance use disorders of beneficiaries within the team service. Providers of ACT services who also provide substance abuse treatment must have a substance abuse treatment license with the additional integrated treatment service category. Team meetings occur Monday through Friday and are attended by all staff members on duty. The status of all beneficiaries is briefly reviewed. Documentation of daily team meetings includes all beneficiaries discussed and all staff members present. The daily schedule is organized and contacts scheduled. |
| Team Composition and Size | The ACT team requires a sufficient number of qualified staff to assure the provision of an intensive array of services on a 24-hour basis. Teams must have at least three staff members but generally are comprised of 4-9 staff members, with the expected average team of 6-7 staff members. The minimum ACT staffing requirements for the Michigan model are below. Teams that have been approved to follow the SAMHSA model must meet and continue to meet the SAMHSA standard. |
|  | - A physician who provides psychiatric coverage for all beneficiaries served by the team. The physician is considered a part of the team but is not counted in the staff-to-beneficiary ratio. The physician meets with the team in the team meeting at least weekly and is assigned to the ACT team at least 15 minutes per beneficiary per week in a capacity that provides immediate access to the physician for individuals on the team to address emergency, urgent or emergent situations. The expectation is that some beneficiaries will need more physician time; some beneficiaries will need less physician time during any given week. Typically, though not exclusively, physician activities include team meetings, beneficiary appointments during regular office hours, psychiatric evaluations, psychiatric meetings/consultations, medication reviews, home visits, staging beneficiaries, phone consultations, and telemedicine. The physician may delegate psychiatric activities to a nurse practitioner but they must be supervised by that physician. The physician (MD or DO) must possess a valid license to practice medicine in Michigan, a Michigan Controlled Substance License, and a DEA registration. The physician must attend a MDCH-approved ACT training for physicians and nurse practitioners within at least one year of hire. Additional ACT training for physicians is voluntary. (revised 4/1/10) |
|  | - A nurse practitioner may perform clinical tasks delegated by and under the supervision of the physician. The nurse practitioner must hold a specialty certification as a nurse practitioner in Michigan, a current license to practice nursing in Michigan, and a master’s degree in psychiatric mental health nursing. If the ACT team includes a nurse practitioner, he/she may substitute for a portion of the physician time but may not substitute for the ACT RN. The nurse practitioner is not counted in the staff-to-beneficiary ratio. Typically, although not exclusively, nurse practitioner activities may include team meetings, beneficiary appointments during regular office hours, psychiatric evaluations, psychiatric meetings/consultations, medication reviews, home visits, staging beneficiaries, telephone consultations, and telemedicine. Nurse practitioners must attend an MDCH-approved ACT training for physicians and nurse practitioners at least once within at least one year of hire. Additional ACT training for nurse practitioners is voluntary. (added 4/1/10) |
- Hot water bottles
- Hypodermic needles/syringes
- Ice bags
- Incontinence pads, pants, and liners
- IV supplies and equipment; related supplies (including IV infusion pump)
- Minor medical/surgical supplies
- Miscellaneous applicators
- Nebulizers (hand-held or used with a compressor)
- Ostomy supplies
- Plastic waste bags
- Recreational/therapeutic equipment and supplies to conduct ongoing activities
- Safety pins
- Sheepskin, devices and solutions for preventing/treating decubiti
- Slings
- Stethoscopes
- Straws
- Syringes/needles
- Thermometers
- Tongue blades (depressors)
- Towels/washcloths
- Tracheostomy care kits and cleaning supplies
- Trochanter rolls
- Water carafes/glasses

**Note:** This list is not complete. Generic equivalents and products in the same family (i.e., same general use) are also included in the facility's per diem rate.

**10.35 Telemedicine [Re-Numbered 7/1/10]**

Telemedicine (also known as telehealth) is the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the beneficiary is performed via a real time interactive audio and video telecommunications system. This means that the beneficiary must be able to see and interact with the off-site practitioner at the time services are provided via telemedicine.

A nursing facility can be an authorized originating site. Refer to the Billing & Reimbursement for Institutional Providers Chapter for information regarding billing the originating site facility fee.

Refer to the Telemedicine Section of the Practitioner Chapter for additional information.
SECTION 20 – TELEMEDICINE

Telemedicine (also known as telehealth) is the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the beneficiary is performed via a real-time interactive audio and video telecommunications system. The beneficiary must be able to see and interact with the off-site practitioner at the time services are provided via telemedicine.

20.1 TELEMEDICINE SERVICES

The following are services may be provided via telemedicine:

- Consultation
- Office visits
- Individual psychotherapy
- Pharmacological management
- End stage renal disease (ESRD) related services

Where face-to-face visits are required (such as ESRD related services), the telemedicine service may be used in addition to the required face-to-face visit, but cannot be used as a substitute. There must be at least one face-to-face hands-on visit (i.e., not via telemedicine) by a physician, nurse practitioner, or physician’s assistant per month to examine the vascular site for ESRD services. Remote access for surgical procedures and use of robotics are not covered under this policy.

For the purpose of telemedicine services, the distant site and originating site must be at least 50 miles apart. Federal telemedicine demonstration projects funded or approved by the Secretary of Human Services as of December 31, 2000 may serve as the originating site regardless of geographic location.

The Telemedicine Services Database, available on the MDCH website, lists the procedure codes that may be billed for telemedicine services. (Refer to the Directory Appendix for website information.)

20.2 AUTHORIZATION REQUIREMENTS

There are no prior authorization requirements when providing telemedicine services for fee-for-service beneficiaries.

Authorization requirements for beneficiaries enrolled in County Health Plans (CHPs) and Medicaid Health Plans (MHPs) may vary. Providers must check with individual CHPs/MHPs for any authorization or coverage requirements.

20.3 AUTHORIZED ORIGINATING SITES

The originating site is the location of an eligible beneficiary at the time the service being furnished via a telecommunications system occurs.
The following are authorized as originating sites for telemedicine services:

- County mental health clinic or publicly funded mental health facility
- Federally Qualified Health Center (FQHC)
- Hospital (inpatient, outpatient, or critical access hospital)
- Office of a physician or other practitioner (including medical clinics)
- Renal dialysis facility
- Rural health clinic
- Skilled nursing facility
- Tribal Health Center (THC)

Information regarding billing for the originating site facility fee is contained in the Billing & Reimbursement for Institutional Providers and the Billing & Reimbursement for Professionals chapters. The Telemedicine Services Database contains procedure code and modifier information related to these services and is available on the MDCH website. (Refer to the Directory Appendix for website information.)

20.4 Distant Site

The location of the physician or practitioner providing the professional service via a telecommunications system is called the distant site. A medical professional is not required to present the beneficiary to the physician or practitioner at the distant site unless medically necessary. However, in order to be reimbursed, services provided must be appropriate and medically necessary. The decision of medical necessity will be made by the physician or practitioner at the distant site. The Telemedicine Services Database contains procedure code and modifier information related to these services and is available on the MDCH website. (Refer to the Directory Appendix for website information.)

20.5 Authorized Practitioners

The following health professionals may provide telemedicine services:

- Physician (MD, DO, DPM)
- Nurse Practitioner
- Nurse Midwife
- Physician's Assistant (billed under the supervising physician)
- Psychologist*
- Social Worker*

In-state providers are to be used whenever possible for distant site services.

* Psychologists and social workers cannot bill MDCH directly. Services must be provided through a PIHP/CMHSP, FQHC, or THC. Psychotherapy services that include medical evaluation and management services cannot be provided by psychologists or social workers.
RURAL HEALTH CLINICS

As required by Executive Order 2009-22, effective for dates of service on and after 07/01/2009, Chiropractic and Vision services (routine eye exams, eyeglasses, contact lenses and other vision supplies) are no longer payable for beneficiaries age 21 and older.

Per Public Act 187 of 2010, effective for dates of service on and after 10/01/2010, the following services have been reinstated for beneficiaries age 21 and older:

- Dental Services
- Low-vision Services (Low-vision Services include low-vision eyeglasses, contact lenses, optical devices, and other related low-vision supplies and services. Refer to the Vision Chapter for low-vision coverage and diagnosis code information.)
- Podiatry Services

Reinstated services reflect the level of services available in June 2009. Refer to specific chapters for additional information. (revised per bulletin MSA 10-47)

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Telemedicine (also known as telehealth) is the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the beneficiary is performed via a real time interactive audio and video telecommunications system. This means that the beneficiary must be able to see and interact with the off-site practitioner at the time services are provided via telemedicine.

An RHC can be an authorized originating site. Refer to the Billing & Reimbursement for Institutional Providers Chapter for information regarding billing the originating site facility fee.

For additional information regarding telemedicine services, refer to the Telemedicine Section of the Practitioner Chapter.
<table>
<thead>
<tr>
<th>Certified Nurse Midwife (CNM)</th>
<th>CNM services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDCH Bulletins.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Infant Health Program (MIHP)</td>
<td>THCs providing Maternal Infant Health Program (MIHP) services must be certified through MDCH. Information specific to the coverages and limitations for MIHP services are detailed in the Maternal Infant Health Program Chapter of this manual. If the THC subcontracts any MIHP services, no duplicate billing is permitted.</td>
</tr>
<tr>
<td>Physician's Assistant</td>
<td>Physician’s assistant services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDCH Bulletins. Physician’s assistant services are billed under a supervising physician’s NPI number.</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>Pharmacy services billed under the practitioner NPI number are included in the encounter rate but do not constitute a separate encounter for reimbursement at the THC MOA rate as they are considered part of the office visit. Under the THC MOA, practitioner pharmacy services do not include drugs provided by a pharmacy. THCs with enrolled pharmacy providers may continue to bill prescription claims to the MDCH Pharmacy Benefits Manager (PBM). MDCH contracts with a PBM for processing of all fee-for-service (FFS) pharmacy claims for Medicaid. The PBM also enrolls new pharmacy providers. (Refer to the Pharmacy Chapter of this manual for an explanation of coverages and limitations.)</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>The Practitioner Chapter of this manual explains the coverages and limitations of the Medicaid laboratory benefit. Laboratory services billed under the practitioner’s NPI number are included in the THC encounter rate but do not constitute a separate encounter for reimbursement purposes as they are considered part of the office visit. THCs cannot bill for any services rendered by an outside laboratory provider or for an outside laboratory’s employees performing tests.</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>Diagnostic testing performed as part of an office visit must be directly related to the presenting condition and substantiated in the medical records. (Refer to the Billing &amp; Reimbursement for Professionals Chapter of this manual for billing information.) Diagnostic testing services do not constitute a separate encounter. These services are regarded as part of the office visit and are included in the encounter reimbursement. Examples of diagnostic tests are allergy testing, audiologic function tests, x-rays, and EKGs.</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>Telemedicine (also known as telehealth) is the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the beneficiary is performed via a real time interactive audio and video telecommunications system. This means that the beneficiary must be able to see and interact with the off-site practitioner at the time services are provided via telemedicine.</td>
</tr>
</tbody>
</table>
A THC can be an authorized originating site. Refer to the Billing & Reimbursement for Institutional Providers Chapter for information regarding billing the originating site facility fee.

For additional information regarding telemedicine services, refer to the Telemedicine Section of the Practitioner Chapter.

<table>
<thead>
<tr>
<th>Therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapy, speech therapy, and occupational therapy are covered when performed at the THCs. Refer to the appropriate chapter of this manual and MDCH Bulletins for an explanation of current coverages and limitations. The Billing &amp; Reimbursement for Professionals Chapter of this manual describes the billing requirements for services provided. Therapies provided on the same date of service as a physician visit are included in the encounter reimbursement.</td>
</tr>
</tbody>
</table>

### 3.2 Dental Coverages and Limitations

THC dental services are covered if provided in the THC and must comply with coverages and limitations for dental services as specified in the Dental Chapter of this manual. Dental benefits covered for beneficiaries under the age of 21 differ from those covered for beneficiaries age 21 and over.

Information for billing dental services is published in the Billing & Reimbursement for Dental Providers Chapter of this manual.

The *Healthy Kids Dental* Program is administered by a contractor in 61 Michigan counties. (Refer to the Directory Appendix for contact information.) Claims for services provided to beneficiaries enrolled in the *Healthy Kids Dental* Program should be submitted to the contractor. Payment is made based on the contractor's fee schedule. No additional reimbursement is made by MDCH.

### 3.3 Vision Coverages and Limitations

Vision services are covered if provided at the THC. Vision providers are ophthalmologists and optometrists. The vision services provided by an ophthalmologist or optometrist must comply with coverages and limitations published in the Vision Chapter of this manual.

MDCH contracts for the volume purchase of frames and lenses from an optical house. Frames and lenses covered by the program must be ordered through the contractor and are listed in the Vision Chapter of this manual.

Some vision services require prior authorization (PA) before they can be rendered. The Vision Services Approval/Order Form (DCH-0893) is used to obtain PA. (Refer to the Vision Chapter for information on services that require PA and to the Forms Appendix for a copy of the form.)

### 3.4 Services Provided to Medicaid Health Plan Enrollees

For Medicaid-covered services provided to Medicaid beneficiaries enrolled in a Medicaid Health Plan (MHP), THCs receive payment from the MHP based on an agreement or contract with the MHP. No additional reimbursement from Medicaid is made to the THC for MHP members, in accordance with the THC MOA.
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Mod</th>
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<th>Status</th>
<th>Fee Screen Non-Facility</th>
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<tr>
<td>00780</td>
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<td>90801</td>
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Minnesota’s state Medicaid program does reimburse for telemedicine consultations. These reimbursements are paid at the full allowable rate. Coverage, however, is limited to three telemedicine consultations per recipient per calendar week. The state statute also specifies that a patient record must include a written opinion from the consulting physician providing the telemedicine consultation. Furthermore, coverage extends to mental health services that are otherwise covered by medical assistance as direct face-to-face services provided via two-way interactive video.

In the area of home health, state Medicaid policy does reimburse for tele-home care services. According to state policy “Tele-home care skilled nurse visits are allowed when the recipient’s health status can be accurately measured and assessed without a need for a face-to-face, hands-on encounter.” The state statute reimburses at the same rate as face-to-face skilled nurse visits however, the law requires tele-home care skilled nurse visits to have prior authorization.
256B.0625 COVERED SERVICES.

Subdivision 1. **Inpatient hospital services.** Medical assistance covers inpatient hospital services. A second medical opinion is required prior to reimbursement for elective surgeries requiring a second opinion. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion prior to reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and the criteria and standards are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether a second medical opinion is required, made in accordance with rules governing that decision, is not subject to administrative appeal.

Subd. 1a. **Services provided in a hospital emergency room.** Medical assistance does not cover visits to a hospital emergency room that are not for emergency and emergency poststabilization care or urgent care, and does not pay for any services provided in a hospital emergency room that are not for emergency and emergency poststabilization care or urgent care.

Subd. 2. **Skilled and intermediate nursing care.** (a) Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with developmental disabilities who are residing in intermediate care facilities for persons with developmental disabilities. Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (1) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (2) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments; (3) the patient was screened as provided by law; (4) the patient no longer requires acute care services; and (5) no nursing home beds are available within 25 miles of the facility. The commissioner shall exempt a facility from compliance with the sole community provider requirement in clause (1) if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.

(b) Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

Subd. 2a. **Skilled nursing facility and hospice services for dual eligibles.** Medical assistance covers skilled nursing facility services for individuals eligible for both medical assistance and Medicare who have waived the Medicare skilled nursing facility room and board benefit and have enrolled in the Medicare hospice program. Medical assistance covers skilled nursing facility services regardless of whether an individual enrolled in the Medicare hospice program prior to, on, or after the date of the hospitalization that qualified the individual for Medicare skilled nursing facility services.

Subd. 3. **Physicians' services.** (a) Medical assistance covers physicians' services.
(b) Rates paid for anesthesiology services provided by physicians shall be according to the formula utilized in the Medicare program and shall use a conversion factor "at percentile of calendar year set by legislature, "except that rates paid to physicians for the medical direction of a certified registered nurse anesthetist shall be the same as the rate paid to the certified registered nurse anesthetist under medical direction.

(c) Medical assistance does not cover physicians' services related to the provision of care related to a treatment reportable under section 144.7065, subdivision 2, clauses (1), (2), (3), and (5), and subdivision 7, clause (1).

(d) Medical assistance does not cover physicians' services related to the provision of care (1) for which hospital reimbursement is prohibited under section 256.969, subdivision 3b, paragraph (c), or (2) reportable under section 144.7065, subdivisions 2 to 7, if the physicians' services are billed by a physician who delivered care that contributed to or caused the adverse health care event or hospital-acquired condition.

(e) The payment limitations in this subdivision shall also apply to MinnesotaCare and general assistance medical care.

(f) A physician shall not bill a recipient of services for any payment disallowed under this subdivision.

Subd. 3a. Sex reassignment surgery. Sex reassignment surgery is not covered.

Subd. 3b. Telemedicine consultations. Medical assistance covers telemedicine consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation. Coverage is limited to three telemedicine consultations per recipient per calendar week. Telemedicine consultations shall be paid at the full allowable rate.

Subd. 3c. Health Services Policy Committee. (a) The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a 13-member Health Services Policy Committee, which consists of 12 voting members and one nonvoting member. The Health Services Policy Committee shall advise the commissioner regarding health services pertaining to the administration of health care benefits covered under the medical assistance, general assistance medical care, and MinnesotaCare programs. The Health Services Policy Committee shall meet at least quarterly. The Health Services Policy Committee shall annually elect a physician chair from among its members, who shall work directly with the commissioner's medical director, to establish the agenda for each meeting. The Health Services Policy Committee shall also recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes.

(b) The commissioner shall establish a dental subcommittee to operate under the Health Services Policy Committee. The dental subcommittee consists of general dentists, dental
(1) certification procedures to ensure that providers of these services are qualified; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

Subd. 6. [Repealed, 1991 c 292 art 7 s 26]

Subd. 6a. Home health services. Home health services are those services specified in Minnesota Rules, part 9505.0295 and sections 256B.0651 and 256B.0653. Medical assistance covers home health services at a recipient's home residence. Medical assistance does not cover home health services for residents of a hospital, nursing facility, or intermediate care facility, unless the commissioner of human services has authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for persons with developmental disabilities, to prevent an admission to a hospital or nursing facility or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home health services or forgoes the facility per diem for the leave days that home health services are used. Home health services must be provided by a Medicare certified home health agency. All nursing and home health aide services must be provided according to sections 256B.0651 to 256B.0653.

Subd. 7. Private duty nursing. Medical assistance covers private duty nursing services in a recipient's home. Recipients who are authorized to receive private duty nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home. To use private duty nursing services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Medical assistance does not cover private duty nursing services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the private duty nursing services or forgoes the facility per diem for the leave days that private duty nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to sections 256B.0651 and 256B.0654 to 256B.0656. All private duty nursing services must be provided according to the limits established under sections 256B.0651 and 256B.0653 to 256B.0656. Private duty nursing services may not be reimbursed if the nurse is the family foster care provider of a recipient who is under age 18, unless allowed under section 256B.0654, subdivision 4.

Subd. 8. Physical therapy. Medical assistance covers physical therapy and related services, including specialized maintenance therapy. Authorization by the commissioner is required to provide medically necessary services to a recipient beyond any of the following onetime service thresholds, or a lower threshold where one has been established by the commissioner for a specified service: (1) 80 units of any approved CPT code other than modalities; (2) 20 modality sessions; and (3) three evaluations or reevaluations. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate.
Subd. 45. **Subacute psychiatric care for persons under 21 years of age.** Medical assistance covers subacute psychiatric care for person under 21 years of age when:

(1) the services meet the requirements of Code of Federal Regulations, title 42, section 440.160;

(2) the facility is accredited as a psychiatric treatment facility by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation; and

(3) the facility is licensed by the commissioner of health under section 144.50.

Subd. 46. **Mental health telemedicine.** Effective January 1, 2006, and subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via two-way interactive video. Use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Subd. 47. **Treatment foster care services.** Effective July 1, 2011, and subject to federal approval, medical assistance covers treatment foster care services according to section 256B.0946.

Subd. 48. **Psychiatric consultation to primary care practitioners.** Effective January 1, 2006, medical assistance covers consultation provided by a psychiatrist via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has:

(1) received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum; or

(2) at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.

Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.
256D.031 GENERAL ASSISTANCE MEDICAL CARE.

Subdivision 1. Eligibility. (a) Except as provided under subdivision 2, general assistance medical care may be paid for any individual who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, and who:

(1) is receiving assistance under section 256D.05, except for families with children who are eligible under the Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) is a resident of Minnesota and has gross countable income not in excess of 75 percent of federal poverty guidelines for the family size, using a six-month budget period, and whose equity in assets is not in excess of $1,000 per assistance unit.

Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, except that the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum.

(b) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

[See Note.]

Subd. 2. Ineligible groups. (a) General assistance medical care may not be paid for an applicant or a recipient who:

(1) is otherwise eligible for medical assistance but fails to verify the applicant's or recipient's assets;

(2) is an adult in a family with children as defined in section 256L.01, subdivision 3a;

(3) is enrolled in private health coverage as defined in section 256B.02, subdivision 9;

(4) is in a correctional facility, including an individual in a county correctional or detention facility as an individual accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order;

(5) resides in the Minnesota sex offender program defined in chapter 246B;

(6) does not cooperate with the county agency to meet the requirements of medical assistance; or

(7) does not cooperate with a county or state agency or the state medical review team in determining a disability or for determining eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration.

(b) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101, subsection (a), paragraph (15), and an undocumented noncitizen is an individual who resides in the United States without approval or acquiescence of the United States Citizenship and Immigration Services.
(c) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources is ineligible for general assistance medical care.

(d) General assistance medical care recipients who become eligible for medical assistance shall be terminated from general assistance medical care and transferred to medical assistance.

[See Note.]

Subd. 3. **Eligibility and enrollment procedures.** (a) Eligibility for general assistance medical care shall begin no earlier than the date of application. The date of application shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

(b) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(c) In determining the amount of assets of an individual eligible under subdivision 1, paragraph (a), clause (2), there shall be included any asset or interest in an asset, including an asset excluded under subdivision 1, paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(d) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include the noncitizen's sponsor's income and
resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(e) Applicants and recipients are eligible for general assistance medical care for a six-month eligibility period, unless a change that affects eligibility is reported. Eligibility may be renewed for additional six-month periods. During each six-month eligibility period, recipients who continue to meet the eligibility requirements of this section are not eligible for MinnesotaCare.

[See Note.]

Subd. 4. General assistance medical care; services. (a) Within the limitations described in this section, general assistance medical care covers medically necessary services that include:

(1) inpatient hospital services;
(2) outpatient hospital services;
(3) services provided by Medicare-certified rehabilitation agencies;
(4) prescription drugs;
(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;
(6) eyeglasses and eye examinations;
(7) hearing aids;
(8) prosthetic devices, if not covered by veterans benefits;
(9) laboratory and x-ray services;
(10) physicians' services;
(11) medical transportation except special transportation;
(12) chiropractic services as covered under the medical assistance program;
(13) podiatric services;
(14) dental services;
(15) mental health services covered under chapter 256B;
(16) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;
(17) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171;
(18) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b;

(19) care coordination and patient education services provided by a community health worker according to section 256B.0625, subdivision 49; and

(20) regardless of the number of employees that an enrolled health care provider may have, sign language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient who has a hearing loss and uses interpreting services.

(b) Sex reassignment surgery is not covered under this section.

(c) Outpatient prescription drug coverage is covered in accordance with section 256D.03, subdivision 3.

(d) The following co-payments shall apply for services provided:

1. $25 for nonemergency visits to a hospital-based emergency room; and

2. $3 per brand-name drug prescription, and $1 per generic drug prescription, subject to a $7 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(e) Co-payments shall be limited to one per day per provider for nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. Reimbursement for prescription drugs shall be reduced by the amount of the co-payment until the recipient has reached the $7 per month maximum for prescription drug co-payments. The provider shall collect the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(f) Chemical dependency services that are reimbursed under chapter 254B shall not be reimbursed under general assistance medical care.

(g) Inpatient hospital services that are provided in community behavioral health hospitals operated by state-operated services shall not be reimbursed under general assistance medical care.

[See Note.]

Subd. 5. Payment rates and contract modification; April 1, 2010, to May 31, 2010. (a) For the period April 1, 2010, to May 31, 2010, general assistance medical care shall be paid on a fee-for-service basis. Fee-for-service payment rates for services other than outpatient prescription drugs shall be set at 37 percent of the payment rate in effect on March 31, 2010.

(b) Outpatient prescription drugs covered under section 256D.03, subdivision 3, provided on or after April 1, 2010, to May 31, 2010, shall be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

(c) If sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4, are implemented effective July 1, 2010:

1. general assistance medical care must be paid on a fee-for-service basis for the period June 1 to June 30, 2010;
(2) fee-for-service payment rates for services other than outpatient prescription drugs must be set at 27 percent of the payment rate in effect on March 31, 2010; and

(3) outpatient prescription drugs considered under section 256D.03, subdivision 3, must be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

[See Note.]

Subd. 6. Coordinated care delivery systems. (a) Effective June 1, 2010, the commissioner shall contract with hospitals or groups of hospitals that qualify under paragraph (b) and agree to deliver services according to this subdivision. Contracting hospitals shall develop and implement a coordinated care delivery system to provide health care services to individuals who are eligible for general assistance medical care under this section and who either choose to receive services through the coordinated care delivery system or who are enrolled by the commissioner under paragraph (c). The health care services provided by the system must include: (1) the services described in subdivision 4 with the exception of outpatient prescription drug coverage but shall include drugs administered in a clinic or other outpatient setting; or (2) a set of comprehensive and medically necessary health services that the recipients might reasonably require to be maintained in good health and that has been approved by the commissioner, including at a minimum, but not limited to, emergency care, medical transportation services, inpatient hospital and physician care, outpatient health services, preventive health services, mental health services, and prescription drugs administered in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded under subdivision 9. A hospital establishing a coordinated care delivery system under this subdivision must ensure that the requirements of this subdivision are met.

(b) A hospital or group of hospitals may contract with the commissioner to develop and implement a coordinated care delivery system as follows:

(1) effective June 1, 2010, a hospital qualifies under this subdivision if: (i) during calendar year 2008, it received fee-for-service payments for services to general assistance medical care recipients (A) equal to or greater than $1,500,000, or (B) equal to or greater than 1.3 percent of net patient revenue; or (ii) a contract with the hospital is necessary to provide geographic access or to ensure that at least 80 percent of enrollees have access to a coordinated care delivery system; and

(2) effective December 1, 2010, a Minnesota hospital not qualified under clause (1) may contract with the commissioner under this subdivision if it agrees to satisfy the requirements of this subdivision.

Participation by hospitals shall become effective quarterly on June 1, September 1, December 1, or March 1. Hospital participation is effective for a period of 12 months and may be renewed for successive 12-month periods.

(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems. The commissioner may assign an applicant or recipient to a coordinated care delivery system if no choice is made by the applicant or recipient. The commissioner shall consider a recipient's zip code, city of residence, county of residence, or distance from a participating coordinated care delivery system when determining default assignment. An applicant or recipient may decline enrollment in a coordinated care delivery system. Upon enrollment into a coordinated care delivery system, the recipient must agree to
receive all nonemergency services through the coordinated care delivery system. Enrollment in a coordinated care delivery system is for six months and may be renewed for additional six-month periods, except that initial enrollment is for six months or until the end of a recipient's period of general assistance medical care eligibility, whichever occurs first. A recipient who continues to meet the eligibility requirements of this section is not eligible to enroll in MinnesotaCare during a period of enrollment in a coordinated care delivery system. From June 1, 2010, to February 28, 2011, applicants and recipients not enrolled in a coordinated care delivery system may seek services from a hospital eligible for reimbursement under the temporary uncompensated care pool established under subdivision 8. After February 28, 2011, services are available only through a coordinated care delivery system.

(d) The hospital may contract and coordinate with providers and clinics for the delivery of services and shall contract with essential community providers as defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the extent practicable. If a provider or clinic contracts with a hospital to provide services through the coordinated care delivery system, the provider may not refuse to provide services to any recipient enrolled in the system, and payment for services shall be negotiated with the hospital and paid by the hospital from the system's allocation under subdivision 7.

(e) A coordinated care delivery system must:

(1) provide the covered services required under paragraph (a) to recipients enrolled in the coordinated care delivery system, and comply with the requirements of subdivision 4, paragraphs (b) to (g);

(2) establish a process to monitor enrollment and ensure the quality of care provided;

(3) in cooperation with counties, coordinate the delivery of health care services with existing homeless prevention, supportive housing, and rent subsidy programs and funding administered by the Minnesota Housing Finance Agency under chapter 462A; and

(4) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(f) The hospital may require a recipient to designate a primary care provider or a primary care clinic. The hospital may limit the delivery of services to a network of providers who have contracted with the hospital to deliver services in accordance with this subdivision, and require a recipient to seek services only within this network. The hospital may also require a referral to a provider before the service is eligible for payment. A coordinated care delivery system is not required to provide payment to a provider who is not employed by or under contract with the system for services provided to a recipient enrolled in the system, except in cases of an emergency. For purposes of this section, emergency services are defined in accordance with Code of Federal Regulations, title 42, section 438.114 (a).

(g) A recipient enrolled in a coordinated care delivery system has the right to appeal to the commissioner according to section 256.045.

(h) The state shall not be liable for the payment of any cost or obligation incurred by the coordinated care delivery system.

(i) The hospital must provide the commissioner with data necessary for assessing enrollment, quality of care, cost, and utilization of services. Each hospital must provide, on a quarterly basis on
a form prescribed by the commissioner for each recipient served by the coordinated care delivery system, the services provided, the cost of services provided, and the actual payment amount for the services provided and any other information the commissioner deems necessary to claim federal Medicaid match. The commissioner must provide this data to the legislature on a quarterly basis.

(j) Effective June 1, 2010, the provisions of section 256.9695, subdivision 2, paragraph (b), do not apply to general assistance medical care provided under this section.

(k) Notwithstanding any other provision in this section to the contrary, for participation beginning September 1, 2010, the commissioner shall offer the same contract terms related to an enrollment threshold formula and financial liability protections to a hospital or group of hospitals qualified under this subdivision to develop and implement a coordinated care delivery system as those contained in the coordinated care delivery system contracts effective June 1, 2010.

(l) If sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4, are implemented effective July 1, 2010, this subdivision must not be implemented.

[See Note.]

Subd. 7. Payments; rate setting for the hospital coordinated care delivery system.

(a) Effective for general assistance medical care services, with the exception of outpatient prescription drug coverage, provided on or after June 1, 2010, through a coordinated care delivery system, the commissioner shall allocate the annual appropriation for the coordinated care delivery system to hospitals participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1, 2010. The payment shall be allocated among all hospitals qualified to participate on the allocation date as follows:

(1) each hospital or group of hospitals shall be allocated an initial amount based on the hospital's or group of hospitals' pro rata share of calendar year 2008 payments for general assistance medical care services to all participating hospitals;

(2) the initial allocations to Hennepin County Medical Center; Regions Hospital; Saint Mary's Medical Center; and the University of Minnesota Medical Center, Fairview, shall be increased to 110 percent of the value determined in clause (1);

(3) the initial allocation to hospitals not listed in clause (2) shall be reduced a pro rata amount in order to keep the allocations within the limit of available appropriations; and

(4) the amounts determined under clauses (1) to (3) shall be allocated to participating hospitals.

The commissioner may prospectively reallocate payments to participating hospitals on a biannual basis to ensure that final allocations reflect actual coordinated care delivery system enrollment. The 2008 base year shall be updated by one calendar year each June 1, beginning June 1, 2011.

(b) Beginning June 1, 2010, and every quarter beginning in June thereafter, the commissioner shall make one-third of the quarterly payment in June and the remaining two-thirds of the quarterly payment in July to each participating hospital or group of hospitals.

(c) In order to be reimbursed under this section, nonhospital providers of health care services shall contract with one or more hospitals described in paragraph (a) to provide services to general assistance medical care recipients through the coordinated care delivery system established by the
hospital. The hospital shall reimburse bills submitted by nonhospital providers participating under this paragraph at a rate negotiated between the hospital and the nonhospital provider.

(d) The commissioner shall apply for federal matching funds under section 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

(e) Outpatient prescription drug coverage is provided in accordance with section 256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

[See Note.]

Subd. 8. Temporary uncompensated care pool. (a) The commissioner shall establish a temporary uncompensated care pool, effective June 1, 2010. Payments from the pool must be distributed, within the limits of the available appropriation, to hospitals that are not part of a coordinated care delivery system established under subdivision 6.

(b) Hospitals seeking reimbursement from this pool must submit an invoice to the commissioner in a form prescribed by the commissioner for payment for services provided to an applicant or recipient not enrolled in a coordinated care delivery system. A payment amount, as calculated under current law, must be determined, but not paid, for each admission of or service provided to a general assistance medical care recipient on or after June 1, 2010, to February 28, 2011.

(c) The aggregated payment amounts for each hospital must be calculated as a percentage of the total calculated amount for all hospitals.

(d) Distributions from the uncompensated care pool for each hospital must be determined by multiplying the factor in paragraph (c) by the amount of money in the uncompensated care pool that is available for the six-month period.

(e) The commissioner shall apply for federal matching funds under section 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

(f) Outpatient prescription drugs are not eligible for payment under this subdivision.

[See Note.]

Subd. 9. Prescription drug pool. (a) The commissioner shall establish an outpatient prescription drug pool, effective June 1, 2010. Money in the pool must be used to reimburse pharmacies and other pharmacy service providers as defined in Minnesota Rules, part 9505.0340, for the covered outpatient prescription drugs dispensed to recipients. Payment for drugs shall be on a fee-for-service basis according to the rates established in section 256B.0625, subdivision 13e. Outpatient prescription drug coverage is subject to the availability of funds in the pool. If the commissioner forecasts that expenditures under this subdivision will exceed the appropriation for this purpose, the commissioner may bring recommendations to the Legislative Advisory Commission on methods to resolve the shortfall.

(b) Effective June 1, 2010, coordinated care delivery systems established under subdivision 6 shall pay to the commissioner, on a quarterly basis, an assessment equal to 20 percent of payments for the prescribed drugs for recipients of services through that coordinated care delivery system, as calculated by the commissioner based on the most recent available data.

[See Note.]
Subd. 10. **Assistance for veterans.** Hospitals participating in the coordinated care delivery system under subdivision 6 shall consult with counties, county veterans service officers, and the Veterans Administration to identify other programs for which general assistance medical care recipients enrolled in their system are qualified.

[See Note.]

**History:** 2010 c 200 art 1 s 12; 1Sp2010 c 1 art 16 s 32,40-42

**NOTE:** Subdivisions 1 to 10, as added by Laws 2010, chapter 200, article 1, section 12, and amended by Laws 2010, First Special Session chapter 1, article 16, sections 32, and 40 to 42, are repealed contingent upon implementation of Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4. Laws 2010, First Special Session chapter 1, article 16, section 47.
MISSISSIPPI

Mississippi’s state Medicaid Program reimburses for medically necessary teleradiology services. Mississippi Medicaid defines medically necessary teleradiology as being covered “…only when the originating site (spoke) documents that there are no local radiologists to interpret the images.” Reimbursement coverage includes one technical and one professional component for teleradiology services. However, reimbursement does not extend to transmission cost or any other associated cost.

The provider at the originating site must be enrolled as a Mississippi Medicaid provider in order to bill for the technical component of the radiological service. Similarly, the distant site (hub) must be enrolled as a Mississippi Medicaid provider in order to bill for the professional component of the radiological service.

Mississippi Medicaid also mandates that hospitals, independent radiological clinics, or physician clinics may not bill Mississippi Medicaid for both the technical and professional component of teleradiology services under their own provider number. Should a hospital choose to bill for purchased or contractual teleradiology services, the state Medicaid requires the services to be billed on a “CMS-1500” claim form under a physician group provider number.

Furthermore, providers are not permitted to bill for services performed by other providers. State statute asserts that each provider must qualify for a Mississippi Medicaid provider number and must bill for their own services.

In the area of tele-home care and remote monitoring services, Mississippi does not provide reimbursements.
Mississippi Medicaid covers medically necessary teleradiology services for all eligible beneficiaries in accordance with the below policies.

Definitions

Consulting provider means a licensed physician who provides the interpretation of the radiological image (professional component) at the distant site (hub). The consulting provider must be licensed in the state within the United States in which he/she practices.

Hub site means the location of the teleradiology consulting provider, also referred to as the distant site. The hub site provides the professional component of the service.

Modifier 26 identifies “professional component”.

Modifier TC identifies “technical component”.

Modifier GT identifies “interactive telecommunication”.

Referring provider means a licensed physician, physician assistant, or nurse practitioner who orders the radiological service. The referring provider must be licensed in the state within the United States in which he/she practices.

Spoke site means the location where the beneficiary is receiving the teleradiology service, also referred to as the originating site. The spoke site provides the technical component of the service.

Store and forward means telecommunication technology for the transfer of medical data from one site to another through the use of a camera, or similar device that records (stores) an image which is then sent (forwarded) via telecommunication to another site for teleconsultation.

Teleradiology is the electronic transmission of radiological images, such as x-rays, CTs, or MRIs (store-and-forward images), from one location to another for the purposes of interpretation.

Transmission Cost means the cost of the line charge incurred during the time of the transmission of a telehealth service.

Criteria for Reimbursement

Mississippi Medicaid will reimburse for one technical and one professional component for teleradiology services.

Medically necessary teleradiology is covered only when the originating site (spoke) documents that there are no local radiologists to interpret the images.

The provider at the originating site (spoke) must be enrolled as a Mississippi Medicaid provider in order to bill for the technical component of the radiological service. The spoke site provider must bill using the appropriate CPT radiological code with the TC and GT modifier.

Example: 70460 – TC – GT
The provider at the distant site (hub) must be enrolled as a Mississippi Medicaid provider in order to bill for the professional component of the radiological service. The hub site provider must bill using the appropriate CPT radiological code with the 26 and GT modifier.

Example: 70460 – 26 - GT

Hospitals, independent radiological clinics, or physician clinics may not bill Mississippi Medicaid for both the technical and professional component of teleradiology services under their own provider number. Providers may not bill for services performed by other providers. Each provider must qualify for a Mississippi Medicaid provider number and must bill for their own services. This also applies to teleradiology services through a purchase or contract arrangement.

If a hospital chooses to bill for purchased or contractual teleradiology services, the services must be billed on a CMS-1500 claim form under a physician group provider number.

No transmission cost or any other associated cost will be reimbursed.

**Quality of Service**

The available teleradiology system must provide images of sufficient quality to perform the indicated task. When a teleradiology system is used to render the official interpretation, there must not be a clinically significant loss of data from image acquisition through transmission to final image display. For transmission of images for display use only, the image quality should be sufficient to satisfy the needs to the clinical circumstance.

Equipment used in teleradiology will vary; however, in all cases, the equipment must provide image quality and availability appropriate to the clinical need.

The radiologic examination at the originating site (spoke) must be performed by qualified personnel trained in the performance of the specified radiological service and operating within the licensure and/or certification requirements of the state in which the service is being performed. Technicians must be working under the supervision of a qualified licensed physician.

**Documentation**

Services delivered via teleradiology are held to the same standard of documentation as non-teleradiology services. All professional and institutional providers participating in the Medicaid program are required to maintain records that disclose the services rendered and billed under the program. Upon request, records should be made available to DOM, the DOM’s fiscal agent, the Medicaid Fraud Control Unit, and any other designated representative of the DOM to substantiate any or all claims.

In each instance, the provider file at the spoke location must include at a minimum:

- Documentation of the reason that teleradiology was utilized to deliver the service
- Date(s) of service
- Beneficiary demographic information, i.e., name, Medicaid ID number, age sex, etc.
- Signed consent for treatment, if applicable
- Medical history
- Patient’s presenting complaint
- Diagnosis
- Specific name/type of all diagnostic studies and results/findings of the studies
In each instance, the provider file at the hub location must include at a minimum:

- Date(s) of service
- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- Medical history
- Patient’s presenting complaint
- Diagnosis
- Specific name/type of all diagnostic studies and results/findings of the studies
- Radiological images

Refer to Section 7.03 for additional documentation requirements.

**Security**

Teleradiology systems should provide network and software security protocols to protect the confidentiality of beneficiaries’ identification and imaging data. There must be measures to safeguard the data and to ensure data integrity against intentional or unintentional corruption of the data. All providers are responsible for ensuring confidentiality in accordance with HIPAA privacy regulations.
MISSOURI

Missouri’s state Medicaid program (MO HealthNet) reimburses for real-time telehealth care at the same level as face-to-face consultations—but only if medically necessary.

In the area of tele-home care and remote monitoring services, Missouri does not cover home telehealth services.
# Rules of
## Department of Social Services
### Division 70—MO HealthNet Division
#### Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

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Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

13 CSR 70-3.180 Medical Pre-Certification Process

PURPOSE: This rule establishes the medical pre-certification process of the MO HealthNet Program for certain covered diagnostic and ancillary procedures and services prior to provision of the procedure or service as a condition of reimbursement. This rule shall only apply to those diagnostic and ancillary procedures or services that are listed in the provider manuals, provider bulletins, or clinical edits criteria which are incorporated by reference and made a part of this rule. The medical pre-certification process serves as a utilization management tool, allowing payment for services that are medically necessary, appropriate, and cost-effective without compromising the quality of care provided to MO HealthNet participants.

PUBLISHER’S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Providers are required to seek pre-certification for certain specified services listed in the provider manuals, provider bulletins, or clinical edits criteria before delivery of the services. This rule shall apply to diagnostic and ancillary procedures and services listed in the provider manuals, provider bulletins, or clinical edits criteria when ordered by a healthcare provider unless provided in an inpatient hospital or emergency room setting. This pre-certification process shall not include primary services performed directly by the provider. In addition to services and procedures that are available through the traditional medical assistance program, expanded services are available to children twenty (20) years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require pre-certification. Certain services require pre-certification only when provided in a specific place or when they exceed certain limits. These limitations are explained in detail in subsections 13(3) and 14(4) of the applicable provider manuals, provider bulletins, or clinical edits criteria, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/mhd, April 1, 2009. The rule does not incorporate any subsequent amendments or additions. This rule shall only apply to those diagnostic and ancillary procedures or services that are listed in the provider manuals, provider bulletins, or clinical edits criteria which are incorporated by reference and made a part of this rule.

(2) All requests for pre-certification must be initiated by an enrolled medical assistance provider and approved by the MO HealthNet Division. A covered service for which pre-certification is requested must meet medical criteria established by the MO HealthNet Division’s medical consultants or medical advisory groups in order to be approved.

(3) An approved pre-certification request does not guarantee payment. The provider must be enrolled and verify participant eligibility on the date of service.

(4) Approved services/procedures must be initiated within six (6) months of the date the pre-certification approval is issued. Services/procedures initiated after the six (6)-month approval period will be void and payment denied.

(5) The pre-certification for a specific service is time and patient status and/or diagnosis sensitive. A denial at any given time shall not prejudice or impact the decision to grant a future request for the same or similar service.

(6) Pre-certifications for exactly the same service may be granted to allow provision over an extended period of time and may be granted for a term of not more than one (1) year.

(7) If a pre-certification request is denied, the medical assistance participant will receive a letter which outlines the reason for the denial and the procedure for appeal. The MO HealthNet participant must contact the Participant Services Unit within ninety (90) days of the date of the denial letter if they wish to request a hearing. After ninety (90) days a request to appeal the pre-certification decision is denied.


13 CSR 70-3.190 Telehealth Services

PURPOSE: This rule establishes coverage of the Telehealth spoke site facility fee and to define services considered appropriate for this form of interactive technology from a hub site to a participant at a spoke site.

PUBLISHER’S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration.

(A) This rule is established pursuant to the authority granted to the Missouri Department of Social Services, MO HealthNet Division, to promulgate rules governing the practice of Telehealth in the MO HealthNet Program.

(B) Definitions.

1. Community Mental Health Center (CMHC) means a legal entity through which comprehensive mental health services are provided to individuals residing in a certain service area.

2. Consultation means a type of evaluation and management service as defined by the most recent edition of the Current Procedural Terminology published annually by the American Medical Association.

3. Consulting provider means a provider who evaluates the patient and appropriate medical data or images through a Telehealth mode of delivery, upon recommendation of the referring provider.

4. Comprehensive Substance Treatment and Rehabilitation (CSTAR) means a MO HealthNet qualified and enrolled outpatient substance abuse treatment program. Coverage is targeted to MO HealthNet-eligible participants who are assessed as requiring substance abuse treatment.

ROBIN CARNAHAN
Secretary of State
(11/30/10)

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5. Department means the Department of Social Services.
6. Distant site means a Telehealth site where the health care provider providing the Telehealth service is physically located at the time the Telehealth service is provided and is considered the place of service.
7. Division means the MO HealthNet Division, within the Department of Social Services.
8. GT modifier means a modifier that identifies a Telehealth service which is approved by the Healthcare Common Procedure Coding System (HCPCS).
9. Health care provider means a:
   A. Missouri licensed physician;
   B. Missouri licensed advanced registered nurse practitioner;
   C. Missouri licensed dentist or oral surgeon;
   D. Missouri licensed psychologist or provisional licensee;
   E. Missouri licensed pharmacist; or
   F. Missouri licensed speech, occupational, or physical therapist.
10. MTN means the Missouri Telehealth Network.
11. Originating site means a Telehealth site where the MO HealthNet participant receiving the Telehealth service is located for the encounter. The originating site must ensure immediate availability of clinical staff during a Telehealth encounter in the event a participant requires assistance. An originating site must be one of the following locations:
   A. Office of a physician or health care provider;
   B. Hospital;
   C. Critical access hospital;
   D. Rural health clinic;
   E. Federally Qualified Health Center;
   F. Nursing home;
   G. Dialysis center;
   H. Missouri state habilitation center or regional office;
   I. Community mental health center;
   J. Missouri state mental health facility;
   K. Missouri state facility;
   L. Missouri residential treatment facility—licensed by and under contract with the Children’s Division (CD) and has a contract with the CD. Facilities must have multiple campuses and have the ability to adhere to technology requirements addressed in this rule. Only Missouri licensed psychiatrists, licensed psychologists or provisionally licensed psychologists, and advanced registered nurse practitioners who are enrolled in the MO HealthNet program may be consulting providers at these locations; or
   M. Comprehensive Substance Treatment and Rehabilitation (CSTAR) program.
12. Participant means an individual eligible for medical assistance benefits on behalf of needy persons through MO HealthNet, under section 208.151, RSMo.
13. Presenting provider means a provider who:
   A. Introduces a patient to a consulting provider for examination, observation, or consideration of medical information; and
   B. May assist in the Telehealth encounter.
14. Telepresenter means a person who introduces a patient to a consulting provider for examination, observation, or consideration of medical information; and
15. Referring provider means a provider who evaluates a patient, determines the need for a consultation, and arranges the services of a consulting provider for the purpose of diagnosis or treatment.
16. Telehealth means the use of medical information exchanged from one (1) site to another via electronic communications to improve the health status of a patient. Telehealth includes the practice of health care delivery, evaluation, diagnosis, consultation, or treatment using the transfer of medical data, audio visual, or data communications that are performed over two or more locations between providers who are physically separated from the patient or from each other.
17. Telehealth service means a medical service provided through advanced telecommunications technology from a distant site to a participant at an originating site.
18. Two (2)-way interactive video means a type of advanced telecommunications technology that permits a real time service to take place between a participant and a presenting provider or a Telepresenter at the originating site and a health care provider at the distant site.
19. Eligible Providers.
   A. Office of a physician or health care provider;
   B. Hospital;
   C. Critical access hospital;
   D. Rural health clinic;
   E. Federally Qualified Health Center;
   F. Nursing home;
   G. Dialysis center;
   H. Missouri state habilitation center or regional office;
   I. Community mental health center;
   J. Missouri state mental health facility;
   K. Missouri state facility;
   L. Missouri residential treatment facility—licensed by and under contract with the Children’s Division (CD) and has a contract with the CD. Facilities must have multiple campuses and have the ability to adhere to technology requirements addressed in this rule. Only Missouri licensed psychiatrists, licensed psychologists or provisionally licensed psychologists, and advanced registered nurse practitioners who are enrolled in the MO HealthNet program may be consulting providers at these locations; or
   M. Comprehensive Substance Treatment and Rehabilitation (CSTAR) program.
20. Coverage of services rendered through Telehealth at the distant site is limited to:
   1. Consultations made to confirm a diagnosis; or
   2. Evaluation and management services; or
   3. A diagnosis, therapeutic, or interpretive service; or
   4. Individual psychiatric or substance abuse assessment diagnostic interview examinations; or
   5. Individual psychotherapy; or
   6. Pharmacologic management.
   (D) The participant must be present for the encounter.
21. (3) Eligible Providers.
   (A) A health care provider utilizing Telehealth at either a distant site or an originating site shall be enrolled as a MO HealthNet provider pursuant to 13 CSR 70-3.020 and licensed for practice in Missouri. A health care provider utilizing Telehealth must do so in a manner that is consistent with the provisions of all laws governing the practice of the provider’s profession.
   (B) A provider agrees to conform to MO HealthNet program policies and instructions as specified in the provider manuals and bulletins, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/mhd, April 1, 2009. This rule does not incorporate any subsequent amendments or additions.
22. Prior Authorization and Utilization Review. All services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, before payment is made, or after payment is made.
   (A) Prior Authorization. Certain procedures or services can require prior authorization from the MO HealthNet Division or its authorized agents. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. A service provided through Telehealth is subject to the same prior authorization and utilization review requirement which exist for the service when not provided through Telehealth.
   (B) Eligibility Determination. Prior authorization of services does not guarantee an individual is eligible for a MO HealthNet service. Providers must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the participant has other health insurance.
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

13 CSR 70-3

(5) Reimbursement.
A Reimbursement to the health care provider delivering the medical service at the distant site is made at the same amount as the current fee schedule for the service provided without the use of a telecommunication system.

B The claim for service will use the appropriate procedure code for the covered services addressed in (2)(C) and the GT modifier indicating interactive communication was used.

C The originating site is eligible to receive a facility fee. Facility fees are not payable to the distant site.

D Services provided by practitioners must be within their scope(s) of practice and according to MO HealthNet policy.

E Reimbursement for services furnished by interns or residents in hospitals with approved teaching program or services furnished in other hospitals that participate in teaching programs is made through institutional reimbursement. The division cannot be billed directly by interns or residents for Telehealth services.

(6) Documentation for the Encounter. Patient records at the distant and originating sites are to document the Telehealth encounter consistent with the service documentation described in MO HealthNet provider manuals and bulletins.

A A request for a Telehealth service from a referring provider and the medical necessity for the Telehealth service shall be documented in the participant’s medical record.

B A health care provider shall keep a complete medical record of a Telehealth service provided to a participant and follow applicable state and federal statutes and regulations for medical record keeping and confidentiality in accordance with 13 CSR 70-3.030 and 13 CSR 70-98.015.

C Documentation of a Telehealth service by the health care provider shall be included in the participant’s medical record.

D A provider of a Telehealth service shall implement confidentiality protocols that include:
1. Identifying personnel who have access to a Telehealth transmission; and
2. Preventing unauthorized access to a Telehealth transmission.

E A provider’s protocols and guidelines shall be available for inspection by the department upon request.

(8) Informed Consent.
A Before providing a Telehealth service to a participant, a health care provider shall document written informed consent from the participant or the participant’s legal guardian and shall ensure that the following written information is provided to the participant in a format and manner that the participant is able to understand:
1. The participant shall have the option to refuse the Telehealth service at anytime without affecting the right to future care or treatment and without risking the loss or withdrawal of a MO HealthNet benefit to which the participant is entitled;
2. The participant shall be informed of alternatives to the Telehealth service that are available to the participant;
3. The participant shall have access to medical information resulting from the Telehealth service as provided by law;
4. The dissemination, storage, or retention of an identifiable participant image or other information from the Telehealth service shall not occur without the written informed consent of the participant or the participant’s legally authorized representative;
5. The participant shall have the right to be informed of the parties who will be present at the originating site and the distant site during the Telehealth service and shall have the right to exclude anyone from either site; and
6. The participant shall have the right to object to the videotaping or other recording of a Telehealth service.

B A copy of the signed informed consent shall be retained in the participant’s medical record and provided to the participant or the participant’s legally authorized representative upon request.

C The requirement to obtain informed consent before providing a service shall not apply to an emergency situation if the participant is unable to provide informed consent and the participant’s legally authorized representative is unavailable.


13 CSR 70-3.200 Ambulance Service Reimbursement Allowance

PURPOSE: This rule establishes the formula for determining the Ambulance Service Reimbursement Allowance each ground emergency ambulance service must pay, except for any ambulance service owned and operated by an entity owned or operated by the board of curators, as defined in Chapter 172, RSMo, or any department of the state, in addition to all other fees and taxes now required or paid, for the privilege of engaging in the business of providing ground emergency ambulance services in Missouri.

(1) Ambulance Service Reimbursement Allowance shall be assessed as described in this section.

A Definitions.
1. Ambulance. Ambulance shall have the same meaning as such term is defined in section 190.100, RSMo.
2. Department. Department of Social Services.
3. Director. Director of the Department of Social Services.
4. Division. MO HealthNet Division.
5. Gross receipts. Emergency ambulance revenue from Medicare, Medicaid, insurance, and private payments received by an ambulance service licensed under section 190.109, RSMo (or by its predecessor in interest following a change of ownership). Revenue from CPT Code A0427/A0425 ambulance service, advanced life support, emergency transport, level 1 (ALS1—emergency), and associated ground mileage; CPT Code A0429/A0425 ambulance services,
Montana’s state Medicaid program does reimburse for services provided via telemedicine. Montana’s Medicaid covers telemedicine services when the consulting provider is enrolled in Medicaid. The requesting provider, however, need not be enrolled in Medicaid nor be present during the telemedicine consult. Telehealth has a long history in Montana; the Eastern Montana Telemedicine Network was founded in 1993, and is now composed of more than 20 partner health centers.

In the area of tele-home care and remote monitoring, Montana does not reimburse for home telehealth services.
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**Telemedicine services**

- Medicaid covers telemedicine services when the consulting provider is enrolled in Medicaid.
- The requesting provider need not be enrolled in Medicaid nor be present during the telemedicine consult.
- Medicaid does not cover network use charges.

**Transplants**

All Medicaid transplant services must be prior authorized (see the PASSPORT and Prior Authorization chapter in this manual). Medicaid covers the following transplant services:

- For clients 21 years or older: only bone marrow, kidney, or cornea transplants.
- For clients less than 21 years old: all transplants that are covered by Medicare that are not considered experimental or investigational.

**Weight reduction**

- Physicians and mid-level practitioners who counsel and monitor clients on weight reduction programs can be paid for those services. If medical necessity is documented, Medicaid will also cover lab work. Similar services provided by nutritionists are not covered for adults.
- Medicaid does **not** cover the following weight reduction services:
  - Weight reduction plans or programs (e.g., Jenny Craig, Weight Watchers, etc.)
  - Nutritional supplements
  - Dietary supplements
  - Health club memberships
  - Educational services of a nutritionist
  - Gastric bypass

**Emergency department visits**

The Department covers emergency services provided in the emergency department. Emergency medical services are those services required to treat and stabilize an emergency medical condition. Beginning August 1, 2003, a service is reimbursed as an emergency if one of the following criteria is met:

- The service is billed with a CPT code of 99284 or 99285
- The client has a qualifying emergency diagnosis code. A list of the Department’s pre-approved emergency diagnosis codes is available on the Provider Information website under Emergency Diagnosis Codes (see Key Contacts).
• For a list of global surgery periods by procedure code, please see the current Department fee schedule for your provider type.

• If the CPT-4 manual lists a procedure as including the surgical procedure only (i.e., a “starred” procedure) but Medicaid lists the code with a global period, the Medicaid global period applies. Almost all Medicaid fees are based on Medicare relative value units (RVUs), and the Medicare relative value units were set using global periods even for starred procedures. Montana Medicaid has accepted these RVUs as the basis for its fee schedule.

• In some cases, a physician (or the physician’s partner of the same specialty in the same group practice) provides care within a global period that is unrelated to the surgical procedure. In these circumstances, the unrelated service must be billed with the appropriate modifier to indicate it was not related to the surgery.

**Telemedicine services**

• When performing a telemedicine consult, use the appropriate CPT-4 evaluation and management (E&M) consult code.

• The place of service is the location of the provider providing the telemedicine service.

• Medicaid does not pay for network use or other infrastructure charges.

**Transplants**

Include the prior authorization number on the claim (field 23 on the CMS-1500 claim form). See the *Completing a Claim* chapter in this manual. All providers must have their own prior authorization number for the services. For details on obtaining prior authorization, see the *PASSPORT and Prior Authorization* chapter in this manual.

**Weight reduction**

Providers who counsel and monitor clients on weight reduction programs must bill Medicaid using appropriate evaluation and management (E&M) codes.

**Unlisted procedures**

Unlisted CPT or HCPCS codes are to be sent to the Department for review. They can be sent to:

- Physician-Related Services
- Claim Review
- P.O. Box 202951
- Helena, MT 59602

Unlisted procedures are paid via the by-report methodology. See page 9.5 for more information on this method.
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NEBRASKA

Nebraska’s state Medicaid program does reimburse for medically necessary care provided via telemedicine. This includes teleradiology provided the services meet the American College of Radiology’s standards for teleradiology. The state’s policy is very broad as reimbursement is provided for essentially any service delivered by telehealth that is ordinarily covered by the state Medicaid program.

In the area of tele-home care and remote monitoring, Nebraska does not reimburse for home telehealth services.
CHAPTER 1-000  ADMINISTRATION

1-001  Introduction: This title addresses services provided under the Nebraska Medical Assistance Program (also known as Nebraska Medicaid).

1-001.01  Legal Basis: The Nebraska Medical Assistance Program (NMAP) was established under Title XIX of the Social Security Act. The Nebraska Legislature established the program for Nebraska in Neb.Rev.Stat. §68-1018. NMAP is administered statewide by the Nebraska Department of Health and Human Services Finance and Support (HHS Finance and Support or the Department).

1-001.02  Purpose: The Nebraska Medical Assistance Program was established to provide medical and other health-related services to aged, blind, or disabled persons; dependent children; and any persons otherwise eligible who do not have sufficient income and resources to meet their medical needs.

1-001.03  Title XIX Plan: The State Plan for Title XIX of the Social Security Act - Medical Assistance Program is a comprehensive written commitment of the state to administer the Nebraska Medical Assistance Program in accordance with federal requirements. The Title XIX Plan is approved by the Federal Department of Health and Human Services. The approved plan is a basis for determining federal financial participation in the state program. The rules and regulations of NMAP implement the provisions of the Title XIX Plan.

1-002  Nebraska Medicaid-Coverable Services: The Nebraska Medical Assistance Program covers the following types of service, when medically necessary and appropriate, under the program guidelines and limitations for each service:

1. Inpatient hospital services;
2. Outpatient hospital services;
3. Rural health clinic services;
4. Federally qualified health center services;
5. Laboratory and x-ray services;
6. Nurse practitioner services;
7. Nursing facility (NF) services;
8. Home health services;
9. Early and periodic screening, diagnosis, and treatment (HEALTH CHECK);
10. Family planning services;
11. Physician services and medical and surgical services of a dentist;
12. Nurse midwife services;
13. Prescribed drugs;
14. Services in intermediate care facilities for the mentally retarded (ICF/MR);
15. Inpatient psychiatric services for individuals under age 21;
1-006  TELEHEALTH SERVICES

1-006.01  Scope and Authority: These regulations govern Medicaid covered telehealth services and implement the Nebraska Telehealth Act (Neb. Rev. Stat. Sections 71-8501 to 8508). This statute authorizes the Department to cover telehealth consultations and transmission costs.

Under the Act telehealth consultation means any contact between a patient and a health care practitioner relating to the health care diagnosis or treatment of such patient through telehealth but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care practitioners. “Consultation” elsewhere in the Nebraska Medical Assistance Program (NMAP) regulations refers to services provided by a physician specialist. Therefore, for purposes of these NMAP regulations, “telehealth service” is used instead of “telehealth consultation” to clarify that coverage is available beyond the traditional meaning of “consultation”.

Medicaid coverage for telehealth services allows clients, particularly those in medically underserved areas of the state, to improve access to essential health care services that may not otherwise be available without traveling long distances.

1-006.02 Definitions:

Electronic Mail (e-mail) Transmission means transactions of a text or graphical nature between two or more persons exchanged by e-mail over public or private data communications networks including the Internet.

Facsimile Transmission means transactions of a text or graphical nature between two or more persons exchanged via facsimile (FAX) over the Public Switched Telephone Network (PSTN) or other public or private data communications networks including the Internet.

FDA means the federal Food and Drug Administration.

H.320 means the industry-wide compressed audiovideo communication standard from the International Telecommunications Union (ITU) for real time, two-way interactive audiovideo transmission with a minimum signal of 384 kbps (kilobits per second) over a dedicated line; this may include a switched connection.

H.323 means the industry-wide compressed audiovideo communication standard from the International Telecommunications Union (ITU) for real time, two-way interactive audiovideo transmission with a minimum signal of 384 kbps (kilobits per second) over an intranet or other controlled environment system.
Health Care Practitioner means a health care professional who is licensed, certified, or registered with Nebraska Department of Health and Human Services Regulation and Licensure or with the comparable agency in the state in which s/he practices his/her profession.

Health Care Practitioner Facility means the residence, office, or clinic or a practitioner or group of practitioners who are enrolled with Medicaid and credentialed under the Uniform Licensing Law or any distinct part of such residence, office, or clinic.

Legally Authorized Representative means the client’s parent if the client is a minor child, a legal guardian, or a person with power of attorney for the client.

T1 Line means a digital transmission service of 1.544 Mbps.

Telehealth means the use of telecommunications technology by a health care practitioner to deliver health care services within his or her scope of practice to a patient located at a site other than the site where the practitioner is located.

Telehealth Service means any contact between a patient and a health care practitioner relating to the health care diagnosis or treatment of such patient through telehealth but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care practitioners.

Telehealth Site means either a health care facility enrolled with Medicaid and licensed under Neb. Rev. Stat. Section 71-2017 to 71-2029, and effective January 1, 2001, licensed under the Health Care Facility Act or a health care practitioner facility whose practitioners are enrolled with Medicaid and credentialed under the Uniform Licensing Law.

Telephone Conversation means a transaction conducted by voice conversations between two or more persons over a private telecommunication system or the Public Switched Telephone Network (PSTN).

Telephone means an instrument for reproducing sounds at a distance; specifically, one in which sound is converted into analog or digital signals for transmission by wire or other modality.

Transmission Cost means the cost of the line charge incurred during the time of the transmission of a telehealth service.

USF means the Universal Services Fund established under the federal Telecommunications Act of 1996.
1-006.03 Standards for Provider Participation:

Health care practitioners must:

1. Act within their scope of practice;
2. Be enrolled with NMAP; and
3. Be appropriately licensed, certified, or registered by the Nebraska HHS Regulation and Licensure agency for the service for which they bill Medicaid. (An exception to this requirement may be allowed when the telehealth service is delivered out-of-state and covered under 471 NAC 1-006.10D Out of State Services.)

Entities enrolled as Medicaid providers other than practitioners (such as hospitals) which bill for practitioner services may bill for telehealth services when the practitioner providing the service meets the above requirements.

In providing telehealth services, health care practitioners and health care facilities shall follow all applicable state and federal laws and regulations governing their practice, including, but not limited to, the requirements for maintaining confidentiality and obtaining informed consent.

Prior to billing Medicaid for any telehealth services, each telehealth site must submit a letter (2 copies) to the Department as required under 471 NAC 1-006.10C regarding quality assurance issues.

1-006.04 Coverage for Telehealth Services and Transmission Costs: Effective July 1, 2000, Medicaid services that are otherwise covered in the NMAP and are provided via telecommunication technologies may be reimbursed under the conditions and limitations set forth in these regulations. Payment for telehealth services must be consistent with the federal requirements of efficiency, economy, and quality. In-person contact between a health care provider and a client is not required under the NMAP telehealth regulations except where otherwise required by federal statute or regulation.

Services otherwise covered by NMAP and delivered via telecommunication technology may be reimbursed when the following conditions are met:

1-006.04A Health Care Practitioner Requirement: Telehealth services are covered only when provided by a health care practitioner meeting the requirements in 471 NAC 1-006.03 Standards for Provider Participation.

1-006.04B NMAP 471 and 482 NAC Requirements: Services provided via telehealth are subject to all current NMAP regulations in 471 and 482 NAC including, but not limited to, the requirement:

1) that services are medically necessary and appropriate to the client’s condition;
2) that active treatment for mental health/substance abuse services is met; and
3) that the service provided is a generally accepted standard of care.
1-006.04C Telecommunications Technology: Coverage is only available for telehealth services and for telehealth transmission costs when, at a minimum, the H.320 or H.323 audiovideo standards for real time, two-way interactive audiovisual transmission are met or when any analog or alternate transmission technology system equals or exceeds the H.320 or H.323 standard for clarity and quality. The Department may request an independent expert opinion as to whether a provider’s system meets the technology standards for this requirement.

In addition, the telecommunication technology and equipment used at the client site and at the practitioner site must be sufficient to allow the health care practitioner to appropriately evaluate, diagnose, or treat the client or to appropriately accomplish the service billed to Medicaid. At a minimum, the equipment must be of a level of quality to accomplish the level of service and to adequately complete all necessary components as defined in the national standard code sets billed to NMAP.

If a peripheral diagnostic scope or device is required to assess the client, it must provide adequate resolution or audio quality for decision making via telehealth.

Coverage is available for teleradiology services when these services meet the American College of Radiology standards for teleradiology (see ACR Standard for Teleradiology: Revised 1998 (Res.35) Effective 1/1/99 as amended – attached and incorporated by reference).

1-006.04D Prior Authorization: All prior authorization requirements outlined in 471 and 482 NAC for specific services must be met to be covered as a telehealth service. Prior authorization requests must state the intent to provide the service as a telehealth service.

1-006.04E Transmission Costs: Transmission costs for line charges are allowable when directly related to a covered telehealth service and when the standards in 1-006.04C are met for real time, two-way interactive audiovisual transmission.

Transmission costs may be covered as outlined in these regulations. However, transmission costs are not a separate billable service and are included in the payment for inpatient hospital services or in the per diem or per monthly payment for the other services below:

1. Inpatient Hospital Services, including general hospital as well as psychiatric and rehabilitation hospital services;
2. Nursing Facility Services;
3. Intermediate Care Facility-Mentally Retarded (ICF-MR) Services;
4. Assisted Living Facility Services;
5. Residential Treatment Center Services;
6. Treatment Group Home Services;
7. Day Treatment Facility Services;
8. Treatment Foster Care Services;
9. Mental Health/Substance Abuse Crisis Facility Services; and

When a client receives a telehealth service as part of the services listed above, the transmission service must be reported on each individual claim and on the facility’s cost report.

1-006.04F Managed Care: Coverage of services delivered via telecommunications technology under contracted Medicaid managed care plans is required to the extent that coverage and reimbursement is available under the Medicaid fee-for-service program. In the event that coverage of services delivered through telehealth proves not to be cost neutral, the appropriate capitation rates may be adjusted.

No fee-for-service coverage outside the managed care plan is available for telehealth services for clients enrolled in managed care.

All managed care referral procedures and authorization requirements shall be followed (see Title 482 NAC).

1-006.05 Non-Covered Telehealth Services: Services provided via telehealth technologies are not covered when any one of the following conditions is met:

1-006.05A Non-Covered Medicaid Services: Services not otherwise covered by Nebraska Medicaid are not covered when delivered via telehealth.

1-006.05B Services Excluded from Coverage as a Telehealth Service: Services covered under other Medicaid regulations but specifically excluded from telehealth coverage are:

1. Medical Equipment and Supplies provided by DME (Durable Medical Equipment) suppliers and pharmacies;
2. Orthotics and Prosthetics provided by DME suppliers and pharmacies;
3. Personal care aide (PCA) services;
4. Home Health Aide Services;
5. Pharmacy services for prescribed drugs;
6. Home and Community Based Waiver services provided by persons who do not meet the standards for a practitioner of telehealth services in 471 NAC 1-006.03;
7. Mental Health, Substance Abuse, and Psychiatric Rehabilitation services provided by persons who do not meet the standards for a practitioner of telehealth services in 471 NAC 1-006.03 (e.g., Community Treatment Aids; Certified Alcohol and Drug Abuse Counselors; Ph. D. candidates who are not licensed or certified; and other enrolled professionals who are not licensed, certified, or registered by HHS – Regulation and Licensure);
8. Medical Transportation services, including ambulance services;
9. Federal Qualified Health Center core services billed as an “encounter” service;
10. Rural Health Clinic core services billed as an “encounter” service;
11. Physician visits to clients in nursing facilities required on the specified periodic schedule for nursing facility certification;
12. Tribal 638 Clinic core services billed as an “encounter” service;
13. Services requiring “hands on” professional services such as eye glass fittings and hearing aid fittings;
14. Services provided in public schools by staff who are not licensed, certified, or registered with HHS – Regulation and Licensure;
15. Ambulatory Room and Board services; and
16. Other services that do not meet the requirements of these telehealth regulations.

1-006.05C  Inappropriate Telecommunications Technologies: Coverage is not available when the minimum standards for telecommunication technologies in 471 NAC 1-006.04C are not met or when the technologies used are not appropriate for the service delivered and billed to Medicaid.

1-006.D Free to the General Public: Medicaid does not reimburse services that are provided free to the general public. See 471 NAC 3-001.02D and 2-001.03(1 through 5).

1-006.05E Distance Requirement: Services provided via telecommunications technologies are not covered if the client has access to a comparable service within 30 miles of his/her place of residence. This requirement does not apply:

1. In emergency or urgent medical situations;
2. When accessing the appropriate service at a distance less than 30 miles poses a significant hardship on the client due to a medical condition or disability; or
3. To clients residing in nursing facilities who require transportation to the appropriate service via ambulance.

When billing a telehealth service or transmission cost within a 30 mile radius of the client’s place of residence, one of the above three reasons must be documented in the medical record and available to the Department upon request.

1-006.05F E-Mail, Telephone, and Facsimile Transmissions: Telehealth services provided via e-mail, telephone, or facsimile transmissions are not covered.

1-006.05G Devices Subject to FDA Approval: Medicaid does not cover services that utilize a device or telecommunication technology subject to FDA approval but not FDA approved for the telehealth service. However, FDA approval does not guarantee coverage of a service.

1-006.05H Prescriptions over the Internet: Neither the prescribing health care practitioner service nor the pharmacy service is covered when the health care practitioner prescribing the medication has only reviewed an e-mail message or e-mail questionnaire about the client.
1-006.05I Investigational/Experimental Services: A telehealth service is not covered when the service delivered via telecommunication technology is deemed to be investigational or experimental under 471 NAC 1-002.02C. Even though a service is covered when provided in-person to a client, the service may be deemed investigational/experimental for Medicaid payment purposes when provided via telecommunications technology. (Also, see 471 NAC 1-006.05G regarding devices requiring FDA approval.)

An example of a service excluded from telehealth coverage because the services are deemed investigational/experimental or do not meet current accepted standards of medical care is as follows: surgery performed by a mechanical device operated by a practitioner who is at a site different from where the patient is located.

1-006.05J Services Requiring Direct Physical Contact with a Practitioner: Services that require direct physical contact with a client by a health care practitioner and that cannot be delegated to another health care practitioner at the site where the client is located are not covered.

1-006.06 Non-Covered Transmission Costs

1-006.06A Low Transmission Capacity: Transmission costs are not covered when the real time, two-way interactive audio-visual transmission is below the standards stated in 471 NAC 1-006.04C; for example, transmission has a signal less than 384 kbps.

1-006.06B Negligible Transmission Time: Transmission costs are not covered when transmission time is negligible. Transmission time is negligible in instances such as, but not limited to, the store and forward transmission of data sent for professional review and interpretation. Transmission time less than 5 minutes for a telehealth service is deemed negligible for Medicaid payment purposes under this section.

1-006.06D Medicare/Insurance Covered Telehealth Service: Providers shall not bill Medicaid or the client for transmission costs incurred as part of a Medicare covered telehealth service and excluded from Medicare coverage. If the practitioner bills insurance or other third party liability entity for the telehealth service, and payment for the telehealth service includes payment for transmission costs, the provider shall not bill Medicaid separately for transmission costs.

1-006.06E Non-Covered Telehealth Services: Transmission costs are not covered when the telehealth service provided by the health care practitioner is not covered under these regulations.
1-006.07 Rural Health Clinic and Federally Qualified Health Center Encounter Rates: Telehealth services are not covered under the encounter rate for rural health clinic (RHC) core services and federally qualified health center (FQHC) core services where reimbursement is based on a “face to face” encounter between a provider and a patient. See 42 CFR 405.2463 (a) (1) and (2); 447.371 (d); and 440.20 (b) (1) and (2). See 471 NAC 29-003.01.

Telehealth services provided by a RHC or FQHC may be covered at a fee-for-service rate per the telehealth regulations using non-RHC and non-FQHC core service provider numbers.

1-006.08 Tribal 638 Clinic Services: Telehealth services are not covered under the reimbursement for core services billed under an encounter rate. Telehealth services provided by Tribal 638 Clinics may be covered under these telehealth regulations for other services billed at the fee-for-service rates.

1-006.09 Nursing Facility Periodic Physician Visits: Telehealth coverage is not available for physician visits to clients in nursing facilities (NF) required on the periodic schedule of at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. This periodic schedule of visits is required for nursing facility certification under regulations that require that a client “be seen” by the physician. See 471 NAC 12-007.09 and 42 CFR 483.40 (c) (1).

1-006.10 Other Requirements and Limitations for Telehealth Services

1-006.10A Informed Consent: Before an initial telehealth service, the practitioner who delivers the service to a client shall ensure that the following written information is provided to the client in a form and manner which the client can understand, using reasonable accommodations when necessary, that:

1. S/he retains the option to refuse the telehealth service at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the client would otherwise be entitled;
2. Alternative options are available, including in-person services, and these options are specifically listed on the client’s informed consent statement;
3. All existing confidentiality protections apply to the telehealth consultation;
4. S/he has access to all medical information resulting from the telehealth consultation as provided by law for patient access to his/her medical records;
5. The dissemination of any client identifiable images or information from the telehealth consultation to anyone, including researchers, will not occur without the written consent of the client;
6. S/he has a right to be informed of the parties who will be present at each end of the telehealth consultation and s/he has the right to exclude anyone from either site; and
7. S/he has a right to see an appropriately trained staff or employee in-person immediately after the telehealth consultation if an urgent need arises, or to be informed ahead of time that this is not available as provided in 471 NAC 1-006.10B Support at Client Site.

The health care practitioner shall ensure that the client’s informed consent has been obtained before providing the initial service. The client’s signature indicates that s/he understands the information, has discussed this information with the health care practitioner or his/her designee, and understands the informed consent may apply to follow-up telehealth services with the same practitioner. The health care practitioner providing the telehealth service or staff at the client site shall retain the signed statement, and the statement must become a part of the client’s medical record. A copy of the signed informed consent must also be given to the client.

If the client is a minor or is incapacitated or is mentally incompetent such that s/he is unable to sign the statement, the client’s legally authorized representative shall sign the informed consent statement to give consent. The health care practitioner providing the telehealth service or staff at the client site shall retain the signed statement, and the statement must become a part of the client’s medical record. A copy of the signed informed consent must also be given to the client’s legally authorized representative.

The requirement to obtain written informed consent before providing a service does not apply in emergency situations where the client is unable to sign the written statement as required above and the client’s legally authorized representative is unavailable. However, within 72 hours after the telehealth service is provided, the health care practitioner shall obtain the signature of the client or his/her legally authorized representative on the informed consent form indicating s/he has been informed that a telehealth service was delivered and all the written statements in the informed consent statement apply. The health care practitioner providing the telehealth service or staff at the client site shall retain the signed statement, and the statement shall become a part of the client’s medical record. A copy of the signed informed consent must also be given to the client or to the client’s legally authorized representative.

A sample informed consent statement is available from the Department upon request. (See suggested form in 471-00-10 of the appendix)
1-006.10B Support at Client Site: An appropriately trained staff or employee familiar with the client’s treatment plan or familiar to the client must be immediately available in-person to the client receiving a telehealth service to attend to any urgencies or emergencies that may occur during the service. “Immediately available” means the staff or employee must be either in the room or in the area outside the telehealth room in easy access for the client. This requirement may be waived on an individual client basis for repetitive services when documentation shows that a safe routine has been established for the client, such as for a home health service, and that the client has consented to this exception. The health care practitioner providing the telehealth service shall document this fact in the medical record, with the rationale as to why an appropriately trained staff or employee need not be immediately available.

1-006.10C Quality Assurance Requirements: Each telehealth site shall have established written quality of care protocols and patient confidentiality guidelines to ensure telehealth services meet the requirements of state and federal laws and established professional patient care standards. Prior to initial billing for telehealth services, each telehealth site shall submit two copies of a letter to the Department, addressed to the Medicaid Medical Director:

1. Certifying written quality of care protocols are operational at the sites where telehealth services are provided;
2. Certifying written patient confidentiality protocols are operational at the sites where telehealth services are provided;
3. Listing the facility provider number, the names of all health care practitioners providing telehealth services and their Medicaid provider identification numbers, and the services provided at that site;
4. Naming an authorized contact person with his/her phone number;
5. Documenting that the telehealth technologies meets the standards in 471 NAC 1-006.04C, and
6. Attaching a sample copy of the provider’s informed consent form (see 471 NAC 1-006.10A).

The provider shall make the protocols and guidelines available for inspection at the telehealth site and to the Department upon request. The provider shall send any changes to the written submitted information to the Department in writing prior to billing under the changes. (Also see 471 NAC 1-006.10F, Medical Records; and 1-006.10G, Confidentiality and Integrity of Data.)

1-006.10D Out-of-State Services: Under 42 CFR 431.52 and 471 NAC 1-002.02G, Nebraska Medicaid covers telehealth services furnished in another state to the same extent it would pay for telehealth services furnished in Nebraska if the services are furnished to a client who is a resident of Nebraska but who is physically located in another state at the time the service is delivered, and any of the following conditions are met:
1. Medical services are needed because of a medical emergency;
2. Medical services are needed and the client’s health would be endangered if s/he were required to travel to his/her state of residence;
3. The Department determines, on the basis of medical advice, the needed medical services, or necessary supplementary resources, are more readily available in the other state; or
4. It is general practice for clients in a particular locality to use medical resources in another state.

The practitioner providing the telehealth service to a Nebraska Medicaid client while the client is physically located in another state must meet the requirements for provider participation in 471 NAC 1-006.03 except for item 3. Instead of item 3, the practitioner must be appropriately licensed, certified, or registered by the state agency in that state for the service billed to Nebraska Medicaid.

All prior authorization requirements for out-of-state services must be met.

1-006.10E Requirements for Services to Medicaid Eligible Persons with Other Health Care Coverage:

1-006.10E1 Medicare/Medicaid Eligible Clients: All Medicare-covered services must first be billed to Medicare. Medicaid does not cover services denied by Medicare for lack of medical necessity. Medicaid pays only coinsurance and deductibles for Medicare-covered services. No additional payments will be made for transmission costs for Medicare-covered services.

1-006.10E2 Clients with Other Health Care Coverage: Because Medicaid is the payer of last resort, services must first be billed to other liable third party payers. When a service is covered by a third party payer and includes the transmission costs, Medicaid will not make an additional payment for the transmission costs.

1-006.10F Medical Records: The practitioner shall keep a complete medical record on all telehealth services provided to clients, following all applicable statutes and regulations for medical record keeping and confidentiality. The use of telehealth technology must be appropriately documented in the medical record, including the treatment plan, progress notes, and treatment plan reviews.

In addition, the medical record must include the following:

1. A full notation describing the health care service delivered via telecommunication technology and indicating which site initiated the call;
2. A list of the telehealth technologies used for the service (e.g., real-time two-way interactive audio-visual transmission via a T1 line; digitalized radiology transmission via store and forward technology; electronic stethoscope; etc.).
3. Documentation showing the time the service began and ended;
4. When applicable, a notation by the practitioner that a copy of the required signed telehealth informed consent statement is in the client’s record at the site where the client is physically located (see 471 NAC 1-006.10A Informed Consent);
5. Documentation in the medical record supporting the need for the level of care delivered via telehealth, and
6. When applicable, reasons for an exception to the 30-mile distance requirement (see 471 NAC 1-006.05E).

1-006.10G Confidentiality and Integrity of the Data: All confidentiality laws and other requirements that apply to written medical records shall apply to electronic medical records, including the actual transmission of the service and any recordings made during the time of the transmission.

All transmissions must be performed on a dedicated secure line or must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.

Providers of telehealth services shall implement confidentiality protocols that include, but are not limited to:

1. specifying the individuals who have access to electronic records;
2. usage of unique passwords or identifiers for each employee or other person with access to the client records;
3. ensuring a system to prevent unauthorized access, particularly via the internet or intranet; and
4. ensuring a system to routinely track and permanently record access to such electronic medical information.

1-006.11 Payment Methodology: The Nebraska Medical Assistance Program (NMAP) pays for covered telehealth services and transmission costs as follows:

1-006.11A Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

1-006.11B Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of:

1. The provider’s submitted charge; or
2. The maximum allowable amount. (See the appropriate Nebraska Medicaid Practitioner Fee Schedule in effect for the date of service.)
The Medicaid maximum allowable is determined by using the highest USF subsidized monthly rate in Nebraska for transmission up to a T1 line, assuming an 8 hour per day/5 days per week usage to determine a per minute unit reimbursement. The Medicaid maximum allowable rate for transmission costs may be reviewed periodically by the Department.

1-006.12 Billing Requirements: Providers of telehealth services shall bill Medicaid for services provided via telecommunication technology according to the Medicaid requirements and claim submission instructions for the service type.

Only the provider incurring the cost of a transmission shall bill for the telehealth transmission cost. Providers shall bill transmission costs at the rate charged the general public. Providers shall bill the transmission costs for the actual length of time of the transmission of the telehealth service.

Reimbursement is not available for stand-by time when the sites are in contact but either the patient or the provider is not available for the service.
NEW MEXICO

New Mexico’s state Medicaid program (Medical Assistance Division) does reimburse for an extensive range of medically necessary services provided via telemedicine at the same rate for which face-to-face encounters are reimbursed with the exception of store-and-forward. Currently, telehealth advocates are working to secure Medicaid reimbursement for telehealth audiology services as well. Following passage of the New Mexico Telehealth Act in 2006, many private insurers also reimburse for telehealth services.

In the area of tele-home care and remote monitoring services, New Mexico does reimburse, but on a limited basis. There have been some reimbursement cuts in the past year due to New Mexico’s budget deficit and other changes to home care services are ongoing.
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8.310.13 TELEHEALTH SERVICES

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ISSUING AGENCY: New Mexico Human Services Department (HSD).

SCOPE: The rule applies to the general public.

STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).

DURATION: Permanent

EFFECTIVE DATE: August 1, 2007, unless a later date is cited at the end of a section.

OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medical assistance programs.

DEFINITIONS: [RESERVED]

MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

TELEHEALTH SERVICES: The New Mexico MAD pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive medically necessary services, MAD pays for covered telehealth services.

ELIGIBLE PROVIDERS:

A. Upon approval of a New Mexico medical assistance division provider participation agreement by MAD or its designee, licensed practitioners or facilities that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program policies, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, providers receive instructions on how to access these documents. It is the provider’s responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to request hard copies of any program policy manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials.

To be eligible for reimbursement, a provider is bound by the provisions of the MAD provider participation agreement. Reimbursement for services provided through an interactive telecommunication system can be made when the service is rendered by one of the following providers at an allowed originating sight:

1. individuals licensed to practice medicine or osteopathy by the New Mexico board of medical examiners or the New Mexico board of osteopathic medical examiners;

2. podiatrists licensed by the board of podiatry under the state New Mexico;
(3) facilities licensed as diagnostic and treatment centers by the New Mexico department of health (DOH), community mental health centers, core service agencies, hospitals, rural health clinics, school-based health centers, and federally qualified health centers; services performed in these facilities must be furnished by individual practitioners who are enrolled as providers;

(4) individuals licensed as certified nurse practitioners and licensed registered nurses by the New Mexico board of nursing may provide services in collaboration with a physician or as independent providers within the scope of their practice. See Section 61-3-23.2(B)(2) NMSA 1978 (Cum. Supp. 1992);

(5) physician assistants certified by the national commission on certification of physician assistants inc. and licensed by the New Mexico board of medical examiners or New Mexico board of osteopathic medical examiners when furnishing services within the scope of their practice as defined by state law; direction and supervision of physician assistants must be performed by the licensed physicians who are enrolled providers and are approved by the New Mexico board of medical examiners or the New Mexico board of osteopathic medical examiners as supervisory physicians;

(6) nurse midwives licensed by the board of nursing as registered nurses and licensed by the department health as certified nurse midwives;

(7) pharmacist clinicians certified by the New Mexico board of pharmacy may furnish services within the scope of their practice as defined by state law; direction and supervision of pharmacist clinicians must be performed by licensed physicians who are enrolled as providers and are approved by the New Mexico board of medical examiners as supervisory physicians;

(8) individuals licensed as clinical nurse specialists by the New Mexico board of nursing may provide services in collaboration with a physician or as independent providers within the scope of their practice; see NMSA 1978, 61-3-1 to 61-3-30;

(9) psychologists (Ph.D., Psy.D. or Ed.D.) licensed or board eligible as clinical psychologists by the New Mexico board of psychologist examiners;

(10) licensed independent social workers (LISW) licensed by the New Mexico board of social work examiners, licensed professional clinical counselors licensed by, and marriage and family therapists licensed by New Mexico counseling and therapy practice board;

(11) registered dietitians or nutrition professionals when furnishing services within the scope of their practice as defined by state law under the direction of a licensed physician;

(12) Indian health service and tribal 638 facilities;

(13) physical therapists licensed by the physical therapy board under the state of New Mexico regulation and licensing department and meeting licensure requirements of the department of education;

(14) occupational therapist licensed by the board of occupational therapy under the state of New Mexico regulation and licensing department; or

(15) speech pathologists licensed by the board of speech, language, hearing under the state of New Mexico regulation and licensing department;

B. Practices or groups formed by these individuals may receive reimbursement for services when rendered by eligible providers within the practice or group.

C. When the originating-site is in New Mexico and the distant-site is outside New Mexico, the provider at the distant-site must be licensed for telehealth to the extent required by New Mexico state law and regulations or meet federal requirements for providing services to Indian health service facilities or tribal contract facilities.

[8.310.13.10 NMAC - N, 8/1/07]

8.310.13.11 PROVIDER RESPONSIBILITIES: A provider who furnishes services to medicaid and other health care program eligible recipients agree to comply with all federal and state laws and regulations relevant to the provision of medical services as specified in the MAD provider participation agreement. A provider also agrees to conform to MAD program policies and instructions as specified in this manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or up-coding services.

[8.310.13.11 NMAC - N, 8/1/07]

8.310.13.12 COVERED SERVICES: MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the eligible recipient’s condition. All services must be furnished within the limits of provider program policies and within the scope and practice of the provider’s professional standards.
A. The originating-site is the location of an eligible recipient at the time the service is being furnished via an interactive telehealth communications system. An interactive telehealth communication system must include both interactive audio and video and be delivered on a real-time basis at the originating and distant-sites. Coverage for services rendered through telehealth provided at the originating-site are covered to the same extent the service and the provider are covered when not provided through telehealth. See 8.310.2 NMAC, Medical Services Providers, 8.310.8 NMAC, Mental Health Professional Services, MAD-758 [8.324.9 NMAC], Nutrition Services and 8.325.2 NMAC, Dialysis Services.

B. The distant-site is the location where the physician or practitioner is physically located at time of the telehealth service. Coverage of services rendered through telehealth at the distant-site are limited to consultations, evaluation and management services, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examinations, end stage renal disease related services, and individual medical nutrition services. All services are covered to the same extent the service and the provider are covered when not provided through telehealth. For these services, use of the telehealth communications system fulfills the requirement for a face-to-face encounter. See 8.310.2 NMAC, Medical Services Providers, 8.310.8 NMAC, Mental Health Professional Services, MAD-758 [8.324.9 NMAC], Nutrition Services and 8.325.2 NMAC, Dialysis Services.

C. A telehealth originating-site communication system fee is covered if the eligible recipient was present at and participated in the telehealth visit at the an originating-site located in a health professional shortage area (HPSA); a county not classified as a metropolitan statistical area (MSA); a primary medical care health professional shortage area for physicians, nurse practitioners, and physician assistants; primary behavioral health care professional shortage area for psychiatrists and clinical psychologists; a medical specialist shortage area for non-primary care medical specialties; an IHS or tribal 638 facility, a federally qualified health center or rural health clinic or a federal or state telemedicine demonstration project area. An interactive telecommunications system is required as a condition of reimbursement. Allowed originating-sites are an:

1. office or clinic of a physician or other practitioner;
2. hospital;
3. critical access hospital;
4. rural health clinic;
5. federally qualified health center;
6. community mental health center or core service agency;
7. school-based health center;
8. Indian health services and tribal 638 facilities;
9. ambulatory surgical or treatment center;
10. skilled nursing facility;
11. residential treatment center;
12. home health agency;
13. diagnostic laboratory or imaging center;
14. rehabilitation or other therapeutic health setting; or
15. eligible recipient’s residence.

D. End stage renal disease (ESRD) related services included in the monthly capitation payment with two or three visits per month and ESRD-related services with four or more visits per month may be paid when provided through a telehealth communications system. However, at least one visit during the month must be furnished by a physician, nurse practitioner, or physician assistant in a face-to-face encounter with the eligible recipient to examine the vascular access site.

[8.310.13.12 NMAC - N, 8/1/07]

8.310.13.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, before payment is made, or after payment is made. See 8.302.5 NMAC, Prior Authorization and Utilization Review. Once enrolled, the provider receives instructions on how to access provider program policies, billing instructions, utilization review instructions, and other pertinent material and to obtain answers to questions on or not covered by these materials. It is the provider’s responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements.

A. Prior authorization: Certain procedures or services can require prior approval from MAD or its authorized agents. Services for which prior authorization was obtained remain subject to utilization review at any
point in the payment process. A service provided through telehealth is subject to the same prior authorization and utilization review requirements which exist for the service when not provided through telehealth.

B. **Eligibility determination:** Prior authorization of services does not guarantee an individual is eligible for a Medicaid or other healthcare program. Providers must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient has other health insurance.

C. **Reconsideration:** Providers who disagree with prior authorization request denials and other review decisions can request a re-review and a reconsideration. See MAD-953 [8.350.2 NMAC], *Reconsideration of Utilization Review Decisions.*

[8.310.13.13 NMAC - N, 8/1/07]

**8.310.13.14 NONCOVERED SERVICES:** A service provided through telehealth is subject to the same program restrictions, limitations and coverage which exist for the service when not provided through telehealth.

[8.310.13.14 NMAC - N, 8/1/07]

**8.310.13.15 REIMBURSEMENT:** Reimbursement for services at the originating-site and the distant-site are made at the same amount as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for an interactive telehealth system fee at the lessor of the following:

- A. the provider’s billed charge; or
- B. the maximum allowed by MAD for the specific service or procedure.

  1. The provider’s billed charge must be their usual and customary charge for services.
  2. “Usual and customary charge” refers to the amount which the provider charges the general public in the majority of cases for a specific procedure or service.

[8.310.13.15 NMAC - N, 8/1/07]

**8.310.13.16 REIMBURSEMENT FOR SERVICES FURNISHED BY INTERNS OR RESIDENTS:** Reimbursement for services furnished by interns or residents in hospitals with approved teaching programs or services furnished in other hospitals that participate in teaching programs is made through institutional reimbursement. MAD cannot be billed directly by interns or residents for these services.

[8.310.13.16 NMAC - N, 8/1/07]

**HISTORY OF 8.310.13 NMAC:** [RESERVED]
NEW YORK

New York Medicaid does cover certain telehealth services including specialty physician consultations provided to Medicaid beneficiaries in an ER or inpatient setting. Originally, the program was intended to support the state’s telestroke program, but it is no longer restricted to stroke patients.

In the area of tele-home care and remote monitoring services, New York operates a tele-home care program through home care agencies.
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### Pharmacy Prior Authorization Changes
**Effective October 18, 2006**

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**Prior Authorization Process**

**Effective October 18, 2006,** all pharmacy prior authorizations will be initiated by calling the centralized Clinical Call Center at:

**(877) 309-9493.**

Live operators are available for all prior authorization requests other than the Mandatory Generic Program. Other changes will include:

- Serostim and Zyvox prior authorization process will be moved from the current electronic voice interactive phone system (VIPS) to the staffed Clinical Call Center.
- Prior authorization for Revatio will now be handled through the staffed Clinical Call Center as well, rather than the special billing process now in place.
- Several new drug categories will be added to the Preferred Drug Program (PDP). Please refer to the Quick List below.
- Second generation prescription antihistamines and proton pump inhibitors will be transferred into the PDP. (This change includes the availability of additional proton pump inhibitors which may be prescribed without prior authorization, so please review this information carefully.)
nursing services (excluding medical services provided by a nurse practitioner).

Separate Medicaid billing of these long term therapies by clinical practitioners, Article 16, and Article 28 clinics will be prohibited when provided to an ICF/DD resident, regardless of the service location.

Separate time-limited billing of specified therapies will be allowed in response to acute illness, an accident, or a post-hospitalization health need.

OMRDD sent letters to all certified ICFs/DD on May 19, 2006 and June 13, 2006 that contain details about this exception. (Copies of these letters were also sent to OMRDD Article 16 clinics.)

Note: Some of the services listed above are never billable by Article 28 certified clinics.

For ICFs/DD that do not have day treatment program funding included in their rate, separate billing of day treatment to Medicaid continues to be allowed.

Questions? Please contact Karen Desso of OMRDD at (518) 402-4339.

Coverage of Specialist Consultations via Telemedicine

Effective for dates of service on and after September 1, 2006, medically necessary emergency room and inpatient hospital consultation services are payable to physicians with a specialty designation providing consultations via an interactive audio and video telecommunication system.

What is Telemedicine?

An interactive audio and video telecommunication system is a type of technology that permits a "real time" interactive consultation service to take place between the physician and patient.

Telemedicine is reimbursable when a patient is located at a spoke site and the needed specialist is located at a hub site.

- The hub site is where the medical specialist is located (e.g., hospital, office).
- The spoke site is the hospital where the referring health professional and patient are located.

When is Telemedicine Covered?

- A consultation involving a present and participating patient and a specialist is medically necessary, and a specialist is not available at the spoke site to provide a timely consultation;
- The telemedicine system used for the consultation is a fully interactive, secure two-way audio and video telecommunication system and also supports review of diagnostic tests integral to the consultation;
- A request for a consultation and the need for a consultation is documented in the patient’s medical record;
- The consultation opinion is documented in the patient’s medical record and communicated to the requesting provider;
- The consultation code is billed with the appropriate modifier "-GT via interactive audio and video telecommunication systems" to indicate services were performed via telemedicine;
- The consulting physician is licensed in New York State, practicing within the scope of his/her specialty practice, enrolled in the New York State Medicaid Program and meets the credentialing requirements of the spoke site hospital.

Physician Billing for Telemedicine

- Payment for telemedicine specialist consultations will be limited to codes 99241-99245 and 99251-99255. Reimbursement will be the same amount as in-person specialist consultations;
- The specialist at the hub site bills the consult code with the GT modifier;
- The emergency room or attending inpatient physician at the spoke site bills the applicable evaluation and management code without the GT modifier. (Note: if evaluation and management services are already included in the emergency room or inpatient rate then the respective physician cannot bill an evaluation and management code);
- Payment will be made to only one physician for the professional component (reading and interpretation) of
diagnostic tests such as radiological procedures and diagnostic assessments;

- If specialist services are included in the facility rate where the patient is admitted, no separate consultant physician payment is reimbursable;
- The place of service entered on the claim is the location of the patient: "21" for inpatient hospital and "23" for emergency room-hospital.
- If the telemedicine consultation service is owned by a hub hospital and relevant specialist services are already included in the hub facility's rate, then no separate reimbursement is permissible for telemedicine consultations performed by employed specialists.

More Information

For information on funding for rural hospitals for purchasing of telemedicine equipment, please contact the Office of Rural Health at:

(518) 474-5555.

For information on credentialing requirements, please contact the Office of Health Systems Management at:

(518) 408-1828.

For information on procedure codes or fees, please refer to the Physician Fee Schedule, available at:
http://www.emedny.org/ProviderManuals/Physician/PDFS/Physician_Fee_Schedule_2006.pdf, or contact the Division of Medical Review and Provider Enrollment at (518) 474-8161.

For information on claim form completion, please contact Computer Sciences Corporation at:

(800) 343-9000.

General inquiries may be sent via email to: teledem@health.state.ny.us.

Did you know?

Medicaid statistics, including the number of monthly Medicaid eligibles and expenditure reports statewide and/or by county, are available online at:

http://www.nyhealth.gov/nysdoh/medstat/medicaid.htm

Annual Recertification for Providers Submitting Electronic Claims

Providers who submit electronic claims to the New York State Medicaid Program are required by the Department to submit a signed and notarized Certification Statement on a yearly basis.

Signing the Certification Statement binds a provider to the requirements put forth in the Certification Statement.

Providers need to read and understand the Certification Statement requirements before signing.

The certification process links the provider’s assigned Medicaid provider identification number to the Electronic Transmitter Identification Number (ETIN) under which electronic claims are submitted.

The Certification Statement is kept on file and may be presented by the State's Attorney General's office when prosecuting providers for fraudulent billing practices.

Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement. You will be asked to update your Certification Statement annually.

If you receive a recertification notice, your time to recertify is nearing.

Providers are sent two notices to recertify, each containing the date your current certification will expire.

Failure to recertify will cause your claims to be rejected beginning with the decertification date in the notices.

http://www.health.state.ny.us/health_care/medicaid/program/update/2006/sep2006.htm

2/11/2011
North Carolina’s state Medicaid program (Department of Medical Assistance) does reimburse providers licensed in-state for a variety of medically necessary telemedicine services. These services must occur in real time for recipients 21 years of age or younger qualifying for Early and Periodic Screening, Diagnostic, and Treatment. This includes telepsychiatry.

In the area of tele-home care and remote monitoring services, North Carolina currently does not provide reimbursement though the state has considered revising that policy.
1.0 Description of the Service

1.1 Telemedicine

1.2 Telepsychiatry

1.3 Service Sites

1.4 Providers

2.0 Eligible Recipients

2.1 General Provisions

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

3.0 When the Service Is Covered

3.1 General Criteria

4.0 When the Service Is Not Covered

4.1 General Criteria

4.2 Specific Criteria

5.0 Requirements for and Limitations on Coverage

5.1 General Criteria

5.2 Limitations

5.3 Prior Approval

6.0 Providers Eligible to Bill for the Service

6.1 Telemedicine Professional Services

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6.3 Facility Fees

7.0 Additional Requirements

7.1 Medical Record Documentation

7.2 Best Practice Guidelines for Documentation of Mental Health and Substance Abuse Services

7.3 Designating a Primary Provider

7.4 Provision of Care

8.0 Policy Implementation/Revision Information

Attachment A: Claims-Related Information

A. Claim Type

B. Diagnosis Codes

C. Procedure Code(s)

D. Modifiers

E. Place of Service

F. Co-payments

G. Reimbursement
1.0 Description of the Service

1.1 Telemedicine

Telemedicine is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability and/or expertise to provide and support health care when distance separates participants who are in different geographical locations. A recipient is referred by one provider to receive the services of another provider via telemedicine.

1.2 Telepsychiatry

Telepsychiatry is the use of two-way real time-interactive audio and video between places of lesser and greater psychiatric expertise to provide and support psychiatric care when distance separates participants who are in different geographical locations. A recipient is referred by one provider to receive the services of another provider via telepsychiatry.

1.3 Service Sites

The originating site (formally known as the spoke site) is the facility in which the recipient is located. The distant site (formally known as the hub site) is the facility from which the provider provides the telemedicine or telepsychiatric service. All service sites must be Medicaid enrolled providers.

1.4 Providers

The referring provider is the provider who has evaluated the recipient, determined the need for a consultation, and has arranged the services of the consulting provider for the purpose of diagnosis and treatment.

The consulting provider is the provider who evaluates the recipient via telemedicine/telepsychiatry mode of delivery upon the recommendation of the referring provider. Treatment is initiated as needed.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a
condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure
   a. that is unsafe, ineffective, or experimental/investigational.
   b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements
   a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
   b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

   EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Service Is Covered

IMPORANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see Section 2.0 of this policy.
3.1 General Criteria

Medicaid covers telemedicine and telepsychiatry when the service is medically necessary and

a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient’s needs;

b. the procedure can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

4.0 When the Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see Section 2.0 of this policy.

4.1 General Criteria

Telemedicine and telepsychiatry are not covered when the physician does not have a full and unrestricted license to practice medicine in North Carolina, as required by Article 1, Chapter 90, of the General Statutes or when

a. the recipient does not meet the eligibility requirements listed in Section 2.0;

b. the recipient does not meet the medical necessity criteria listed in Section 3.0;

c. the service unnecessarily duplicates another provider’s service;

d. the service is experimental, investigational, or part of a clinical trial;

e. the patient is located in a jail, detention center, or prison; or

f. the consulting provider is not a N.C. Medicaid in-state enrolled provider

4.2 Specific Criteria

a. Facility fees for the distant site are not covered.

b. The following interactions do not constitute reimbursable telemedicine or telepsychiatry and will not be reimbursed:

   1. Telephone conversations
   2. Video cell phone interactions
   3. E-mail messages
4. Facsimile transmission between a health care provider and a recipient
5. “Store and forward” recipient visits and consultations, which are transmitted after the recipient is no longer available

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see Section 2.0 of this policy.

5.1 General Criteria
   a. The recipient must be present.
   b. The telecommunications must permit encrypted real-time interactive audio and video communication with the consulting provider.
   c. The referring provider participates in the service as appropriate to meet the medical needs of the recipient. For more information on this service see Section 5.2, #3.
   d. The provider at the distant site must obtain prior approval for services when these medical or psychiatric services require prior approval, based on service type or diagnosis.

5.2 Limitations
   a. Up to three different consulting providers may be reimbursed for a separately identifiable telemedicine or telepsychiatry service provided to a recipient per date of service.
   b. Only one facility fee is allowed per date of service.
   c. There is no reimbursement to the referring provider at the originating site on the same date of service unless the referring provider is billing for a separately identifiable billable service. Medical records must document that all of the components of the service being billed were provided to the recipient.

5.3 Prior Approval
Prior approval is required when the service is rendered outside a 40-mile radius of North Carolina’s borders (10A NCAC 220.0019).

6.0 Providers Eligible to Bill for the Service

Providers who meet Medicaid’s qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for telemedicine and telepsychiatry when the service is within the scope of their practice.
6.1 **Telemedicine Professional Services**

The following providers enrolled in the N.C. Medicaid program who provide this service may bill Medicaid:

a. Physicians  
b. Nurse practitioners  
c. Nurse midwives

6.2 **Telepsychiatry Professional Services**

The following providers enrolled in the N.C. Medicaid program who provide this service may bill Medicaid:

a. Physicians  
b. Advanced practice psychiatric nurse practitioners  
c. Advanced practice psychiatric clinical nurse specialists  
d. Licensed psychologists (doctorate level)  
e. Licensed clinical social workers (LCSW)  
f. Community diagnostic assessment agencies

6.3 **Facility Fees**

The following providers may bill for a facility fee when their office or facility is the site at which the recipient is located when the service is provided:

a. Physicians  
b. Nurse practitioners  
c. Nurse midwives  
d. Advanced practice psychiatric nurse practitioners  
e. Advanced practice psychiatric clinical nurse specialists  
f. Licensed psychologists (doctorate level)  
g. Licensed clinical social workers (LCSW)  
h. Hospitals (inpatient or outpatient)  
i. Federally qualified health centers  
j. Rural health clinics  
k. Local health departments  
l. Local Management Entities

Refer to **Attachment A, Section C**, for a list of billable codes.

7.0 **Additional Requirements**

7.1 **Medical Record Documentation**

Medical records documenting the telemedicine or telepsychiatry services that were provided must be maintained by the referring and the consulting provider.

7.2 **Best Practice Guidelines for Documentation of Mental Health and Substance Abuse Services**

Medical records of telepsychiatric interventions are to be maintained as with psychiatric interventions in general. Telepsychiatry providers must also follow Medicaid’s best practice guidelines for medical record documentation as published in Attachment B of *Clinical Coverage Policy #8A, Enhanced Mental Health and Substance Abuse Services* on DMA’s Web site at [http://www.ncdhhs.gov/dma/mp/mpindex.htm](http://www.ncdhhs.gov/dma/mp/mpindex.htm).

7.3 **Designating a Primary Provider**

The medical record must document the provider who is designated as having primary responsibility for management and coordination of each major element of care.

7.4 **Provision of Care**

Evaluation and/or treatment must be performed in an environment where there is a reasonable expectation of absence of intrusion by individuals not involved in the patient’s direct care. Providers may not require the use of telemedicine as a condition of treating the recipient. Providers should develop their own methods of informed consent verifying that the recipient agrees to receive services via telemedicine.

8.0 **Policy Implementation/Revision Information**

**Original Effective Date:** August 1, 1999

**Revision Information:**

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<tr>
<th>Date</th>
<th>Section Revised</th>
<th>Change</th>
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<tr>
<td>6/1/07</td>
<td>Section 1.3</td>
<td>Implemented coverage of a facility fee for the originating site.</td>
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<tr>
<td>6/1/07</td>
<td>Section 6.2</td>
<td>Added community diagnostic assessment agencies as a provider type eligible to bill for telemedicine/telepsychiatry services.</td>
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<tr>
<td>6/1/07</td>
<td>Section 6.3</td>
<td>Added provider types eligible to bill for facility fees.</td>
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<tr>
<td>6/1/07</td>
<td>Attachment A, item C</td>
<td>Implemented coverage of HCPCS procedure code T1023 for telemedicine/telepsychiatry services.</td>
</tr>
</tbody>
</table>
Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type
   1. CMS-1500 Claim Form
      Physicians, nurse practitioners, nurse midwives, licensed psychologists, licensed clinical social workers, and certified clinical nurse specialists enrolled in the N.C. Medicaid program bill services on the CMS-1500 claim form.
   2. UB-04 Claim Form
      Hospital providers bill services on the UB-04 claim form.

B. Diagnosis Codes
   Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)
   1. CPT Codes
      The following CPT procedure codes can be billed by the consulting provider for professional services:
      • 90801
      • 90804 through 90809
      • 90862
      • 99201 through 99205
      • 99211 through 99215
      • 99241 through 99245
      • 99251 through 99255
      Advanced practice psychiatric nurse practitioners may bill only the following codes:
      • 90801
      • 90804 through 90809
      • 90862
      Advanced practice psychiatric clinical nurse specialists, licensed psychologists, and licensed clinical social workers as consulting providers may bill only the following codes:
      • 90801
      • 90804
      • 90806
      • 90808

   2. HCPCS Codes
      The following HCPCS code can be billed for the facility fee by the originating site (the site at which the recipient is located): Q3014. Refer to Section 6.3 for list of providers.
HCPCS code T1023 can be billed only by diagnostic assessment agencies for screening/evaluation to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter (1 unit = 1 event). T1023 (1 unit) is billed for the date that the total assessment is completed by the agency that employs the providers of service.

3. **Revenue Codes**

   When the originating site is a hospital, the originating site facility fee must be billed with RC780 and Q3014.

D. **Modifiers**

   Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via “Interactive Telecommunication.” Other modifiers must be appended to the CPT codes, as appropriate.

E. **Place of Service**

   These services may be provided in inpatient, outpatient, and office/clinic settings.

F. **Co-payments**

   Telemedicine and telepsychiatry services are subject to co-payment requirements.

G. **Reimbursement**

   1. When the GT modifier is appended to a code billed for professional services, the service is paid at 100% of the allowed amount of the fee schedule.

   2. For hospitals, this is a covered service for both inpatient and outpatient and is part of the normal hospital reimbursement methodology.

   3. Reimbursement for these services is subject to the same restrictions as face-to-face contacts (e.g., place of service, allowable providers, multiple service limitations, prior authorization).
NORTH DAKOTA

North Dakota’s state Medicaid program does reimburse for health care services provided via telemedicine. A patient must be present during a consultation, the appropriate CPT codes must be utilized by the consulting site along with a GT modifier, and the originating site uses HCPC code “Q3014.”

In the area of tele-home care and remote monitoring services, North Dakota does not provide reimbursement for home telehealth services.
GENERAL INFORMATION
FOR PROVIDERS
MEDICAID AND OTHER
MEDICAL ASSISTANCE PROGRAMS

Published by:
Medical Services
North Dakota Department of Human Services
600 E Boulevard Avenue, Dept 325
Bismarck, North Dakota 58505

November 2010
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* Revenue codes 490 and 987 require CPT codes in Form Locator 44. Payment is based on Medicaid fee schedule. We will only accept the following CPT codes for revenue code 987: 99221-99239; 99251-99263; 99291-99297; and 99431-99440.
reported with the appropriate E/M code. Code 99292 is used to report each additional block of time, up to 30 minutes beyond the first 74 minutes.

PROLONGED CARE

Codes 99354-99357 are used for prolonged services involving direct (face-to-face) patient contact. Codes 99354-99357 are used to report the total duration of face-to-face time spent on a given date. Codes 99358 and 99359 are used when prolonged services not involving direct (face-to-face) care is provided. These services are not covered by North Dakota Medicaid. Code 99360 is used to report standby services that are requested by another physician and involves prolonged attendance without direct (face-to-face) patient contact. The only time that operative standby services would be covered is in the case of a documented existing risk or distress, such as documented fetal distress.

CARE PLAN OVERSIGHT SERVICES

Codes 99374-99380 are not covered by North Dakota Medicaid.

TELEMEDICINE SERVICE

Telemedicine Services are a covered Medicaid service provided the following criteria is met:

- The recipient must be present during the provision of the service;
- The appropriate CPT codes are used by the consulting site along with a GT modifier; and
- The originating site uses HCPC code Q3014.

Physicians at both the originating and consulting sites may bill for services. Supplies needed for any procedures performed are considered part of the procedure and are not separately billable.

Separate long distance charges required for out-of-network sites are billable to North Dakota Medicaid. Medicaid will pay for the actual cost charged by the telephone company.