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**Appendix**  
County Human Services Agencies  
Available online at: [http://www.dhs.state.mn.us/provider/pdf/manual/appendix.pdf](http://www.dhs.state.mn.us/provider/pdf/manual/appendix.pdf)
Chapter 1

Requirements for Providers

Requirements All Providers Must Meet

Policy

Providers who choose to participate in Minnesota Health Care Programs (MHCP) must meet professional requirements and/or licensure requirements as set forth in applicable state and federal laws and regulations.

Eligible Providers

The following providers of health care may be eligible for enrollment in MHCP:

Advanced Practice Registered Practice Nurse (APRN)  
Ambulatory Surgical Center (ASC)  
Audiologist  
Certified Nurse Midwife (CNM)  
Certified Registered Nurse Anesthetist (CRNA)  
Chemical Dependency  
Child and Teen Checkup Clinic (C&TC)  
Chiropractor  
Clinical Nurse Specialist (CNS)  
Community Health Clinic  
Community Mental Health Center  
County Case Manager  
County Contracted Mental Health Rehabilitative Services  
County Human Services Agency  
Day Training and Habilitation Center (DT & H)  
Day Treatment Program  
Dental Lab  
Dentist/Dental Group  
Family Planning Agency  
Federally Qualified Health Center (FQHC)  
Hearing Aid Dispenser  
Home Health Agency  
Hospice  
Hospital  
Intermediate Care Facility for the Mentally Retarded (ICF-MR)  
Independent Diagnostic Testing Facility  
Independent Laboratory  
Indian Health Service (IHS)  
Institution for Mental Disease (IMD)
Licensed Independent Clinical Social Worker (LICSW)
Licensed Marriage and Family Therapist (LMFT)
Licensed Psychological Practitioner (LPP)
Medical Supply/Durable Medical Equipment
Medical Transportation
Mental Health Targeted Case Management for SPMI/SED
Nursing Home
Nurse Practitioner (NP)
Occupational Therapist (OT)
Optical Company
Optometrist
PCA Choice
Personal Care Provider Organization (PCPO)
Personal Care Assistant, Independent (PCA)
Pharmacy
Physical Therapist (PT)
Physician/Clinic (Group)
Physician Assistant
Podiatrist
Prepaid Health Plan (PPHP)
Private Duty Nurse/Private Duty Nursing Agency (PDN)
Psychiatrist
Psychologist
Public Health Clinic
Public Health Nursing Agency
Regional Treatment Center (RTC)
Registered Nurse (RN)/Licensed Practical Nurse (LPN)
Rehabilitation Agency
Renal Dialysis
Rural Health Clinic (RHC)
School District
Speech Language Pathologist
Waivered (Home & Community-Based) Services
X-Ray

**Enrollment Process for Providers Located in Minnesota**

Providers who choose to participate must complete, sign and return an [MHCP Enrollment Application](#) and [Provider Agreement](#) to the Department of Human Services (DHS). The Provider Agreement includes a statement of terms for participation. Providers located in Minnesota are approved for participation:

- The first day of the month of application;
- Retroactive for up to 90 days to the effective date of Medicare provider certification; or
- Retroactive to the date of MHCP recipient’s eligibility.
An out-of-state provider may apply for enrollment retroactive to the date services were provided to an eligible MHCP recipient. To be eligible for payment under MHCP, an out-of-state provider must:

- Comply with the licensing and certification requirements of the state where the provider is located; and
- Complete, sign, and return the MHCP Enrollment Application and Provider Agreement to DHS, and obtain DHS’ approval for enrollment

Providers who want to participate in an MHCP prepaid health plan's network should contact the appropriate health plan for participation requirements. Refer to Prepaid Health Care Programs chapter (Ch. 3) for additional information about PPHP.

**Change of Enrollment Information**

DHS Provider Enrollment must be notified in writing of any change in information (including address changes) provided on the enrollment application.

**Use of Billing Agents**

If a billing agent (person or entity that submits a claim or receives MHCP payment on behalf of a provider) is used, the name and address of the billing agent must also be listed on the enrollment application. DHS Provider Enrollment must be notified in writing if a billing agent is hired after enrollment. The notification must include the provider name, MHCP provider ID number, office address, and billing agent's name and address. Send the notice to:

Minnesota Department of Human Services  
Provider Enrollment  
444 Lafayette Road  
St. Paul, MN 55155-3856  
FAX 651/297-1273

**Payment to Provider or Billing Agent**

All MHCP payment must be made to the provider. However, MHCP payment may be mailed to a billing agent (such as an accounting firm or billing service) that furnishes statements and receives payments in the name of the provider, if the agent's compensation for these services is:

- Related to the cost of processing the billing;
- Not related on a percentage (or other basis) to the amount that is billed or collected; and
- Not dependent on collection of the payment.

**Sale or Transfer of an Entity**

An MHCP provider who sells or transfers ownership or control of an entity that is enrolled in MHCP must notify DHS Provider Enrollment at (651) 282-5330 or 1-800-657-3991, no later than 30
days before the effective date of the sale or transfer. DHS has the right to pursue monetary recovery, or civil or criminal action against the seller or transferor.

Advance notification to DHS Provider Enrollment is critical for providers of home care and/or waivered services due to the impact of a provider number change on service agreements through which they bill. See additional requirements in the Home Care Services chapter (Ch. 24) and the HCBS Waiver Programs and the AC Program chapter (Ch. 26).

Affirmative Action Plan Requirement

A provider applying for MHCP enrollment that has employed more than 40 full-time employees at any time during the past year, and who anticipates reimbursement in excess of $100,000 in a one year period, must have an affirmative action plan for the employment of minority persons, women, and the disabled that is approved by the Commissioner of Human Rights. As part of the enrollment process, DHS may ask providers to submit documents showing compliance with, or exemption from, the affirmative action requirement plan of the Minnesota Human Rights Act.

Affirmative Action Plan Compliance or Exemption Documentation

For Minnesota-based providers, one of the following must be submitted with the provider's application:

- A copy of a certificate of compliance obtained from the Minnesota Department of Human Rights;
- A statement that the provider currently, and for the past year, has had fewer than 40 full-time employees; or
- A statement that the provider does not expect to seek payment of program funds in excess of $100,000 within one year of the date of enrollment.

Certificates of compliance may be obtained from:

Minnesota Department of Human Rights
Contract Compliance Section
190 East 5th Street, Suite 700
St. Paul, MN 55101
(651) 296-5663 or 1-800-657-3704

If a provider fails to obtain a certificate of compliance as required by the Human Rights Act, the Commissioner of Human Rights may take action to void the provider agreement. The provider may also be ineligible for payment in excess of $100,000.

DHS Review and Notice to Provider

The DHS Provider Enrollment reviews the provider's application and notifies the provider of its determination in writing within 30 days of receipt of the application.
Duration of MHCP Participation

MHCP participation remains in effect until:

- The ending date specified in the agreement;
- The provider fails to comply with the terms of participation;
- The provider sells or transfers ownership, assets, or control of an entity that has been enrolled to provide MHCP services;
- Thirty days following the date of DHS's request to the provider to sign a new provider agreement, if the provider has not signed the new agreement; or
- The provider requests to end the agreement.

Violating Provider Agreement

A provider who fails to comply with the terms of participation in the provider agreement or with requirements of the rules governing MHCP, is subject to monetary recovery, Minnesota Rule 9505 program sanctions, or civil or criminal action. Unless otherwise provided by law, no provider of health care services will be declared ineligible without prior notice and an opportunity for a hearing under MS 14.

Limits on Recipient Services

Minnesota Rules 9505.0195, subp. 10 states in part:

"A provider shall not place restrictions or criteria on the services it will make available, the type of health conditions it will accept, or the persons it will accept for care or treatment, unless the provider applies those restrictions or criteria to all individuals seeking the provider's services. A provider shall render to recipients services of the same scope and quality as would be provided to the general public. Furthermore, a provider who has such restrictions or criteria shall disclose the restrictions or criteria to DHS so DHS can determine whether the provider complies with the requirements of this subpart."

For example, providers cannot deny treatment for a certain diagnosis (e.g., pregnancy) to MHCP recipients unless treatment for that diagnosis is also not available for other clients. Requirements regarding the need for a referral, or which days are available for treatment, etc., are legitimate requirements for MHCP recipients only if they are also applied to other clients.

Provider Participation Requirements - Rule 101

Rule 101 establishes requirements for provider participation in MHCP. In order for a provider to be reimbursed for other state sponsored health care programs, the provider must also participate in MHCP and accept, on a continuous basis, new patients who are recipients in these programs. Health maintenance organizations (HMO) must, as a condition of retaining a certificate of authority, participate in MHCP and must submit proposals to serve individuals in these programs.
in a geographic region of the state if the statutory requirements are met (MS 62D.04, subd.5).

Other state sponsored health care programs include:

- State employees' health insurance plans;
- Workers' compensation insurance;
- Public employees' insurance program;
- Insurance plans provided through the Minnesota Comprehensive Health Association; and
- Health insurance plans offered to local statutory or home rule charter city, county, and school district employees.

DHS uses the Current Procedural Terminology (CPT) definition of a new patient: "A new patient is one who has not received any professional service from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years." According to the CPT, a client who changes from another payer source to MHCP eligibility is not a "new patient" simply because of that change.

**Rule 101 Non-Compliance**

A provider who fails to comply with the requirements of Rule 101 will be excluded from state sponsored health care programs. DHS provides lists of providers who comply with participation requirements on a quarterly basis to the State Departments of Commerce, Employee Relations, and Labor and Industry.

If DHS has reason to believe a provider is not in compliance with the participation requirements, DHS will notify the provider. The provider will have 30 days to provide DHS with evidence of participation compliance. After the response period expires, those who have not submitted evidence of compliance will be excluded from participation in the other state health care programs.

**Limiting MHCP Case Load Rule 101**

A provider may limit acceptance of new MHCP recipients if the MHCP recipient caseload is 20% of the provider's annual active caseload (the total number of patient encounters that result in a billing during the provider's most recent fiscal year).

An encounter is one patient encounter per patient, per day, regardless of the number of service sites. However, patient encounters from all service sites enrolled under the provider's ID number may be included in the total caseload count.

Encounters involving patients enrolled in either fee-for-service or prepaid health plans count toward the calculation of a caseload.

If at least 20% of the provider's annual active patient case load is, and continues to be MHCP recipients, the provider may refuse to accept new MHCP recipients for the remainder of the provider's fiscal year only after submitting patient encounter data to the Provider Enrollment as
outlined below.

Providers that wish to limit acceptance of new patients should notify DHS Provider Enrollment in writing at least 10 days before limiting the acceptance of new MHCP patients. The notice must include the provider's name, MHCP provider ID number, fiscal period, total number of patient encounters for the last fiscal year, and the total number of MHCP patient encounters. If needed, a notification form is available from the DHS Provider Enrollment:

Minnesota Department of Human Services
Provider Enrollment
444 Lafayette Road
St. Paul, MN 55155-3856
(651) 282-5330 or 1-800-657-3991

DHS Provider Enrollment will notify the provider in writing whether its notice to limit MHCP caseload has been accepted. This acceptance will be effective 10 days after the provider is notified by DHS, and will remain in effect for the remainder of the provider's fiscal year. If a provider wishes to continue limiting MHCP caseload, it must file a new notice each year. In addition, a provider who has a contract with an MHCP prepaid health plan must notify the plan of its intention to limit acceptance of new MHCP patients.

Prohibited Practices

Nursing Homes

MS 256B.48, subd. 1, provides that a nursing home is not eligible to receive Medical Assistance (MA) payments unless it refrains from requiring any resident of the nursing facility to utilize a vendor of health care services chosen by the nursing facility.

MS 256B.48, subd. 1, addresses payment agreements between nursing homes and providers of ancillary medical care. It provides that a nursing home is not eligible to receive MA payments unless it refrains from requiring any vendor of medical care (as defined by section 256B.02, subd. 7), who is reimbursed by MA under a separate fee schedule, to pay any portion of the provider's fee to the nursing home except as payment for renting or leasing space or equipment or purchasing support services from the nursing facility as limited by section 256B.433.

MS 256B.48, subd. 1, addresses payment rates and special services for nursing homes and its private pay residents. It provides that a nursing home is not eligible to receive MA payments unless it refrains from requiring its residents to pay more than its MA rate for similar services.

Exceptions are made for:

- Private paying residents in private/single bedrooms; and
• Special services not included in the daily rate, if MA residents are charged the same rate for the same service.

In addition, a nursing facility participating in the demonstration project under MS 256B.434 may charge private pay residents up to the Medicare rate for the first 100 days after admission only if the private pay resident's stay is less than 101 days. Refer to these statutes for additional details of these provisions.

Federal Anti-Fraud Statutes

Federal anti-fraud and abuse provisions prohibit certain types of business transactions or arrangements. A pertinent provision of these statutes is: Whoever knowingly and willfully offers/pays or solicits/receives any compensation (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind:

• To refer, or in return for referring, an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the MHCP program; or
• To refer, or in return for purchasing, leasing, ordering, or arranging for or recommending, purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years or both.

The following practices are prohibited:

Offering or transferring remuneration to any individual eligible for benefits under this program, that such persons knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner or supplier any item or service for which payment may be made in whole or in part by this program. Examples of benefits include, but are not limited to such items as coupons providing discounts, cash, merchandise or other goods or services of value in exchange for utilizing services or obtaining goods from a particular provider.

Factors

Factor: An individual or organization that advances money to a provider for their accounts receivable for an added fee or a deduction of the accounts receivable worth. Payment for any covered service furnished to a recipient by a provider may not be made to or through a factor, either directly or indirectly.

Advance Directives

Background

Inpatient hospitals, nursing facilities, providers of home health and personal care services, hospice programs and managed care plans are required by federal and state law to inform all
adult patients about their rights to accept or refuse medical or surgical treatment, and the right to execute an advance directive. Out-of-state providers must comply with all terms of this section and follow laws of the state in which the provider is located.

Definitions

**Advance Directive:** A written instruction such as a living will or durable power of attorney for health care, recognized under state law and relating to the provision of care when the patient is incapacitated. The intent of an advance directive is to enhance a patient's control over medical treatment decisions.

**Patient:** Any adult resident, patient, recipient, or client receiving medical care from or through the provider.

Requirements

Inpatient hospitals, nursing facilities, providers of home health and personal care services, hospice programs and managed care plans must maintain written policies and procedures and:

- Give updated, written information to all patients about their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and to execute an advance directive. Providers may contract with other entities to furnish this information but are still legally responsible for ensuring this requirement;
- Give written information to patients regarding the provider's policies and procedures concerning implementation of these rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. At a minimum, the provider's statement of limitation should:
  - Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;
  - Identify the State legal authority permitting such objection; and
  - Describe the range of medical conditions or procedures affected by the conscience objection;
- Within limited circumstances, only if allowed under state law, a facility or physician may conscientiously object to an advance directive. If state law is silent regarding conscientious objection, the facility or physician may not conscientiously object to an advance directive that is permissible in that state;
- Document in the patient's medical record whether or not the patient has executed an advance directive;
- Shall not condition the provision of care, or otherwise discriminate against the patient, based on whether or not the patient has executed an advance directive, including not conditioning the provision of care on that basis;
- Comply with state law governing advance directives; and
• Provide for educational campaigns, individually or with other providers and organizations, to educate staff and the community on issues concerning advance directives. This requirement may be met by making copies of the required documents available in reception areas.

Providers are encouraged to work with associations and advocacy groups to further educate the community on these issues. Providers must be able to document their community education efforts.

When Providers Must Inform Patients

In accordance with federal law, written information on state laws regarding the patient’s right to make decisions and the provider's policies concerning implementation of those rights must be given by the following providers at the following times:

- **Inpatient hospitals**, at the time of the individual's admission as an inpatient.
- **Nursing facilities**, at the time of the individual's admission as a resident.
- **Home health or personal care services providers**, in advance of the individual coming under the care of the provider (this means on or before the initial visit).
- **Hospice programs**, at the time of the individual's initial receipt of hospice care.
- **HMO's**, at the time the individual enrolls with the organization.

Patient Incapacity

If a patient is incapacitated at one of the above times, and if the provider issues materials about policies and procedures to families, surrogates, or other concerned persons, the provider must include in those materials the information concerning advance directives. The provider must document in the medical record that the patient was unable to receive the information and/or was unable to articulate whether he/she has executed an advance directive. Once the patient is no longer incapacitated, the provider must give the information on advance directives to the individual. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

Executed Advance Directives

The provider must document in the patient's medical record whether or not the patient has executed an advance directive. If the patient has an advance directive, and the provider has been given a copy, the provider must comply with the terms of the advance directive, to the extent allowed under state law.

Objection Based on Conscience

Federal law does not affect the rights a provider may have under state law to object, based on conscience, to the treatment or withdrawal of an advance directive.
Informed Consent

Federal law does not affect a provider's obligation to obtain informed consent to treatment.

Forms Available

Although providers are not required by law to assist patients in formulating advance directives, providers may wish to have copies of the Minnesota Health Care Declaration (living will) form or the Durable Power of Attorney for Health Care form available for patients who request one. The Minnesota Health Care Directive suggested form is found in MS 145C.

Surveillance & Integrity Review Section (SIRS)

Background

Minnesota Rules 9505.2160 to 9505.2245 (enacted June 10, 1991 amended March 18, 1995) establish a program of surveillance, integrity, review, and control. They authorize a post payment review process to ensure compliance with MHCP requirements by monitoring the use of health services by recipients and the delivery of health services by vendors. Within DHS, the SIRS section is responsible for identifying and investigating suspected fraud, theft, and abuse. SIRS is authorized to seek monetary recovery, to impose administrative sanctions, and to seek civil or criminal action through the office of Attorney General (AG). Referrals are made both to the Medicaid Fraud Control Unit (MFCU), and to the civil section of the AG’s office. Information concerning the monitoring of recipient use of health services is found in the Health Care Programs and Services chapter (Ch. 2).

Definitions

Abuse: In the case of a vendor, a pattern of practice that is inconsistent with sound fiscal, business, or health service practices, and that results in unnecessary costs to MHCP or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health services. The following practices are deemed to be abuse by a provider:

- Submitting repeated claims:
  - With missing or incorrect information;
  - Using procedure codes that overstate the level or amount of health service provided;
  - For health services that are not reimbursable by MHCP;
  - For the same health service provided to the same recipient;
  - For health services that do not comply with the requirements to be a covered service under Minnesota Rules 9505.0210 and, if applicable, 9505.0215;
  - For services not medically necessary;
- Failing to develop and maintain health service records as required under Minnesota Rules 9505.2175;
- Failing to use generally accepted accounting principles or other accounting methods which relate entries on the recipient's health service record to corresponding entries on the billing invoice, unless another accounting method or principle is required by federal or state law or rule;
- Failing to disclose or make available to DHS the recipient's health service records or the vendor's financial records as defined under Minnesota Rules 9505.2180;
- Repeatedly failing to report duplicate payments from third party payers for covered services provided to MHCP recipients and billed to DHS;
- Failing to obtain information and assignment of benefits as specified in Minnesota Rule 9505.0070, subpart 3, or failing to bill Medicare as required by Minnesota Rule 9505.0440;
- Failing to keep financial records as defined under Minnesota Rule 9505.2180;
- Repeatedly submitting or causing repeated submission of false information for the purpose of obtaining (prior) authorization, inpatient hospital admission certification, or a second medical opinion;
- Knowingly and willfully submitting a false or fraudulent application for provider status;
- Soliciting, charging, or receiving payments from recipients or non-Medical Assistance sources, in violation of Code of Federal Regulations, title 42, section 447.15, or Minnesota Rule 9505.0225, for services for which the vendor has received reimbursement from, or should have billed to, MHCP;
- Payment of program funds by a vendor to another vendor whom the vendor knew or had reason to know was suspended or terminated from MHCP participation;
- Repeatedly billing MHCP for health services after entering into an agreement with a third party payer to accept an amount in full satisfaction of the payer's liability; and
- Repeatedly failing to comply with the requirements of the provider agreement that relate to the programs covered by Minnesota Rules 9505.2160 to 9505.2245.

**Electronically Stored Data:** Data stored in a typewriter, word processor, computer, existing or pre-existing computer system or computer network, magnetic tape, or computer disk.

**Fraud:** Acts which constitute a crime against any program, or attempts or conspiracies to commit those crimes including the following:

- Theft, perjury, forgery and aggravated forgery, MA fraud, or financial transaction card fraud;
- Making a false statement, claim, or representation to a program where the person knows or should reasonably know the statement, claim, or representation is false; and

**Health Plan:** An HMO or other organization that contracts with DHS to provide health services to recipients under a prepaid contract.

**Health Services:** Goods and services eligible for MHCP payment under MS 256B.02, subd. 8 and 256B.0625.
Health Service Record: Electronically stored data, and written or diagrammed documentation of the nature, extent, and evidence of the medical necessity of a health service provided to a recipient by a vendor and billed to MHCP.

Investigative Costs: Investigative costs are subject to the provisions of MS 256B.064, subd. 1d, and means the sum of the following expenses incurred by a DHS investigator on a particular case:

- Hourly wage multiplied by the number of hours spent on the case;
- Employee benefits;
- Travel;
- Lodging;
- Meals; and
- Photocopying costs, paper, computer data storage or diskettes, and computer records and printouts.

Medically Necessary or Medical Necessity: A health service that is consistent with the recipient's diagnosis and condition and:

- Is recognized as the prevailing standard or current practice by the provider's peer group;
- Is rendered in response to a life-threatening condition or pain; to treat an injury, illness, or infection; to treat a condition that could result in physical or mental disability; to care for a mother and child through the maternity period; or to achieve a level of physical or mental function; or
- Is a preventive health service.

Ownership or Control Interest: Has the meaning given in Code of Federal Regulations, title 42, part 455, sections 101 and 102.

Pattern: An identifiable series of more than one event or activity.

MHCP (Minnesota Health Care Programs): The Medical Assistance (MA) Program, General Assistance Medical Care (GAMC) Program, MinnesotaCare, Consolidated Chemical Dependency Treatment Fund (CCDTF) Program, Prepaid Medical Assistance Program (PMAP), home and community-based services under a waiver from HCFA, or any other DHS administered health service program.

Provider: An individual, organization, or entity that has entered into an agreement with DHS for the provision of health services, including a personal care assistant.

Restriction: In the case of a vendor, excluding or limiting the scope of the health services for which a vendor may receive a payment through a program for a reasonable time.

Suspending Participation or Suspension: Making a vendor ineligible for reimbursement through MHCP funds for a stated period of time.
Suspending Payments: Stopping any or all program payments for health services billed by a provider pending resolution of the matter in dispute between the provider and DHS.

Terminating Participation or Termination: Making a vendor ineligible for reimbursement through MHCP funds.

Theft: The act defined in MS 609.52, subd. 2 (3)(c).

Third Party Payer: The term defined in part Minnesota Rule 9505.0015, subp. 46, and, additionally, Medicare.

Vendor: The meaning given to "vendor of medical care" in MS 256B.02, subd. 7. The term vendor includes a provider and also a personal care assistant.

Withholding Payments: Reducing or adjusting the amounts paid to a provider to offset overpayments previously made to the provider.

Health Service Records

Documentation: Health service records must be developed and maintained as a condition of payment by MHCP. Each occurrence of a health service must be documented in the recipient's health record. MHCP funds paid for health care not documented in the health service record are subject to monetary recovery.

Health Service Records: Must contain the following information when applicable. There may also be other record obligations located throughout this manual specific to vendors of a particular service:

- The record must be legible at a minimum to the individual providing care.
- The recipient's name must be on each page of the recipient's record.
- Each entry in the health service record must contain:
  - The date on which the entry is made;
  - The date or dates on which the health service is provided;
  - The length of time spent with the recipient, if the amount paid for the service depends on time spent;
  - The signature and title of the person from whom the recipient received the service;
  - Reportage of the recipient's progress or response to treatment, and changes in the treatment or diagnosis;
  - When applicable, the countersignature of the vendor or the supervisor as required under Minnesota Rules 9505.0170 to 9505.0475; and
  - Documentation of supervision by the supervisor.
- The record must state:
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- The recipient's case history and health condition as determined by the vendor's examination or assessment;
- The results of all diagnostic tests and examinations; and
- The diagnosis resulting from the examination.
- The record must show the quantity, dosage, and name of prescribed drugs ordered for or administered to the recipient. Prescriptions for name brand drugs must be handwritten by the prescriber, and specifically indicate “dispense as written – brand necessary” or “DAW brand necessary.”
- The record must contain reports of consultations that are ordered for the recipient.
- The record must contain the recipient's plan of care, individual treatment plan, or individual program plan.
- The record of a laboratory or x-ray service must document the provider's order for service.

Health Service Records of Specific Providers

These vendors must follow additional requirements in their health service records:

**Pharmacy service record** must comply with Minnesota Rules relating to pharmacy licensing and operations and electronic data processing of pharmacy records. The pharmacy service record must be a hard copy made at the time of the request for service and must be kept for five years.

**Medical transportation record** must document:
- The origin, destination, and distance traveled in providing the service to the recipient;
- The type of transportation; and
- If applicable, a physician's certification for non-emergency, ancillary, or special transportation services as defined in Minnesota Rules 9505.0315, subp. 1.

**Medical supplies and equipment record** must:
- Document that the medical supply or equipment is eligible for payment; and
- Contain a hard copy of the physician’s order or prescription, including the name and amount of the medical supply or equipment provided for the recipient.

**Rehabilitative and therapeutic service records** must comply with requirements listed in the Rehabilitative Services chapter (Ch. 17).

**Personal care provider records** must document:
- The physician's initial order for personal care services, which shall be included within a reasonable time after the start of such services;
- The physician's order has been reviewed by the physician at least once every 365 days;
- The DHS care plan completed by the supervising registered nurse which details the nurse's instruction to the personal care assistant;
• DHS notice of prior authorization which identifies the amount of personal care service and registered nurse supervision authorized for the recipient;
• DHS notice of approval or denial of a relative hardship waiver request; and
• Whether or not the recipient is in a shared care arrangement.

In a shared care arrangement, the documentation requirements must be met separately for each recipient.

The following daily documentation must be made by each personal care assistant of services provided to the recipient:

• Recipient's name;
• Name of the personal care assistant providing services;
• Day, month, and year the personal care services were provided;
• Total number of hours spent providing personal care services;
• Time of arrival and the time of departure of the personal care assistant at the site where services were provided;
• Personal care services provided;
• Notes by the personal care assistant regarding changes in the recipient's condition, documentation of calls to the supervising nurse, and other notes as required by the supervising nurse;
• Personal care assistant's signature; and
• Recipient's signature, stamp, mark, or the responsible party's signature, if the recipient requires a responsible party.

Each recipient record must also document:

• Authorization by the recipient's responsible party, if any, for personal care services provided outside the recipient's residence;
• Authorization by the responsible party, who is a parent of a minor recipient or a guardian of recipient, which is approved and signed by the supervising nurse, to delegate to another adult the responsible party function for absences of at least 24 hours but not more than six days; and
• Supervision by the supervising nurse, including the date of the provision of supervision of personal care services as specified in Minnesota Rules 9505.0335, subp. 4.

Record Keeping

Financial records, including written and electronically stored data, of a vendor who receives payment for a recipient's services under MHCP must contain:

• Payroll ledgers, canceled checks, bank deposit slips and any other accounting records prepared by or for the vendor;
• Contracts for services or supplies relating to the vendor's costs and billings to MHCP for the recipient's health services;
• Evidence of the vendor charges to MHCP recipients and to persons who are not MHCP recipients, consistent with the requirements of Minnesota Government Data Practices Act;
• Evidence of claims for reimbursement, payments, settlements, or denials resulting from claims submitted to third party payers or programs;
• The vendor's appointment books for patient appointments and the provider's schedules for patient supervision, if applicable;
• Billing transmittal forms;
• Records showing all persons, corporations, partnerships, and entities with an ownership or controlling interest in the vendor;
• Employee records for those persons currently employed by the vendor (or who have been employed by the vendor at any time within the previous five years) which, under the Minnesota Government Data Practices Act, would be considered public data for a public employee, such as employee name, salary, qualifications, position description, job title, and dates of employment. In addition, employee records shall include the current home address of the employee or the last known address of any former employee; and
• Nursing/board and care homes must, in addition to the foregoing, maintain purchase invoices, records of deposits, expenditures for patient personal needs and allowance accounts.

Record Keeping

Subpart 1. Recipient's consent to access. A recipient of Medical Assistance is deemed to have authorized in writing a vendor or others to release to DHS for examination according to MS 256B.27, subd. 4, upon request, the Medical Assistance recipient's health service records related to services under a program. The Medical Assistance recipient's authorization of the release and review of health service records for services provided while the person is a Medical Assistance recipient shall be presumed competent if given in conjunction with the person's application for Medical Assistance. This presumption shall exist regardless of whether the application was signed by the person or the person's guardian or authorized representative as defined in Minnesota Rules 9505.0015, subp. 8.

Subp. 2. Department access to records. A vendor shall grant DHS access during the vendor's regular business hours to examine health service and financial records related to a health service billed to a program. Access to a recipient's health service records shall be for the purposes in Minnesota Rules 9505.2200, subp. 1. DHS shall notify the vendor no less than 24 hours before obtaining access to a health service or financial record, unless the vendor waives notice.

Retention of Records 9505.2190

Subp. 1. Retention required, general. A vendor shall retain all health service and financial records related to a health service for which payment under a program was received or billed for at least five years after the initial date of billing. Microfilm records satisfy the recordkeeping requirements of this subpart and Minnesota Rules 9505.2175, subp. 3, in the fourth and fifth years after the date of billing.
Subp. 2. **Record retention after vendor withdrawal or termination.** A vendor who withdraws or is terminated from a program must retain or make available to DHS on demand the health service and financial records as required under subpart 1.

Subp. 3. **Record retention under change of ownership.** If the ownership of a long-term care facility or vendor service changes, the transferor, unless otherwise provided by law or written agreement with the transferee, is responsible for maintaining, preserving, and making available to DHS on demand the health service and financial records related to services generated before the date of the transfer as required under subpart 1 and Minnesota Rules 9505.2185, subp. 2.

Subp. 4. **Record retention in contested cases.** In the event of a contested case, the vendor must retain health service and financial records as required by subpart 1 or for the duration of the contested case proceedings, whichever period is longer.

**Copying Records 9505.2195**

DHS, at its own expense, may photocopy or otherwise duplicate any health service or financial record related to a health service for which a claim or payment is made under a MHCP program. Photocopying shall be done on the vendor's premises unless removal is specifically permitted by the vendor. If a vendor fails to allow DHS to use the department's equipment to photocopy or duplicate any health service or financial record on the premises, the vendor must furnish copies at the vendor's expense within two weeks of a request for copies by DHS.

**Investigative Process**

- SIRS has the authority to conduct routine audits of vendors to monitor compliance with program requirements.
- SIRS is authorized to use information from sources including:
  - Government agencies; Third-party payers including Medicare;
  - Professional review organizations;
  - Consultants under contract in Minnesota Rules part 9505.0185;
  - Recipients and their responsible relatives;
  - Vendors and persons employed by or under contract to vendors;
  - Professional associations of vendors and their peers; Recipient advocacy organizations and recipients; and
  - Members of the public.

- A SIRS investigation may include:
  - Examination of health service and financial records;
  - Examination of equipment, materials, prescribed drugs, or other items used in or for a recipient's health service under MHCP;
  - Examination of prescriptions written for MHCP recipients;
  - Interviews of contacts;
Verification of the professional credentials of a vendor, the vendor's employees and entities under contract with the vendor;
Consultation with DHS peer review mechanisms; and
Determination of whether the health care provided was medically necessary.

Monetary Recovery and Sanctioning

- Following completion of the investigation, DHS will determine whether:
  - The vendor is in compliance with the requirements of a program;
  - Insufficient evidence exists that fraud, theft, or abuse has occurred; or
  - The evidence of fraud, theft, or abuse supports administrative, civil, or criminal action.

- After completing the determination, DHS will take one or more of the actions specified in items listed below:
  - Close the investigation when no further action is warranted;
  - Impose administrative sanctions;
  - Seek monetary recovery;
  - Refer the investigation to the appropriate state regulatory agency;
  - Refer the investigation to the attorney general or, if appropriate, to a county attorney for possible civil or criminal legal action;
  - Issue a warning that states the practices are potentially in violation of program laws or regulations; and/or DHS may also seek recovery of investigative costs from a vendor under MS 256B.064, subd. 1d.

The commissioner will seek monetary recovery from a vendor if payment for a recipient's health service under MHCP was the result of fraud, theft, abuse, or error on the part of the provider, DHS, or local agency. The commissioner is authorized to calculate the amount of monetary recovery based on estimation from systematic random samples of claims submitted and paid. The commissioner will recover money by the following means:

- Permitting voluntary repayment of money, either in lump sum payment or installment payments;
- Deducting or withholding from MHCP payments;
- Withholding payments to a provider under Code of Federal Regulations, title 42, section 447.31; or
- Using any legal collection process.

If DHS permits use of installment payments, DHS shall assess interest on the funds, unless the overpayment occurred because of department error. The rate will be established by the Department of Revenue under MS 270.75.

If a vendor willfully submits a claim for reimbursement for medical care or services the vendor knows or reasonably should have known is a false representation and which results in payments for which the vendor is ineligible, DHS may seek recovery of investigative costs.
• Administrative sanctions may be imposed for any of the following:
  ▪ Fraud, theft, or abuse in connection with health care services billed to MHCP; and
  ▪ Refusal to grant DHS access to records.

• For a vendor, the sanctions which may be imposed are:
  ▪ Referral to the appropriate peer review mechanism or licensing board;
  ▪ Suspending or terminating the provider's or vendor's participation;
  ▪ Suspending or terminating the participation of any person or corporation with whom the provider or vendor has any ownership or control interest;
  ▪ Requiring attendance at education sessions provided by DHS;
  ▪ Requiring authorization of services; and
  ▪ Restricting the vendor's participation in MHCP.

• For a provider, the sanctions which may be imposed are those described in previous, as well as:
  ▪ Requiring a provider agreement of limited duration;
  ▪ Requiring a provider agreement which stipulates specific conditions of participation; and
  ▪ Review of the provider's claims before payment.

• DHS has the authority to simultaneously seek monetary recovery and to administer sanctions.
• DHS will notify vendors in writing of any intent to recover money or impose sanctions.
• A vendor may meet with DHS informally to discuss the matter in dispute.
• A vendor has the right to appeal DHS's proposed action. An appeal is considered timely if written notice of appeal is filed with the commissioner within 30 days of the date that the notice of proposed action was mailed. The appeal request must specify:
  ▪ Each disputed item;
  ▪ The reason for the dispute;
  ▪ An estimate of the dollar amount involved, if any, for each disputed item;
  ▪ The computation or other disposition that the appealing party believes is correct;
  ▪ The authority in statute or rule upon which the appealing party relies for each disputed item;
  ▪ The name and address of the person or firm with whom contracts may be made regarding the appeal; and
  ▪ Other information required by the commissioner.

• The appeal shall be a contested case proceeding under the provisions of the Minnesota Administrative Procedure Act.
• Under certain conditions, DHS has the authority to withhold payments to vendor prior to notice or to a hearing.
• No claims may be submitted personally by a vendor who has been suspended or terminated from MHCP, nor may claims be submitted by any clinic, group, corporation, or association on behalf of a vendor who has been suspended or terminated from MHCP. Claims for health
care provided prior to the suspension or termination may be submitted, but will be subject to review.

- The vendor who is restricted from participation may not submit a claim for payment under MHCP for services or charges specified in the notice of action, either through a claim as an individual or through a claim submitted by a clinic, group, corporation, or professional association, except in the case of claims for payment for health services otherwise eligible for payment and provided before the restriction. No payments may be made to a vendor either directly or indirectly, for restricted services or charges specified in the notice of action.

- A vendor who is convicted of a crime related to the provision, management, or administration of MHCP related health services will be suspended from participation effective on the date of conviction. The commissioner will notify the vendor of the date and duration of the suspension.

**Fraud or Abuse of Medicare Program**

DHS will suspend or terminate any vendor who has been suspended or is currently under suspension or termination from participation in the Medicare program because of fraud or abuse.

**Reporting Suspected Fraud or Abuse**

To report suspected fraud or abuse by a provider, call the DHS SIRS Division at (651) 296-2680 or 1-800-657-3750.

**Kickbacks and Other Criminal Activities**

A vendor who commits any of the following acts may be convicted of a felony and fined up to $25,000 and/or imprisoned for up to five years:

- Makes a statement known to be false in an application for payment or for use in determining rights to such payment;
- Fails to disclose a fact affecting the vendor's initial or continuing right to receive payments with the intent to wrongfully obtain such payments;
- Receives payments for the benefit of another and knowingly uses them for a purpose other than on behalf of the beneficiary;
- Receives, solicits, offers, or pays in any manner and in any form in return for:
  - Referring, or inducing another to refer, a recipient for the furnishing of benefits for which payment may be made under this program; or
  - Obtaining, or inducing another to obtain, in any manner, goods or services for which payment may be made under this program.

This does not apply to:

- A properly disclosed reduction in price that is reflected in cost claimed by the provider; or
Salaries paid by an employer to an employee.

- Makes a statement known to be false so that a facility may qualify, or continue to qualify, as a hospital, skilled nursing facility, intermediate care facility, or home health agency; or
- Requests or receives from a recipient payment in excess of reimbursement received from the program; or charges or accepts value in excess of rates established by DHS under this program as a condition precedent to admitting a patient to a hospital, skilled nursing facility, intermediate care facility, or as a requirement for a patient's continued stay in such facility.

### Crimes Related to MHCP

**Convicted:** A judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from the judgment is pending, and includes a plea of guilty or *nolo contendere*.

- A vendor convicted of an MHCP-related crime is automatically suspended from participation in MHCP. The effective date of the suspension is the date of the conviction. The commissioner will notify the vendor of the date and duration of the suspension.
- Suspension and termination sanctions are applicable to vendors who share ownership or control interest with a vendor convicted of a crime related to MHCP. The determination of ownership or control interest will be made using the definitions in Code of Federal Regulations, title 42, sections 455.101 and 455.102. A provider suspended under this provision may seek reinstatement as a provider when the convicted provider ceases ownership or control interest in the other provider.
- A vendor will be notified in writing of DHS's intent to suspend the vendor from MHCP participation, the reasons for the suspension, and the effective date and duration of the suspension.

### Access Services

#### Transportation

- Transportation and other related travel services are covered when the services are necessary to enable a recipient to obtain a covered health service from a participating provider. Transportation to nonparticipating providers shall also be paid if:

  - The service is covered under the MA state plan;
  - The nonparticipating provider could be a participating provider if application was made; and
  - It results in proper and efficient administration of Minnesota Health Care Programs due to cost effectiveness.

- MA covers the cost of the most appropriate and cost-effective forms of transportation incurred by an ambulatory recipient. Funded completely by state and federal funds, this
program is administered by counties who reimburse the recipient or the provider directly for costs incurred. Examples of services and expenses for which reimbursement is, or may be, available: Mileage and parking expenses incurred by a recipient or recipient's driver; bus or taxi fare; food and lodging expenses; and sign language interpreters.

- Local human service agencies must assist recipients in finding necessary transportation whenever transportation is not available to obtain covered health services. Each local human service agency has a plan detailing how it will assure that a recipient obtains necessary transportation services. Local human service agencies may require authorization for the transportation services they provide or reimburse. Refer to the Prepaid Minnesota Health Care Programs chapter (Ch. 3) for information about services provided by prepaid health plans.

**Sign Language Interpreter Services**

All providers are required to provide sign language interpreter services when such services are necessary to enable hearing impaired recipients to obtain covered services. Provider responsibility for paying for the interpreter services depends on the number of persons the provider employs.

- When 15 or more persons are employed, the provider must pay for the service. Providers may contact the Interpreter Referral Center (IC) for assistance in locating interpreters. The IC regional telephone numbers are:
  - CSD Interpreting Referral Services (651) 224-6548 voice/TTY
  - Northern Minnesota Referral 1-877-456-3839 voice/TTY
  - Central Minnesota Referral 1-877-456-7589 voice/TTY
  - Southern Minnesota Referral 1-866-333-9275 voice/TTY

- When fewer than 15 persons are employed, the local human services agency must pay for the sign language interpreter services. The local human service agency is responsible for establishing fees appropriate to the situation and the certification level of the interpreter. The rate should be agreed upon before services begin. If services are needed for four or more hours per week, it may be beneficial to negotiate a reduced rate and a contract for services.

- The DHS Deaf and Hard of Hearing Services Division manages the statewide program for interpreter referral. The suggested guideline is to make a *minimum of two weeks advance notice*. Call DHS Deaf Services Division information line at 651/297-1316 voice, or 651/297-1313 TDD/TTY for the number of your regional center.

- Prepaid health plans, under contract to provide MHCP services to MA, GAMC, and MinnesotaCare recipients, must provide sign language services when such services are required for the recipient to receive or understand the health care services provided.

**Foreign Language Interpreter Services**

Foreign language interpreter services are a covered benefit for Minnesota Health Care Programs (MHCP) fee-for-service recipients on Medical Assistance. Recipients of all 3 major programs (Medical Assistance, General Assistance Medical Care, and MinnesotaCare) that are enrolled...
through a prepaid health plan, are covered for interpreter services. Contact the prepaid health plans for billing information.

- All enrolled providers except inpatient hospitals and special transportation providers* can bill DHS for language interpreter services. Providers are responsible for arranging the interpretation service, and paying the interpreter. Use the same principles that you normally use when hiring, contracting, or arranging with a person to provide services to your patients.

- Use HCPCS code T1013 (1 unit = 15 minutes) to bill for the foreign language interpreter service. The MHCP payment rate is the lower of $12.50, or your usual and customary charge, for each fifteen-minute unit. When applicable, bill the patient’s Third Party Liability (TPL) insurance prior to billing MHCP. Bill directly to DHS when the patient is dually eligible (Medicare and Medicaid) since Medicare does not cover the service.

- Three people must be present (or on the phone in the case of the interpreter) for the service to be covered; the provider, the patient and the interpreter. Neither the provider nor the patient’s family member can act as the interpreter and receive reimbursement from MHCP.

- In the case of a minor, interpreter services are covered to interpret for the parent/guardian.

- Bill only for the direct face-to-face service time. If the patient fails to show up for the appointment, then the interpreter service cannot be billed to MHCP.

- Interpreter services performed in a dental office must be billed on either the ADA or HCFA-1500 claim form to bill the number of units. Older versions of the ADA claim form lack a units field so providers using it must bill interpreter services by listing the amount of units being billed in the comment or remarks field. If you are using a current version of the ADA form (2000 version) it already has a field to list quantity/units. In either case, when billing with the ADA claim form enter a 22 modifier next to the interpreter procedure code (T1013). The HCFA-1500 can also be used because the claim form has a unit field in box 24G.

* Language interpreter services are part of the inpatient hospital DRG payment and cannot be billed separately during an inpatient stay. Special transportation providers cannot bill due to the nature of the service performed. The service (transporting) does not require interpreting.

**Legal References**

MS 145C
MS 256B.02
MS 246B.03
MS 256B.04
MS 256B.27
MS 256B.48
MS 256B.064
MS 256B.0625, subd. 18d
Chapter 1: Requirements for Providers

MS 256B.0625, subd. 39
MS 256B.0644
MS 363.073
Minnesota Rules 9505.0195; 9505.5200 to 9505.5240
Minnesota Rules 9505.0140; 9505.0315
Minnesota Rules 9505.0455 to 9505.0475
Minnesota Rules 9505.2160 to 9505.2245
Section 504 of the Rehabilitation Act of 1973
Title XI, section 1128(b) (formerly Title XIX, section 1909) of the Social Security Act
Title XVIII, section 1877(b) of the Social Security Act
42 CFR 431.53
42 CFR 431.107
42 CFR 447.10
42 CFR 455
Stipulated Settlement Agreement, Day v. Noot
Chapter 2

Health Care Programs and Services

Medical Assistance (MA)

MA, established under Title XIX of the Social Security Act, is a program that provides medical care for low-income persons. MA is funded jointly by the state and federal governments. Within broad federal rules, each state decides the types of health care services that will be covered under its MA program. There are several programs that qualify people for health care coverage through MA. This program is also referred to as Program "MA."

**Minnesota Family Investment Program (MFIP):** Authorized under the federal Temporary Assistance to Needy Families (TANF) block grant to provide cash assistance and employment support to needy families. People who receive MFIP are also covered by MA. MFIP replaced the AFDC program.

**MA for Families and Children, and persons who are blind, disabled or over age 65:** Pays for future medical bills for covered health care services.

**MA for Pregnant Women and Infants:** Pays for covered health care services provided to pregnant women and children under age two.

**MA for Disabled Children (TEFRA):** Available for some disabled children who ordinarily would not be eligible for MA because of parental income. Applicants must be reviewed by the State Medical Review Team.

**MA for Employed Persons with Disabilities (MA-EPD):** Allows working people with disabilities to qualify for MA under higher income and asset limits.

**Qualified Medicare Beneficiaries (QMB):** Helps people pay their Medicare premiums, and for Medicare-covered services, the deductibles, coinsurance, and co-payments.

**Qualified Working Disabled Individuals (QWD):** Helps people pay for their Medicare Part A premiums.

**Service Limited Medicare Beneficiaries (SLMB):** Helps people pay for their Medicare Part B premiums.

**Qualifying Individuals (QI):** Helps people pay for all or part of their Medicare Part B premiums.

**Program NM:** Available for certain non-citizens who have authorization to reside in the United States but are barred from federal funding under MA. The 1997 Minnesota Legislature passed legislation (MS 256B.06, subd. 4), providing MA funding for these non-citizens under program "NM." Program "NM" provides all the same service benefits to recipients as the MA program.
Effective October 1, 2003, program “NM” covers people receiving services from the Center for Victims of Torture (CVT) who are not otherwise eligible for MA or GAMC.

**Refugee (county administered):** Provides the same services as MA for refugees in the U.S. for eight months or less and who have no basis of eligibility for regular MA (program "RM").

**Program HH:** The MN Department of Human Services Program HH is a public program which receives both state and federal funding to help eligible Minnesotans gain access to medical care. Program HH is administered and eligibility is determined at the state level.

There are four benefits sets under Program HH. A person enrolled in Program HH is eligible to receive one or more of the following benefit sets:

- **Drug Benefits** - covers a recipient's portion of the cost of drugs from a limited formulary.

- **Insurance Benefits** - pays premiums for a recipient's cost-effective health, dental or vision policies (the cost of the premium may be applied towards the recipient's MA spenddown).

- **Dental Benefits** - covers the same dental benefit set as MA with the addition of a third annual cleaning.

- **Nutrition Benefits** - covers up to $50.00 per calendar month of prescribed enteral nutritional products.

Eligibility is very limited. In some cases, a person may be dually enrolled in Program HH and another Minnesota Health Care Program.

For more information about program HH, or to verify which benefit set a recipient is eligible to receive, call the Program HH Office: (651) 582-1980 or 1-800-657-3761.

**Program IM:** Recipients who reside in an Institute for Mental Disease (IMD) may be eligible for program IM if they are otherwise eligible for MA or GAMC. Effective October 1, 2003, some people are not eligible for federally funded MA while residing in an IMD, but may be eligible for state funded MA (program “NM”).

**General Assistance Medical Care (GAMC)**

The purpose of GAMC (program “GM”) is to provide payment for certain types of medical services to persons in need. GAMC is determined by state law and supported by state funds. Effective October 1, 2003, full benefits remain available to recipients with incomes no greater than 75% of the FPG, and eligibility for GAMC begins no earlier than the date of application.
GAMC Hospital Only (GHO)

The GHO program offers benefits for adults without children who have incomes between 75% and 175% of the FPG. Benefits in GHO are limited to:

- Inpatient hospital services
- Physician services provided during the inpatient hospital stay; and
- Certified registered nurse anesthetist (CRNA) services for hospitals that have elected to have CRNA costs excluded from the inpatient hospital rates during the admission.

MA and GAMC Eligibility

- Persons wanting to apply for MA or GAMC should contact their local county human services agency. (A county listing is located in the Appendix of this manual). Eligibility is determined at the local county human services agency.

- Under certain conditions, MA eligibility is available prior to the month of application. MA retroactive eligibility may extend for up to three months prior to the month of application.

- If a GAMC recipient, disabled by HIV or AIDS, is under your care and has not yet applied for MA, refer the patient to their local county human services agency.

Providers are encouraged to refer individuals who are not eligible for MA or GAMC to the Program HH Office at (651) 582-1980 or 1-800-657-3761. Many services are available for people with HIV infection regardless of their MHCP eligibility. Contact the AIDS line for information at (612) 373-AIDS or 1-800-248-AIDS.

- An IMD is defined as a residential facility with 17 or more beds that is primarily engaged in providing diagnosis, treatments, or care of persons with mental diseases, including medical attention, nursing care and related services. Adults between the ages of 21 and 65 residing in an IMD are not eligible for MA but may be eligible for GAMC.

- In order to meet the income eligibility guidelines for MA some recipients may have to pay part of the cost of their medical bills. The portion of the medical bills that the recipient must pay is called a *spenddown*.

- Persons with MA coverage incarcerated in a correctional facility must receive medical coverage through the correctional facility. Persons with GAMC coverage incarcerated in a county jail for less than one year can receive medical coverage through GAMC if they were covered by GAMC when they entered the correctional facility. Persons with GAMC coverage incarcerated in other than a county jail (i.e., state prison) must receive medical coverage through the correctional facility.

- A person, regardless of age, who is detained by law in the custody of a correctional or detention facility as a person accused or convicted of a crime is not eligible for MA.
Emergency Medical Assistance

EMA is available to non-citizens who are not eligible for federally-funded MA because of their immigration status. This includes undocumented and non-immigrant people, as well as non-qualified non-citizens who might also be eligible for state-funded MA (program NM).

To qualify for EMA, non-citizens must meet all MA eligibility requirements not related to immigration status. They must have an MA basis, be Minnesota residents and meet applicable income and asset limits.

A qualifying emergency for EMA may be either a short-term, acute condition (including labor and delivery) or an ongoing chronic condition. For short-term emergencies, eligibility exists for the duration of the emergency only and may begin or end mid-month. EMA for services related to chronic conditions meeting the emergency definition may continue indefinitely.

Service Limitations

EMA does not cover:

- Preventive, routine, screening, and counseling/risk factor reduction services
- Preventive dental: oral exams, x-rays, cleaning, fluoride, sealants, and oral hygiene instruction
- Organ transplants and related services/drugs
- Waivered services
- Immunizations
- Screening tests – lab, x-rays, mammograms, etc
- Prenatal services
- Health promotion and counseling PHN visits
- Child and Teen Check-up services
- Family planning services
- Sterilization
- Hearing screening, hearing aids
- Vision screening, eyeglasses
- Non-emergency transportation for routine/preventative care
- Pharmacy – vitamins, aspirin, Viagra, Levitra, Cialis (drugs that treat impotence of organic origin), Muse, Caverject, acne medications, contraception, smoking deterrents, organ rejection drugs, fertility drugs, drugs to promote weight loss, growth hormone, ADHD drugs, Antabuse, Drysol, antihyperlipidemic agents, hydroquinone cream, drugs not covered by Medical Assistance
- Home care for non-chronic care for those on EMA
MinnesotaCare

MinnesotaCare is a state-subsidized health care program for people who live in Minnesota and do not have health insurance. The program is open to all Minnesota residents who meet program guidelines. MinnesotaCare is funded by recipients' premiums, copayments, and statewide taxes.

MinnesotaCare is administered by DHS and some local county agencies. MinnesotaCare applicants and enrollees who reside in participating counties can choose to have their MinnesotaCare case administered by the local county agency or by the DHS MinnesotaCare Operations Office.

All MinnesotaCare recipients are enrolled in DHS contracted prepaid health plans. Additional information is also located in the Prepaid Minnesota Health Care Programs chapter (Ch. 3).

Some children who are enrolled in MinnesotaCare may have other health insurance in addition to their prepaid health plan.

Limitations

Persons may be eligible for either MinnesotaCare or MA. However, they cannot have coverage from both programs at the same time, with certain time-limited exceptions (for example, certain abortion services) and must choose one, except for abortion for health reasons. This does not apply to one month MA retroactive eligibility, related to a hospital stay.

MinnesotaCare recipients are no longer required to apply for MA when they are admitted to a hospital. MinnesotaCare recipients who have expenses not covered by MinnesotaCare may apply for MA if they choose.

A person in a correctional facility, government owned/operated halfway house, or a locked juvenile facility is not eligible for MinnesotaCare. A person residing in one of these facilities, and covered by MinnesotaCare, will be terminated at their renewal date.

A person cannot have simultaneous coverage under both MinnesotaCare and GAMC.

MinnesotaCare will not reimburse providers when a recipient has gone outside of their prepaid health plan network, unless it is for family planning (including sterilization, abortion services, and pregnancy services in conjunction with abortion services). Infertility treatment must stay within the prepaid health plan network.

There are six benefit sets for MinnesotaCare recipients:

1. **Basic Benefit Set** - (Program "XX"): Adults who are over 21 and not pregnant who are at or over 175% of the FPG.

2. **Expanded Benefit Set** - (Program "KK" or "LL"): Children (to age 21) and pregnant women.
3. **Basic Plus Benefit Set** - (Program “FF” or “JJ”): Parents above 175% of the FPG.

4. **Basic Plus One Benefit Set** - (Program "BB"): Adults, 21 and older who are not parents, and not pregnant who are at or below 175% of the FPG.

5. **Basic Plus Two Benefit Set** - (Program "FF" or "JJ"): Parents at or below 175% of the FPG.

6. Limited Benefit Set – (Program BB) Adults without children between 75% and 175% of the FPG. The MinnesotaCare Limited Benefit Set includes only:
   - Inpatient hospitalization benefits
   - Outpatient hospital care
   - Physician services provided by a physician, clinical nurse specialist, nurse practitioner, or physician assistant
   - Drugs
   - Chiropractic services
   - Lab and radiology

   The MinnesotaCare Limited Benefit Set provides up to $5,000 per calendar year for services listed above, excluding inpatient hospitalization benefits.

**Inpatient Hospital Benefit Limit**

The MinnesotaCare inpatient hospital benefits and limitations are as follows for the five benefits sets:

- **Basic Benefit Set:**
  - $10,000 annual inpatient coverage limit; and
  - 10% copay for inpatient services (up to $1,000 per adult per year, $3,000 per family).

  Adult recipients who are not pregnant may also have to pay for charges above the $10,000 benefit limit. Providers should encourage these recipients to apply for MA.

- **Expanded Benefit Set:**
  - No annual inpatient hospital coverage limit; and
  - No inpatient copays.

- **Basic Plus Benefit Set:**
  - $10,000 annual inpatient coverage limit; and
  - No inpatient copays.

- **Basic Plus One Benefit Set:**
  - $10,000 annual inpatient coverage limit; and
  - 10% copay for inpatient services (up to $1,000 per adult per year, $3,000 per family).
• Basic Plus Two Benefit Set:
  ▪ No annual inpatient hospital coverage limit; and
  ▪ No inpatient copays.

• Limited Benefit Set:
  ▪ $10,000 annual inpatient coverage limit; and
  ▪ 10% copay for inpatient services (up to $1,000 per year).

**Adult Dental Care**

Effective October 1, 2003, the Basic Benefit Set and the Basic Plus Benefit Set include preventive and restorative dental services. Restorative benefits are subject to the $500 annual cap. The 50% restorative dental copay will not apply to enrollees in the MinnesotaCare Basic and MinnesotaCare Basic Plus benefit set.

The Expanded Benefit Set includes the full MA dental benefit set. Enrollees in the Basic Plus One and Basic Plus Two Benefit Sets receive preventive and non-preventive services except for orthodontic services. These recipients are required to pay a 50% copay equal to 50% of the fee-for-service rate for non-preventive dental care services. The dental care provider's office should tell the patient about the required copay before giving treatment. The copay should be paid directly to the dental care provider.

**MinnesotaCare Application Materials**

MinnesotaCare legislation mandates that application and informational materials be made available to provider offices, local human services agencies, and community health offices. To have applications mailed to your office, contact MinnesotaCare at:

MinnesotaCare  
P.O. Box 64838  
St. Paul, Minnesota 55164-0838  
1-800-657-3672 or (651) 297-3862

**Minnesota Children with Special Health Needs**

Minnesota Children with Special Health Needs (MCSHN, programs EE and TT)) was a public program administered by the Minnesota Department of Health (MDH) which sought to improve the quality of life for Minnesota children with special health needs and their families. MCSHN paid for diagnostic services and medical care for eligible children. MCSHN also provided education, information, support, and referral.

Funding for major programs EE and TT ended June 30, 2003.
Providers may bill for services rendered on or before June 30, 2003, for up to one year after the date of service. If you have questions, contact MCSHN at (651) 215-8956 or 1-800-728-5420.

Two types of programs for MCSHN recipients existed for care provided on or before June 30, 2003:

**Major Program EE - *SCH Evaluation**

Children with a suspected medical disability or chronic illness could receive financial assistance for a diagnostic evaluation without regard to family income. Coverage of evaluations must have had prior approval by MCSHN. All recipients eligible under Major Program EE require a service agreement for payment of claims.

**Claims Submission:** Providers submit claims for MCSHN eligible recipients on the CMS-1500 in the same manner as MHCP claims. A service agreement number must be entered in Box 23 or the electronic equivalent in order to receive payment.

**Major Program TT - *SCH General Care**

To be eligible for financial assistance for medical treatment, a child must live in Minnesota, be under age 21 and have an eligible medical condition. Adults with cystic fibrosis may also qualify. Depending on income, some families may be asked to share in costs. MCSHN's treatment coverage is similar to the MA program with a few exceptions such as no coverage for PCA services. Contact MCSHN if you have questions regarding specific coverage.

- **Authorization:** MCSHN follows the same authorization requirements as MA. Authorization requests for MCSHN eligible recipients must be requested through CDMI.

- **Inpatient Hospital Benefit Limit:** MCSHN requires prior notification of inpatient hospital care, or in an emergency, notification within 72 hours of the admit date. The facility (hospital) requires a service agreement for coverage of the admission. Service agreements are issued by MCSHN staff.

- **Claims Submission:** Providers submit claims for MCSHN eligible recipients on the CMS-1500 in the same manner as MHCP claims.

- **Maximum Benefit Limits:** MCSHN has a $15,000 limit on services per eligibility year.

MCSHN Treatment and Evaluation Eligibility can overlap with other MHCP eligibility (e.g., MinnesotaCare, MA, GAMC). Since MCSHN has a limited benefits package, when overlapping eligibility spans occur, MCSHN is not the payer.

If you have any questions regarding the MCSHN Program or the services it provided, call (651) 215-8956 or toll free at 1-800-728-5420 (voice or TDD).
Waivered Services Programs

Programs that have received federal approval for expanded coverage of services to MA recipients that are not usually covered under MA are called Waivered Services. Additional information about the Waivered Services programs can be found in the HCBS Waiver Programs and the AC Program chapter (Ch. 26). These programs include the:

- Elderly Waiver (EW)
- Persons with Mental Retardation or Related Conditions (MR/RC)
- Community Alternative Care (CAC) for chronically ill individuals
- Community Alternatives for Disabled Individuals (CADI)
- Traumatic Brain Injury (TBI) Waiver

State Funded Program

Alternative Care (AC): The Alternative Care (AC) Program is a state funded program that supports certain home and community based services for MN residents age 65 or older who meet eligibility guidelines and are at risk of a nursing home level of care. Additional information about the Alternative Care Program is available in the HCBS Waiver Programs and the AC Program chapter (Ch. 26).

Prescription Drug Program

Some low-income Minnesota seniors are able to receive assistance purchasing prescription drugs through the Department of Human Services Prescription Drug Program. The Prescription Drug Program pays prescription drug costs on a fee-for-service basis for those 65 and over or disabled who have incomes at or below 120% of the Federal Poverty Guidelines. The Prescription Drug Program is not available for residents of nursing homes whose care is paid for by MA.
Only drugs manufactured by pharmaceutical companies that have signed a Prescription Drug Program rebate contract with DHS will be covered. Drug coverage information is available through the DHS NDC line at (651) 282-2599 or 1-800-657-3985.

**Fees and Payments**

All recipients must pay a $35 per person monthly deductible to their pharmacy provider up-front as the expenses are incurred. Point of Sale (POS) will reduce the DHS payment amount by $35. Payment of the $35 deductible will be reflected on the pharmacy Remittance Advice with a Base Rate Change code "16" indicating Prescription Drug Deductible and a major program code "VV" indicating Prescription Drug Program.

Recipients with spenddowns may pay the $35 deductible up-front, and other spenddown amounts should be treated as usual.

**Eligibility Verification**

DHS's Eligibility Verification System (EVS) will identify recipients who are enrolled in the Prescription Drug Program. EVS will not indicate the $35 recipient deductible; however, POS will clearly reflect the deductible.

**For More Information**

Seniors may not be able to make a decision as to whether or not this program may benefit them until they know if their drugs are covered and how much they cost. They may look to their pharmacist or physician for assistance. Those who are not on any Minnesota Health Care Program may call the Senior LinkAge Line at 1-800-333-2433. Recipients who are already on a Minnesota Health Care Program may call the DHS Recipient Help Desk at (651) 296-7675 or 1-800-657-3739 for assistance. Physicians and pharmacists with questions may call the Provider Help Desk at (651) 282-5545 or 1-800-366-5411.

**Copays**

**Definitions**

**Emergency services:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- The recipient must be seen by the medical professional on the same day that the recipient contacted the medical professional in order for the situation to be considered an emergency.
• The situation is not considered an emergency if the recipient contacts the medical professional and is not given an appointment for the same day of the call.
• Prescheduled services are not considered an emergency.
• Services provided as follow-up to initial emergency care are not considered emergency services.

**Family planning services:** A family planning supply or health service, including screening, testing, and counseling for sexually transmitted diseases, such as HIV, when provided in conjunction with the voluntary planning of the conception and bearing of children and related to a recipient's condition of fertility. "Family planning supply" means a prescribed drug or contraceptive device ordered by a physician or other eligible provider with prescribing authority for treatment of a condition related to a family planning service.

**Medical Institution:** Hospital, nursing facility, Regional Treatment Center (RTC), Institution for Mental Disease hospital (IMD), or Intermediate Care Facility for the Mentally Retarded (ICF-MR).

**Non-preventive visit:** An episode of service which is required because of a recipient’s symptoms, diagnosis, or established illness. Copays are applied to non-preventive visits.

**Preventive medicine services** are defined as:
- CPT procedure codes 99381 through 99429, or
- CPT codes 99201 - 99215 when provided for the following diagnoses: V03 - V06.9, V20 - V20.2, V21.1 - V21.2, V70.0

**Copays are not applied to preventive visits.**

**Eyeglasses:** Complete frames and lenses. A copay does not apply if only the frames are dispensed or only the lenses are dispensed.

**DHS Copay Guidelines**

- MA and GAMC recipients and MinnesotaCare enrollees are responsible to pay copays to providers.
- For MinnesotaCare, existing copays remain in effect; however, exemptions will extend only to fee-for-service MinnesotaCare recipients who have copays.
- Providers are responsible to collect copays from recipients and enrollees.
- Payment to providers will be reduced by the amount of the copay, except that payment for prescription drugs will not be reduced after a recipient has reached the $20 monthly maximum.
- Copays will be applied to claims after the spenddown has been met. Recipients are responsible for 100% of the spenddown.
- Providers serving recipients who are in managed care plans should contact the plan regarding the providers’ contractual requirements.
Copays as Unpaid Debt

Providers cannot deny services to recipients who are unable to pay copays. A provider must accept a recipient’s assertion that he or she is unable to pay a copay and cannot require additional documentation of inability to pay.

An unpaid copay is considered to be unpaid debt, and the provider is not required to continue to serve recipients with unpaid debt. If it is the provider’s general practice to refuse to serve all individuals with unpaid debt, and the provider gives the recipient advance notice and a reasonable opportunity to pay the debt, and the recipient does not pay the copay(s) owed, the provider can then refuse to provide care.

Recipients retain the ability to seek services from other enrolled MHCP providers.

Providers may choose to continue to service recipients who are unable to pay the copays.

Note: If the recipient is unable to pay the copay, providers may accept payment of the copay on behalf of the recipient from another source.

How Does This Affect Me, and What Do I Need To Do?
If an MHCP recipient receives a service, or if the recipient is scheduled to receive a service that requires a copay, and the recipient asserts the inability to pay the copay, you must provide the service to the recipient on the first visit or occurrence that the recipient is unable to pay the copay.

You may deny services only after the recipient has a history of unpaid debt, including unpaid copays. You must provide advance notice and a reasonable opportunity for payment before denying the next service/visit.

If it is not your office policy to deny services to individuals who have unpaid debt, including unpaid copays, you must continue to provide services.

When a recipient has a copay obligation, DHS will pay only the allowable, minus the copay.

Health Plan Enrollees

- MA and GAMC enrollees in health plans are required to pay copays.
- The MA and GAMC copay exemptions apply to MA and GAMC enrollees in health plans.
- MinnesotaCare enrollees in health plans must pay any copays that apply in their benefit sets.
- Health plans (Medica, UCare Minnesota, and Metropolitan Health Plan) participating in Minnesota Senior Health Options (MSHO) have chosen to waive all copays for enrollees in their MSHO products only. Providers should contact the MSHO health plan with questions.
MA and GAMC Recipient Copays

<table>
<thead>
<tr>
<th>Type of Copay</th>
<th>MA Copays</th>
<th>GAMC Copays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-preventive visit</td>
<td>$3</td>
<td>$3</td>
</tr>
<tr>
<td>Non-preventive services provided by a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>physician or physician ancillary,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>chiropractor, podiatrist, nurse midwife,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>advanced practice nurse, physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>assistant, audiologist, optician and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>optometrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglasses – frames and lenses</td>
<td>$3</td>
<td>$25</td>
</tr>
<tr>
<td>Non-emergency visit to a hospital-</td>
<td>$6</td>
<td>$25</td>
</tr>
<tr>
<td>based emergency room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs - $20 per month maximum</td>
<td>$3 for brand name</td>
<td>$3 for brand name</td>
</tr>
<tr>
<td></td>
<td>$1 for generic</td>
<td>$1 for generic</td>
</tr>
<tr>
<td>Restorative adult dental services</td>
<td>(Not applicable)</td>
<td>50% of fee-for-service allowable</td>
</tr>
<tr>
<td>Type of Copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copay Limits</td>
<td>One per day per treating provider, except drugs</td>
<td>One per day per treating provider, except drugs</td>
</tr>
</tbody>
</table>

Copay Exemptions

**Individuals exempt** from copays:
- Recipients under age 21
- Pregnant women whose pregnancy has been verified and coded in MMIS
- Major Programs RM, VV, HH
- Recipients who have elected hospice care
- Recipients residing or expecting to reside for 30 days or more in a medical institution
- PDP enrollees are not subject to drug copays, but are responsible for the first $35 deductible of drug costs

**Examples of Services exempt** from copays:
- 100% federally funded services provided by a facility of the Indian Health Service
- Antipsychotic drugs and contraceptive drugs
- Case management services
- Copays that exceed one per day per treating provider for non-preventive visits, eyeglasses, and non-emergency visits to a hospital-based emergency room
- Emergency services
- Family planning services and supplies
- Home and Community Based waivered services
- Home-based services, including home health and personal care attendant services
- Inpatient visits
- Interpreter services
• Lab
• Radiology
• Medical supplies and equipment
• Mental health services, including community mental health center services and, regardless of provider: psychotherapy, psychiatrist services, day treatment, clozaril monitoring, partial hospitalization, and adult rehabilitative mental health services (ARMHS), health and behavior assessment and intervention
• Occupational therapy, physical therapy, speech therapy
• Repair of eyeglasses
• Services paid by Medicare for which MA pays the coinsurance and deductible
• Hearing aids
• Orthotics and prosthetics
• Preventive services as defined above

**MinnesotaCare Copays**

<table>
<thead>
<tr>
<th>Type of Copay</th>
<th>MinnesotaCare recipients, age 21 and older, and not pregnant</th>
<th>Limited Benefit enrollee copays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital stays</td>
<td>10% of inpatient hospital charges up to $1000</td>
<td>10% per stay up to $1,000 (doesn’t start over again until 1/1/04 for those who currently have this benefit)</td>
</tr>
<tr>
<td>Hospital-based emergency room visit, regardless of whether the service was or was not an emergency</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>Non-preventive services provided by a physician, advanced practice nurse, or physician assistant visit</td>
<td>$5</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>$3 for each prescription</td>
<td>$20 per month maximum $3 for brand name $3 for generic</td>
</tr>
<tr>
<td>Copay Limits</td>
<td></td>
<td>One per day per treating provider, except drugs</td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>$25 for each pair of eyeglasses</td>
<td></td>
</tr>
</tbody>
</table>

Children under age 21 and pregnant women have no copayments.
MHCP ID Numbers and Cards

When recipients are approved for one of the Minnesota Health Care Programs, they are assigned an 8-digit MHCP ID number that is printed on their MHCP ID card.

- If approved for one of the health care programs, each member of a household is issued their own individual MHCP card.

- Once assigned, the MHCP ID number does not change, and follows the recipient through any changes in program eligibility or address.

- All recipient MHCP ID cards are issued in the same format and contain the same information.

- The MHCP recipient ID card does not include information about current program eligibility, prepaid health plan (PPHP) or HMO enrollment, spenddown, other health insurance coverage, Medicare coverage, or recipient restriction.

- Providers must verify eligibility once a month per recipient or on the day the service is rendered by calling the DHS Eligibility Verification System (EVS):

  EVS Metro (651) 282-5354 or 1-800-657-3613
  EVS may also be accessed online at www.mnevs.state.mn.us.

- New MHCP ID cards began being distributed January 2003. New cards are issued to new recipients and people who have lost their card and have requested a new card. Old cards are still valid. Recipients in the same family may have both versions of the ID card.
MA/GAMC/MinnesotaCare Covered Service Requirements

In order to be covered, a health service must be:

- determined by prevailing community standards or customary practice and usage to be:
  - medically necessary;
  - appropriate and effective for the medical needs of the patient;
  - the most cost effective health service available for the medical needs of the patient; and

A health service also must:

- meet quality and timeliness standards.
- represent an effective and appropriate use of program funds;
- meet specific limits outlined in rules adopted by DHS and explained in this manual; and
- be personally furnished by a provider, except as specifically authorized in this manual.

MHCP Benefits Table

- The following tables summarize covered benefits for MA, GAMC, and MinnesotaCare. Specific coverage policy is listed in the provider services chapters. Recipients and enrollees are entitled to these benefits regardless of whether they are enrolled in a prepaid health plan or fee-for-service.

- A list of MHCP non-covered services is located after the MHCP Benefits table.
- Be sure to follow the guidelines for these covered services as specified in this manual.
- **Out-of-country care**: MHCPs do not cover non-US/Canada care. (MS 256B.25).

### MHCP Benefits by Program

#### Minnesota Care

<table>
<thead>
<tr>
<th>MinnesotaCare Programs</th>
<th>Expanded Benefit Set</th>
<th>Basic Plus Two</th>
<th>Basic Plus One</th>
<th>Basic Plus</th>
<th>Basic</th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Recipients</strong></td>
<td>pregnant women &amp; kids</td>
<td>parents</td>
<td>non-parents</td>
<td>parents</td>
<td>parents</td>
<td>non-parents</td>
</tr>
<tr>
<td><strong>Income Limit % of Federal Poverty Guidelines (FPG)</strong></td>
<td>≤ 275%</td>
<td>≤ 175%</td>
<td>≤ 75%</td>
<td>&gt;175% ≤ 275%</td>
<td>&gt;275% in 18 month extension (eliminated 2/1/04)</td>
<td>&gt;75% to ≤ 175%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Sets</th>
<th>Expanded Benefit Set</th>
<th>Basic Plus Two</th>
<th>Basic Plus One</th>
<th>Basic Plus</th>
<th>Basic</th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health Rehab/Adult Mental Health Crisis Services</td>
<td>X(A)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/Drug Treatment: Residential &amp; Outpatient (B)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Case Management</td>
<td>X(A)(C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child &amp; Teen Check-ups (C&amp;TC)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Common Carrier Transportation and Mileage Reimbursement</td>
<td>X(D)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual calendar year cap</td>
<td>No cap</td>
<td>$500 annual</td>
<td>$500 annual</td>
<td>$500 annual</td>
<td>$500 annual</td>
<td></td>
</tr>
<tr>
<td>Copay</td>
<td>No copay</td>
<td>50% copay on restorative</td>
<td>50% copay on restorative</td>
<td>No copay</td>
<td>No copay</td>
<td></td>
</tr>
<tr>
<td>Emergencies/dentures/partials or extractions for dentures/partials outside of cap</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Benefit Sets</td>
<td>Expanded Benefit Set</td>
<td>Basic Plus Two</td>
<td>Basic Plus One</td>
<td>Basic Plus</td>
<td>Basic</td>
<td>Limited</td>
</tr>
<tr>
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<td>----------------</td>
<td>---------------</td>
<td>------------</td>
<td>-------</td>
<td>---------</td>
</tr>
<tr>
<td><em>Orthodontia</em></td>
<td>included (limited circumstances)</td>
<td>not covered</td>
<td>not covered</td>
<td>not covered</td>
<td>not covered</td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Eye Exams</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>$5 copay (E)</td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>no co-pay</td>
<td>$25 co-pay</td>
<td>$25 co-pay</td>
<td>$25 co-pay</td>
<td>$25 co-pay</td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>family planning visit $5 copay (E)</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Home Care</td>
<td>Includes private duty and PCA</td>
<td>Excludes private duty and PCA</td>
<td>Excludes private duty and PCA</td>
<td>Excludes private duty and PCA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>No copay (5)</td>
</tr>
<tr>
<td>Individual Education Plan (IEP) Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X(C)</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>no co-pay or annual limit</td>
<td>no co-pay or annual limit</td>
<td>10% co-pay, up to $10,000 annual limit</td>
<td>10% co-pay, up to $10,000 annual limit</td>
<td>10% co-pay, up to $10,000 annual limit</td>
<td></td>
</tr>
<tr>
<td>Interpreters (hearing, language)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lab, X-ray and Diagnostics</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Medical Transportation</td>
<td>emergency and special trans</td>
<td>emergency only</td>
<td>emergency only</td>
<td>emergency only</td>
<td>emergency only</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>$5 copay (E)</td>
</tr>
<tr>
<td>Nursing Home/ICF-MR Facility</td>
<td>X(C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Benefit Sets**

<table>
<thead>
<tr>
<th>Benefit Sets</th>
<th>Expanded Benefit Set</th>
<th>Basic Plus Two</th>
<th>Basic Plus One</th>
<th>Basic Plus</th>
<th>Basic</th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgical Center</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Hospital Outpatient Surgical Center (does not include freestanding surgical center)</td>
</tr>
<tr>
<td>Physicians and Clinics</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>$5 copay on non-preventive visit (E)</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>no co-pay</td>
<td>$3 co-pay</td>
<td>$3 co-pay</td>
<td>$3 co-pay</td>
<td>$3 co-pay</td>
<td>$3 co-pay; $20 monthly maximum</td>
</tr>
<tr>
<td>(no copay on anti-psycho-tics)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Visits</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>(E)</td>
</tr>
<tr>
<td>Rehab Therapies (OT, PT, Speech)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The MA/GAMC copay exclusions do not apply to MinnesotaCare enrollees in health plans and are not reflected in this chart.

The following services are not available to MHCP recipients enrolled in a health plan, but are available otherwise as noted:

(A) SED/SPMI, CW TCM, VA/DD TMC — available through the county.

(B) Alcohol and Drug Treatment—health plans are responsible for Primary Residential Inpatient care in all benefit sets; halfway house and extended care will be paid fee-for-service in all benefit sets. Outpatient CD treatment is covered in all benefit sets except the Limited Benefit set and is paid for by the health plan.

(C) Nursing home stays after 90 days, ICF/MR facilities, IEP services, abortion, CW TCM, VA/DD TMC, Adult Rehab MH services, Adult MH crisis services—paid fee-for-service.

(D) Common carrier transportation costs and personal mileage reimbursement—available through the MinnesotaCare division.

(E) In Limited Benefit, these services are only covered if provided by a physician, physician assistant, nurse practitioner or clinical nurse specialist. Physicians include MD specialists (e.g., psychiatrists, surgeons, and ophthalmologists).
<table>
<thead>
<tr>
<th>Benefit Set</th>
<th>Medical Assistance (MA), Program NM and IM</th>
<th>General Assistance Medical Care (GAMC)</th>
<th>GAMC Hospital Only (GHO)</th>
<th>Emergency Medical Assistance (EMA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(May be enrolled in a health plan)</em></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health Rehab/Adult Mental Health Crisis Services</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/Drug Treatment: Residential &amp; Outpatient</td>
<td>X</td>
<td>X</td>
<td>Inpatient hospital only</td>
<td>X</td>
</tr>
<tr>
<td>Case Management</td>
<td>X(A)(C)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Child &amp; Teen Check-Ups (C&amp;TC)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic: $3 copay</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Common Carrier Transportation and Mileage Reimbursement</td>
<td>X(B)</td>
<td>X(B)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Dental: $500 annual calendar year cap</td>
<td>Includes orthodontia in limited circumstances</td>
<td>Includes orthodontia in limited circumstances; 50% copay on restorative services</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$6 copay on non-emergency visits to the ER</td>
<td>$25 copay on non-emergency visits to the ER</td>
<td>Billed separately: not covered; Combined with inpatient billing: covered</td>
<td>$6 copay on non-emergency visits to ER</td>
</tr>
<tr>
<td>Eye Exams: $3 copay</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>$3 copay</td>
<td>$25 copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Home Care</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Education Plan (IEP) Services</td>
<td>X(3)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>X</td>
<td>X</td>
<td>$1,000 copay per admission</td>
<td>X</td>
</tr>
<tr>
<td>Interpreters (hearing, language)</td>
<td>X</td>
<td>X(D)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Lab, X-ray and Diagnostic</td>
<td>X</td>
<td>X</td>
<td>no coverage for screening procedures</td>
<td></td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
## Benefit Set

<table>
<thead>
<tr>
<th>Benefit Set</th>
<th>Medical Assistance (MA), Program NM and IM</th>
<th>General Assistance Medical Care (GAMC)</th>
<th>GAMC Hospital Only (GHO)</th>
<th>Emergency Medical Assistance (EMA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Transportation</td>
<td>emergency and special trans</td>
<td>emergency</td>
<td></td>
<td>emergency and special trans</td>
</tr>
<tr>
<td>Mental Health</td>
<td>X(C)</td>
<td>X(C)</td>
<td>Same as MA except excludes targeted case management</td>
<td></td>
</tr>
<tr>
<td>Nursing Home/ICF-MR Facility</td>
<td>X(C)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgical Center</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Physicians and Clinics</td>
<td>$3 copay on non-preventive services</td>
<td>$3 copay on non-preventive visits</td>
<td>Limited to physician services provided in inpatient hospital setting</td>
<td>No coverage for routine, screening or preventive services</td>
</tr>
<tr>
<td>Podiatrist: $3 copay</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- $3 copay on brand name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- $1 copay on generic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- $20 monthly copay max; no copay on anti-psychotics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Visit</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Rehab Therapies (PT, OT, speech)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

The following services are not available to MHCP recipients enrolled in a health plan, but are available otherwise as noted:
(A) SED/SPMI, CW TCM, VA/DD TCM — available through the county.
(B) Bus, taxi and/or volunteer driver (paid through health plan, personal mileage available through the county)
(C) Nursing home stays after 90 days, ICF/MR facilities, IEP services, abortion, CW TCM, VA/DD TCM, Adult Rehab MH/Adult MH crisis services — paid fee-for-service.
(D) Covered only for prepaid health plan enrollees.

## MA/GAMC/MinnesotaCare Non-covered Services

The following services are not covered under the MA, GAMC, or MinnesotaCare programs:

- Health services paid for directly by the recipient or other source, except when the recipient made the payment for services incurred during the recipient's retroactive eligibility period. See the [Billing Policy chapter](#) (Ch. 4)

- Autopsies.

- Missed appointments (MHCP recipients may not be billed).
• Aversive procedures, including cash penalties, unless otherwise authorized under state law.

• Health services not provided directly to the recipient unless the service is identified as a covered service in this manual.

• Health services, other than emergency health services, provided without the full knowledge and consent of the recipient or the recipient's legal guardian.

• Health services for which a physician's order is required but not obtained.

• Health services not in the recipient's plan of care, individual treatment plan, IEP, or individual service plan.
• Health services not documented in the recipient's health/medical record.

• Health services that do not contain documentation of supervision, if supervision is required.

• Health services of a lower standard of quality than the prevailing community standard of the provider's professional peers. (Providers of services that are determined to be of low quality must bear the cost of these services).

• Vocational or educational services, including functional evaluations or employment physicals, except as provided under IEP-related services.

• More than one home visit for a particular type of home health service by a home health agency per recipient per day, except for respiratory therapy visits or skilled nurse visits as specified in the recipient's plan of care.

• Artificial insemination.

• Reversal of voluntary sterilizations.

• Surgery primarily for cosmetic purposes.

• A health service, other than an emergency health service, provided to a recipient in a long term care facility that is not in the recipient's plan of care and has not been ordered, in writing, by a physician when an order is required.

• Ear piercing.

• Home modifications: grab bars, handrails, widening of doorways, bathroom modifications, stair lifts, ramps.
• Vehicle modifications: adapted seating, door handle replacements, door widening, wheelchair lifts, wheelchair securing devices.

• Environmental Products: air purification systems, de-humidifiers (central or room).

• Other Items:
  ▪ Adaptive furniture
  ▪ Air conditioners
  ▪ Appliances
  ▪ Bed baths
  ▪ Bedboards
  ▪ Beds (oscillating and lounge)
  ▪ Bicycle
  ▪ Blankets
  ▪ Blood glucose analyzer (reflectance colorimeter)
  ▪ Bottle washers
  ▪ Cell phone
  ▪ Cervical roll or pillow
  ▪ Computers
  ▪ Control units and battery device adapters
  ▪ Dehumidifiers (room or central)
  ▪ Diathermy machines
  ▪ Disinfectants
  ▪ Disposable wipes
  ▪ Electric toothbrush/water pick
  ▪ Elevators and stair lifts
  ▪ Enuresis or bedwetting alarms
  ▪ Environmental products (air filters, purifiers, conditioners, hypoallergenic bedding, and linens)
  ▪ Exercise equipment
  ▪ Feeding instruments
  ▪ Food blenders
  ▪ Grab bars
  ▪ Home security systems
  ▪ Hot tubs
  ▪ Humidifiers (room or central)
  ▪ Hygiene supplies and equipment
  ▪ Ice packs (disposable)
  ▪ Instructional materials (pamphlets and books)
  ▪ Isolation gowns
  ▪ Lotion
  ▪ Magnifying glasses
  ▪ Massage devices
  ▪ Medical identification bracelet
  ▪ Non-prescription over-the-counter ointments, creams, and lubricants
Menses products (sanitary pads)
Motorized lifts for vehicle
Orthopedic mattresses
Personal computers and printers
Pulse tachometers
Ramps
Reading glasses
Reachers
Stock orthopedic shoes (unless attached to a leg brace or for a diabetic)
Switches
Surgical masks/gowns
Table foods
Tableware
Tape recorders
Telephone
Telephone alert systems
Telephone answering machines
Telephone arms
Tennis-gym shoes
Terbutaline pump therapy
Therapeutic tables
Thermometer covers
Toothettes/tooth brushes
Toys
Trampolines
Transfer board
Treadmill
Underwear
Utensils
Video recorders
Water beds

**Health Care Designated Providers Program**

The purpose of the Health Care Designated Providers Program (formerly MHCP Primary Care Utilization Review program) is to identify recipients who have used services at a frequency or amount that is not medically necessary and/or who have used health services that resulted in unnecessary costs to the program. Once identified, such recipients will be placed under the care of a primary care physician and/or other designated providers who will coordinate their care for a 24-month period.

**Investigation**

The Health Care Designated Providers Program staff conduct investigations to determine:
If a fraud, theft or abuse situation exists and can be supported by documentation;

If sufficient justification exists to support restricting a recipient to a primary care physician and/or other designated providers; and/or

If sufficient evidence exists to support the imposition of other sanctions.

**Abuse:** In the case of a recipient, the use of health services that results in unnecessary cost to MHCP, or in reimbursement for services that are not medically necessary. The following practices are deemed to be abuse:

- Obtaining equipment, supplies, drugs, or health services that are in excess of MHCP limitations, or that are not medically necessary and that are paid for by MHCP;

- Obtaining duplicate services for the same health condition from multiple providers. Duplicate service does not include an additional opinion that is medically necessary for the diagnosis, evaluation, or assessment of the recipient's condition or required under MHCP rule, or a service provided by a school district as specified in the recipient's individualized education plan under MS 256B.0625, subd. 26;

- Continuing to engage in practices that are abusive of the program after receiving a written warning from DHS that the conduct must cease;

- Altering or duplicating the MHCP ID card for the purpose of obtaining additional health services billed to MHCP;

- Using a MHCP ID card or ID number that belongs to another person, or allowing others to use their MHCP ID card or ID number to obtain services, drugs or equipment;

- Using the MHCP ID card to assist an unauthorized individual in obtaining a health service for which MHCP is billed;

- Duplicating or altering or falsifying prescriptions;

- Misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, health services, or drugs;

- Furnishing incorrect eligibility status or information to a provider;

- Furnishing false information to a provider in connection with health services previously rendered to the recipient that were billed to MHCP;

- Obtaining health service by false pretenses;

- Obtaining health services that are potentially harmful to the recipient;
- Repeatedly obtaining emergency room health services for non-emergency care; or

- Using medical transportation to obtain health services from providers located outside the local trade area when health services are available within the local area.

**Grounds for Sanctions Against Recipients**

The Health Care Designated Providers Program may impose administrative sanctions against recipients for the use of health services that result in unnecessary costs to the health care programs or in reimbursements for services that are not medically necessary.

**Sanctions Against Recipients**

The Health Care Designated Providers Program may impose any of the following sanctions:

- Referring the recipient to the appropriate authority for possible criminal or civil legal action;

- Recovery from the recipient, to the extent permitted by law, all amounts incorrectly paid by MHCP; and

- Restricted status: Requiring that the recipient receive health care from a designated primary care physician and other designated health service providers for a period of 24 months.

  ▪ A recipient may be given an additional 24 months of restricted status if patterns of program abuse continue and are supported by documentation.

**Notification and Recipient Rights to Appeal**

DHS must notify recipients in writing of any sanctions to be imposed. A recipient may appeal any sanction proposed by DHS.

**Obtaining Restriction Information**

Providers may obtain information about the types of services to which a recipient is restricted by calling the DHS Eligibility Verification System (EVS). Typically, a recipient is restricted to one primary care physician, pharmacy, and hospital. A recipient may also be restricted to other designated providers or referred by the primary care physician to other providers, if appropriate. Recipients may receive services that are not subject to restriction from any enrolled MHCP provider. Long term care facility services are not subject to restriction.
Selection of Providers by the Health Care Designated Providers Program

A recipient placed on restriction is required to select a primary care physician, hospital and an individual pharmacy to coordinate their care. The recipient may choose a primary care physician provider. If the recipient fails to choose providers, DHS will assign a physician based on considerations of geographic proximity, the recipient's prior experience with a specific physician, and the physician's willingness to provide health care services.

Responsibilities of the Primary Care Physician

Any physician enrolled as a general practitioner, internal medicine, or family practice physician may be selected by the recipient as his/her primary physician. The primary care physician will be asked to review each recipient's profile of utilization, develop an appropriate care plan, and authorize referrals. To participate as primary care physician, the physician must be enrolled as an MHCP provider.

Limitations on Physician Participation

The commissioner may limit a primary care physician's participation in the Health Care Designated Providers Program based on the quality or quantity of health care services delivered or a review of sanctions previously imposed by MHCP or by the physician's professional licensing board. The commissioner also may limit the number of recipients restricted to an individual primary care physician.

"Medical Referral of Health Care Designated Providers Program Recipient" Form

The primary care physician must mail or fax a "Medical Referral of Restricted Recipient" form to the Health Care Designated Providers Program unit as soon as a recipient is referred to another physician for care. This information is necessary for the referral provider’s claim(s) to be processed in a timely manner.

Emergency Services

Emergency health care services may be provided to a Health Care Designated Providers Program recipient without the authorization of the primary care physician if these services are provided in response to a condition that, if not immediately diagnosed and treated, could cause a person serious physical or mental disability, continuation of severe pain, or death. Documentation of the emergency situation may be required by the Health Care Designated Providers Program unit in order to determine payment of the claim.

Program Requirements

In addition to the Health Care Designated Providers Program, the provider(s) must follow all MHCP requirements (such as: authorization, second surgical opinion, program limitations, etc.).
Claims Reimbursement

Services provided to a Health Care Designated Providers Program recipient will be reimbursed when:

- The service is provided by the recipient's primary care physician or his/her designee;
- The primary care physician has submitted a "Medical Referral of Health Care Designated Providers Program Recipient" form to DHS; or
- The service is of a provider or service type that is not listed as restricted on the recipient's file.

Reporting Suspected Misuse of Services or Requests for Additional Information

To report actual or suspected fraud, abuse, or misutilization of service by recipients, or for questions regarding the Health Care Designated Providers Program call (651) 297-1099 or 1-800-657-3674.

Legal References

MS 256B.02
MS 256B.055 to 256B.061; 256L.01 to 256L.15
MS 256B.0625; 256D.03; 256L.03
Minnesota Rules 9505.0010 to 9505.0140
Minnesota Rules 9505.0010 to 9506.0090
Minnesota Rules 9505.0170 to 9505.0475
Minnesota Rules 9505.2160 to 9505.2245
42 CFR 435 (MA Eligibility)
42 CFR 440 (MA Services)
42 CFR 456 (MA Utilization Control)
Chapter 3

Prepaid Minnesota Health Care Programs

DHS contracts with health plans to provide health care services for Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Program (PGAMC) recipients in selected counties, and MinnesotaCare recipients statewide. The Centers for Medicare & Medicaid Services (CMS; formerly HCFA), the federal agency responsible for administration of the MA program, has granted Minnesota several waivers of Title XIX of the Social Security Act to allow this program to be administered. For a list of contracting health plans by program and by county, contact the Provider Relations Call Center at 1-800-366-5411 or (651) 282-5545.

Definitions

County Based Purchasing (CBP): The Minnesota Health Care Program (MHCP) option through which a county or group of counties can elect to purchase or provide health services to MA and GAMC recipients residing in their county(ies). CBP is an alternative to state-purchased PMAP. It covers the same populations and has the same benefit sets as PMAP and PGAMC. This program is authorized by the Minnesota legislature. For purposes of this chapter, CBP entities are included wherever the term ‘health plan’ is used.

Fee-For-Service (FFS): For purposes of this chapter, the DHS health care program through which MHCP recipients who are not enrolled in a prepaid health plan receive health care services.

Health Plan Network: Health care providers employed by or under contract with a particular health plan to provide health services to recipients.

MinnesotaCare: The health care program for uninsured, low income Minnesotans.

Minnesota Disability Health Option (MnDHO): A voluntary managed care program for persons with physical disabilities receiving Medicaid, who are between ages 18 and 65 and are residents of Anoka, Dakota, Hennepin or Ramsey Counties. MnDHO is a flexible, person-centered service delivery model providing specialized services and coordination of care across acute and long term care, including nursing home and home and community-based waiver services. This program integrates financing and service delivery in a comprehensive managed care delivery system. Prescription drugs are paid through fee-for-service MA rather than through the health plan. Recipients with spenddowns and those on MA–EPD are also eligible to enroll.

Minnesota Senior Health Option (MSHO): A demonstration prepaid program for PMAP eligible seniors with Medicare and Medicaid or seniors eligible for Medicaid without Medicare. Currently operating in ten counties, this program integrates acute and long term care (nursing facility and waivered services). In MSHO, prepaid health plans are capitated for Medicaid services by DHS and for Medicare services by CMS. Enrollment in MSHO is voluntary.
Prepaid Health Plan: A health plan contracted with DHS to provide health care services to PMHCP recipients.

Prepaid General Assistance Medical Care (PGAMC): The prepaid program for GAMC recipients.

Prepaid Medical Assistance Program (PMAP): The prepaid program for MA recipients.

Prepaid Minnesota Health Care Programs (PMHCP): PMAP, PGAMC, MinnesotaCare, MSHO, and MnDHO.

Recipient: For purposes of this chapter, an MHCP client who is enrolled in a prepaid health plan.

Eligible Providers

Each health plan establishes its own provider network. For the most part, recipients must receive services from providers who are part of the health plan network. Providers interested in providing medical care to PMHCP recipients must contract with one or more of the health plans under contract with DHS. Providers should be familiar with the terms of their health plan contracts, including financial arrangements, provider responsibilities, authorization and referral requirements, and other provisions within the health plan contract. Providers are not required to enroll in MHCP to contract with a prepaid health plan.

Eligible Recipients

All MinnesotaCare recipients statewide must enroll in a PMHCP health plan. In PMHCP counties, all eligible Medical Assistance and General Assistance Medical Care recipients must enroll in a health plan unless they have a basis for exclusion.

Excluded Recipients

Excluded from participation in the PMAP/PGAMC are recipients who:

- Have a non-institutional spenddown;
- Are eligible for the Federal Refugee Assistance Program;
- Are certified by the Social Security Administration or the State Medical Review Team as blind or disabled, and under 65 years of age;
- Are residents of RTCs, state hospitals, or IMDs at the time of enrollment. Recipients already enrolled in managed care who enter state institutions will remain enrolled in the health plan;
• Are GAMC recipients eligible for Medicare benefits, residing in a nursing home, eligible for GAMC Hospital Only (GHO) Program, or receiving services at the Center for Victims of Torture;

• Have private health insurance coverage through an HMO licensed under MS 62D. They are eligible to enroll voluntarily if the private HMO and provider network is the same as the health plan they will select under PMAP/PGAMC;

• Are QMB, SLMB, QWD, or QI eligible only, and not otherwise eligible for MA;

• Are terminally ill as defined under Minnesota Rules 9505.0297, subp. 2(N) and who, at the time of notification of enrollment in PMAP, have a permanent relationship with a primary physician who is not part of any PMAP health plan;

• At the time of notification of enrollment in PMAP:
  ▪ Have a communicable disease;
  ▪ The prognosis of the communicable disease is terminal, even though the terminal illness may exceed six months;
  ▪ The recipient’s primary physician is not a participating provider in a PMAP health plan; and
  ▪ The physician certifies that disruption of the existing physician-recipient relationship is likely to result in the recipient becoming non-compliant with medication or other health services.

• Are children who are identified to the state as severely emotionally disturbed pursuant to MS 245.487 to 245.4887, and are eligible to receive mental health case management services. They may elect to enroll in PMAP on a voluntary basis.

• Are American Indians eligible for MA/GAMC living on an Indian Reservation if the tribal government of that reservation chooses to exclude them.

• Receive only Emergency MA due to non-documented alien status.

• Are Special Income Standard (SIS) Elderly Waiver recipients whose income exceeds the basic SIS maintenance needs amount. They may enroll voluntarily.

• Are adults identified to the State as having serious and persistent mental illness (SPMI) and who are eligible to receive mental health case management services. These adults may enroll voluntarily.

• IV-E and non IV-E adoption assistance children. These children may voluntarily enroll.

• Recipients with cost-effective employer sponsored private health insurance or persons enrolled in an individual health plan determined to be cost effective AND for whom the county or state is paying an insurance premium.

• Women receiving MA through the Breast and Cervical Cancer Control Program.

Identification Cards

MHCP recipients receive medical identification cards directly from their health plans in addition to MHCP ID cards. A recipient should show both ID cards prior to receiving health care services.
Eligibility Verification

Providers are encouraged to verify individual eligibility and health plan enrollment status by contacting the Eligibility Verification System (EVS) by telephone:

   Metro (651) 282-5354
   Toll-free 1-800-657-3613

or online at:
   http://www.mnevs.state.mn.us

Providers may call the health plan directly if they have questions regarding a recipient's health plan coverage.

Except as described in this chapter, prepaid health plans are not obligated to pay for services provided outside their networks. Providers who fail to verify eligibility and who render services to PMHCP recipients without following the plan's authorization and referral procedures will not receive payment for those services.

PMAP recipients may access services outside their health plan networks without authorization in the following cases:

- Family planning services;
- Services at Indian Health Services (IHS) facilities or Tribal providers; and
- Medical emergencies.

Recipients with questions regarding PMAP/PGAMC should be referred to their county offices. For TDD/TTY, they may contact the Minnesota Relay service at 1-800-627-3529 or 7-1-1. MinnesotaCare recipients may contact the MinnesotaCare Call Center at (651) 297-3862 or 1-800-657-3672. (TDD/TTY (651) 215-0086 or 1-800-366-8930).

Covered Services/Optional Benefits

MHCP Covered Services

Prepaid health plans are under contract with DHS to provide, at a minimum, all medically necessary health services that would be covered under MA, GAMC or MinnesotaCare, except:

- Services provided by school districts identified in an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP);
- Child Welfare - Targeted Case Management (CW-TCM);
• Mental Health Targeted Case Management services for persons with SPMI or severe emotional disturbances (SED);
• DD Case Management;
• CAC, CADI, TBI, EW, and MR/RC Waivered Services;
• Abortion services;
• ICF/MRs;
• Nursing facility per diems beyond the managed care benefit (to cover PMAP 90-day and MSHO 180-day coverage);
• Rule 5 services;
• Dental services are not covered by the health plan for enrollees whose county of residence is Cass, Crow Wing, Morrison, Todd or Wadena; and
• Adult Rehabilitation Mental Health Services (ARMHS) and Adult Mental Health Crisis Services.

Clients on the Elderly Waiver are not excluded from participation in a prepaid health plan. MA services (e.g., PCA) must be prior authorized and provided by the health plan. Waivered services (e.g., Extended PCA) must be prior authorized by the county case manager on a service agreement. See the HCBS Waiver Programs and the AC Program chapter (Ch. 26) for more information.

Under the MSHO program, some long term care services must be provided by the health plan. Providers with questions should call the Provider Relations Call Center at (651) 282-5545 or 1-800-366-5411. (TDD (651) 215-0086 or 1-800-366-8930).

• As of January 1, 2001, PMAP requires health plans to be liable for 90 days of nursing facility care for the community-based elderly. When the 90 days have been incurred, additional days must be billed to MHCP.

Each prepaid health plan determines its provider network, how services are delivered, which services require authorization or referral and reimbursement rates to providers. Providers and recipients should direct questions concerning coverage to the health plans.

**Interpreter Services**

Prepaid health plans are required to provide language and hearing interpreter services for PMAP, PGAMC and MinnesotaCare recipients with MA benefits. Interpreter services may be arranged through the health plans or their participating clinics.

**Common Carrier Transportation**

When required by contract, prepaid health plans must provide common carrier transportation for their PMAP and PGAMC recipients who have no other means of transportation to their medical appointments. Recipients may contact the health plan to arrange a ride. MinnesotaCare recipients with MA benefits may contact the DHS MinnesotaCare office for information regarding
reimbursement policy. Recipients in the CBP health plans (Itasca Medical Care, South Country Health Alliance, and PrimeWest Health System) should contact their county financial worker for information regarding how to obtain rides to medical appointments.

Optional Benefits

A health plan may choose to provide additional benefits and alternative services that are cost effective and appropriate to the needs of the enrollee.

Education and Enrollment

County staff provides education and enrollment for MA and GAMC recipients. Education and enrollment for MinnesotaCare recipients is completed by mail. Recipients are:

- Informed of their health plan options when they apply for MA, GAMC or MinnesotaCare;
- Encouraged to select a health plan (health plans are assigned when not selected); and
- Required to receive their health care services through their health plan network.

Coverage for recipients in a prepaid health plan is effective the first day of the next available month. Depending on when a recipient applies and is made eligible, MA and GAMC recipients may be placed on the FFS system for a short period of time before they are enrolled in a health plan. MinnesotaCare recipients are enrolled in prepaid health plans upon determination of eligibility for the next available month.

Recipients may change health plans:

- **Once during the first year of initial enrollment**: Recipients may change health plans once during the first year of initial health plan enrollment for any reason. To request this change, PMAP and PGAMC recipients must contact the county managed care enrollment office. MinnesotaCare recipients must contact the MinnesotaCare office. The change is effective for a future month.
- **During open enrollment**: Recipients are notified by mail once a year of the opportunity to change health plans during open enrollment. Recipients who elect to change health plans during open enrollment will be enrolled in the new health plan at a date determined by DHS. Generally, open enrollment takes place in the fall and any changes in health plans are effective January 1 of the following year. Recipients who do not respond to the mailing will remain in their current health plans. Recipients not eligible at the time of open enrollment should contact their county managed care office or their MinnesotaCare representative.
- **Within their first 90 days of MCO enrollment**: This change option will be available to recipients each time they are enrolled in a new MCO for 90 days or less.
- **Following a break of more than 2 full calendar months from managed care**: The recipient must request the change within 90 days of being reenrolled.
• If the enrollee relocated permanently to another county: The recipient must request a change within 60 days from the move date.
• If the health plan no longer provides services in the recipient’s county of residence.
• For good cause: At any time, a recipient may request a change in health plans for good cause, including: lack of access to services and providers, amount of travel time to get primary care, or poor quality of care. Recipients should contact their county managed care advocate of the State Ombudsman to request this change.

FFS to PMHCP Transition Guidelines

DHS is responsible for payment of authorized services and services that do not require authorization through the last day of a recipient's FFS eligibility. Services that are authorized by DHS and not provided by the last day of FFS eligibility will not be reimbursed by DHS. Providers may need to request health plan authorization for DHS authorized services not rendered during FFS eligibility.

While health plans are required to provide covered services that DHS had authorized prior to enrollment in the health plan, the health plan may require that the services be received in their network.

If an MA or GAMC recipient is in the hospital on the day new health plan enrollment is effective, the new health plan enrollment will be delayed until the first day of the month after the month of hospital discharge. The recipient continues to be covered by the previous coverage (either the old health plan or fee-for-service) for the remainder of the discharge month. Contact the county managed care advocate in these situations. The county managed care advocates are listed on the internet at [www.dhs.state.mn.us/healthcare/asstprog/advocates.htm](http://www.dhs.state.mn.us/healthcare/asstprog/advocates.htm)

Health plan coverage for persons who are hospitalized at the time initial MinnesotaCare coverage would otherwise become effective, begins the first day after discharge from the hospital. For MinnesotaCare recipients changing health plans, who are hospitalized on the day the change would take effect, the new health plan would begin coverage on the first of the month after the month of hospital discharge.

Newborns will be enrolled in the mother’s health plan effective the first day of the next available month, based on when the newborn is added to the case. Effective October 1, 2003, newborns are no longer enrolled into health plans retroactively to the month of birth.

If a recipient is receiving on-going medical services, such as mental health services, and the provider is not a member of the recipient's health plan, the provider must contact the recipient's health plan for authorization to continue the service. The health plan will develop a transition plan for the recipient. Under some circumstances, the health plan may continue to authorize services by the non-participating provider, or may authorize a limited number of visits. Under some circumstances, the recipient may be required to change to a provider in the health plan network.
Provider Guidelines/Responsibilities

DHS will not pay providers for services provided to PMHCP recipients.

Providers who render health care services to recipients participating in PMHCP must seek reimbursement from the health plan. In most cases, a health plan will pay only for services provided through its provider network. Providers must follow the health plan's authorization and referral requirements, if any.

Patients may be referred to providers who are not in the health plan network. These providers must follow the health plan's referral and authorization process. If additional unauthorized services are required or recommended, the provider must seek approval from the health plan.

Health plans may refer recipients to providers outside of their health plan network. In such cases, the prepaid health plans are responsible for payment. Each plan has a system for authorizing and documenting referrals. Health plans will only pay for services that are authorized. If the health plan does not pay for an unauthorized service, the provider is at risk for the cost of care.

Recipients traveling outside of the health plan's service area are covered by their health plan for urgent and emergency care. Other services are not covered outside of the service area, unless authorized by the prepaid health plan.

Health plans are responsible for the payment of emergency services, even if a recipient seeks care out-of-plan. In emergency cases, the health plan must be contacted as soon as the provider is aware of the recipient's participation in a prepaid health plan.

Prepaid health plan providers must follow the health plan's authorization, admission certification, and coordination of benefits requirements, and second medical opinion requirements. Each plan has its own process for authorizing these services. Providers who have questions about these processes must check with the recipient's health plan.

Complaint/Advocacy

Each health plan contracting with DHS is required to have procedures for handling recipient grievances and appeals.

PMAP/PGAMC recipients may also enlist the assistance of the county managed care advocates for resolving health plan grievances, appeals, and state Fair Hearing requests.

All PMHCP recipients may contact the State Ombudsman's Office for Managed Care at (651) 296-1256 or 1-800-657-3729, for assistance in resolving health plan grievances, appeals, and state Fair Hearings.
Appeal Rights

PMHCP recipients have the right to receive written notice of denial of payment or the denial, reduction, or termination of services requested by the recipient or the recipient's medical provider. This notice contains the following information:

- The action the health plan is taking;
- The reason the health plan is taking this action;
- The state or federal laws or health plan policies that support the health plan's action; and
- The process the recipient must follow to file a grievance or an appeal with the health plan and/or a state Fair Hearing request with the state.

The appeal must be filed with the health plan within 90 days from the date of notification of the denial, termination, or reduction of services.

A request for a Fair Hearing must be filed with the state within 30 days from the date of the final notice of action from the health plan.

A provider, acting on behalf of the enrollee and with the enrollee’s written consent, may file an appeal or request a state Fair Hearing.

When a health plan reduces or terminates ongoing medical services that the recipient's health plan physician or another health plan physician has ordered, and the recipient has filed an appeal with the health plan, or with the state within ten days after receiving notice, or before the date of the proposed action, whichever is later:

- The health plan must pay for the disputed services that the recipient receives while the appeal is pending. If the appeal is subsequently denied, the recipient may be held responsible for paying for the disputed services that were provided while the appeal was pending.
- The health plan must notify the State Ombudsman's Office within three working days after a grievance or appeal has been filed with the health plan.
- If the recipient has an appeal that is urgent, the recipient may ask the health plan or the state ombudsman or state referee for an expedited appeal.
- In addition, PMHCP recipients may file complaints with the Minnesota Department of Health or with the appropriate licensing board.
# Health Plan Provider Contacts

<table>
<thead>
<tr>
<th>Health Plan Provider Contacts</th>
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<tbody>
<tr>
<td><strong>Blue Plus</strong></td>
</tr>
<tr>
<td>Network Management</td>
</tr>
<tr>
<td>P.O. Box 64179</td>
</tr>
<tr>
<td>St. Paul, MN 55164-0179</td>
</tr>
<tr>
<td>Provider Service Center:</td>
</tr>
<tr>
<td>(651) 662-5200 or 1-800-262-0820</td>
</tr>
<tr>
<td>Behavioral Health:</td>
</tr>
<tr>
<td>1-800-469-1110</td>
</tr>
<tr>
<td><strong>First Plan Blue</strong></td>
</tr>
<tr>
<td>525 So. Lake Ave Suite 222</td>
</tr>
<tr>
<td>Duluth, MN 55802</td>
</tr>
<tr>
<td>FAX: (218) 727-7247</td>
</tr>
<tr>
<td>Behavioral Health:</td>
</tr>
<tr>
<td>1-800-469-1110</td>
</tr>
<tr>
<td><strong>HealthPartners</strong></td>
</tr>
<tr>
<td>8100 34th Avenue South</td>
</tr>
<tr>
<td>P.O. Box 1309</td>
</tr>
<tr>
<td>Minneapolis, MN 55440-1309</td>
</tr>
<tr>
<td>Claims Customer Service:</td>
</tr>
<tr>
<td>(952) 967-7699 or 1-866-429-1474</td>
</tr>
<tr>
<td>Primary Contracting:</td>
</tr>
<tr>
<td>(952) 883-5589</td>
</tr>
<tr>
<td>Specialty Contracting:</td>
</tr>
<tr>
<td>(952) 883-5657</td>
</tr>
<tr>
<td>Mental And Chemical Health Contracting:</td>
</tr>
<tr>
<td>(952) 883-5657</td>
</tr>
<tr>
<td><strong>Itasca Medical Care (IM Care)</strong></td>
</tr>
<tr>
<td>Itasca Resource Center</td>
</tr>
<tr>
<td>1209 SE 2nd Avenue</td>
</tr>
<tr>
<td>Grand Rapids, MN 55744-3983</td>
</tr>
<tr>
<td>Provider Relations</td>
</tr>
<tr>
<td>Cindy Palkki: (218) 327-6133 or 1-800-843-9536 ext 6133</td>
</tr>
<tr>
<td>FAX: (218) 327-5545</td>
</tr>
<tr>
<td><strong>Medica</strong></td>
</tr>
<tr>
<td>P.O. Box 9310, Mail Route CP340</td>
</tr>
<tr>
<td>Minneapolis, MN 55440-9310</td>
</tr>
<tr>
<td>Provider Services:</td>
</tr>
<tr>
<td>(952) 992-2232 or 1-800-458-5512</td>
</tr>
<tr>
<td>FAX: (952) 992-8667</td>
</tr>
<tr>
<td><strong>Metropolitan Health Plan (MHP)</strong></td>
</tr>
<tr>
<td>822 South 3rd Street, Suite 140</td>
</tr>
<tr>
<td>Minneapolis, MN 55415</td>
</tr>
<tr>
<td>MHP Provider Services:</td>
</tr>
<tr>
<td>(612) 347-4740</td>
</tr>
<tr>
<td>FAX: (612) 904-4267</td>
</tr>
<tr>
<td><strong>PrimeWest Health System</strong></td>
</tr>
<tr>
<td>305 8th Avenue West</td>
</tr>
<tr>
<td>Alexandria, MN 56308</td>
</tr>
<tr>
<td>Member Services:</td>
</tr>
<tr>
<td>1-866-431-0801</td>
</tr>
<tr>
<td>Provider Services:</td>
</tr>
<tr>
<td>1-866-431-0802</td>
</tr>
<tr>
<td>Provider Contracting:</td>
</tr>
<tr>
<td>(320) 762-2911</td>
</tr>
<tr>
<td><strong>South Country Health Alliance (SCHA)</strong></td>
</tr>
<tr>
<td>303 South Cedar Street</td>
</tr>
<tr>
<td>Owatonna, MN 55060</td>
</tr>
<tr>
<td>FAX: (507) 444-7770 or 1-866-613-1395</td>
</tr>
<tr>
<td><strong>UCare Minnesota</strong></td>
</tr>
<tr>
<td>Provider Relations Department</td>
</tr>
<tr>
<td>P.O. Box 52</td>
</tr>
<tr>
<td>Minneapolis, MN 55440-0052</td>
</tr>
<tr>
<td>FAX: (612) 676-3300 or 1-888-531-1493</td>
</tr>
<tr>
<td>(612) 676-6555</td>
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</tbody>
</table>
## HEALTH PLAN SUBCONTRACTORS

### Chiropractic Subcontractors

<table>
<thead>
<tr>
<th>Subcontractor</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Plus - Blue Select</td>
<td>(651) 662-5200 or 1-800-262-0820</td>
</tr>
<tr>
<td>HealthPartners - ChiroCare</td>
<td>(952) 938-0212 or 1-800-873-4575</td>
</tr>
<tr>
<td>Medica - ChiroCare</td>
<td>(952) 938-0212 or 1-800-873-4575</td>
</tr>
<tr>
<td>SCHA - Clinical Resources Group (CRG)</td>
<td>1-866-281-1997</td>
</tr>
<tr>
<td>UCare Minnesota - ChiroCare</td>
<td>(952) 938-0212 or 1-800-873-4575</td>
</tr>
</tbody>
</table>

### Dental Subcontractors

<table>
<thead>
<tr>
<th>Subcontractor</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Plus - Delta Dental</td>
<td>(651) 406-5907 or 1-800-774-9049</td>
</tr>
<tr>
<td>First Plan Blue - Delta Dental</td>
<td>(651) 406-5907 or 1-800-774-9049</td>
</tr>
<tr>
<td>HealthPartners Dental (Metro)</td>
<td>Metro: (952) 883-7511</td>
</tr>
<tr>
<td>Premier Dental (Greater MN)</td>
<td>Greater MN: (763) 559-5435/1-800-392-3112</td>
</tr>
<tr>
<td>Medica - Delta Dental</td>
<td>(651) 406-5919 or 1-800-459-8574</td>
</tr>
<tr>
<td>Metropolitan Health Plan - Delta Dental</td>
<td>(651) 406-5907 or 1-800-774-9049</td>
</tr>
<tr>
<td>PrimeWest Dental Claims processed by</td>
<td>Dental Eligibility/Service Authorization</td>
</tr>
<tr>
<td>Midwest Dental Benefits, mail to:</td>
<td>(320) 762-2953 or 1-888-588-4420</td>
</tr>
<tr>
<td>PrimeWest Health System</td>
<td></td>
</tr>
<tr>
<td>2236 Marshall Ave Suite 150</td>
<td></td>
</tr>
<tr>
<td>St. Paul, MN 55104</td>
<td></td>
</tr>
<tr>
<td>SCHA - Doral Dental</td>
<td>1-800-341-8478</td>
</tr>
<tr>
<td>UCare Minnesota - Doral Dental</td>
<td>1-800-341-8478</td>
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### Mental Health Subcontractors

<table>
<thead>
<tr>
<th>Subcontractor</th>
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<tbody>
<tr>
<td>Medica - United Behavioral Health (UBH)</td>
<td>1-888-455-2726</td>
</tr>
<tr>
<td></td>
<td>Customer Service: 1-800-848-8327 or (763) 732-6900</td>
</tr>
<tr>
<td>Metropolitan Health Plan - Behavioral Health Care Providers (BHP)</td>
<td>(763) 525-9919 or 1-800-361-0491</td>
</tr>
<tr>
<td>PrimeWest Health System</td>
<td>1-866-431-0803</td>
</tr>
<tr>
<td>MH administration is done by</td>
<td>After hours and weekends: 1-888-668-4336</td>
</tr>
<tr>
<td>Metropolitan Health Plan</td>
<td></td>
</tr>
<tr>
<td>SCHA – Behavioral Health Care Providers</td>
<td>General number: (763) 525-9919</td>
</tr>
<tr>
<td></td>
<td>Intake: (763) 525-1746 or 1-800-361-0491</td>
</tr>
<tr>
<td>UCare Minnesota - BHP</td>
<td>General number: (763) 525-9919</td>
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<td>Intake: (763) 525-1746 or 1-800-361-0491</td>
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Pharmacy Subcontractors

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<tr>
<th>Pharmacy Subcontractor</th>
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<tr>
<td>Blue Plus - Gold Select</td>
<td>1-800-821-4795</td>
</tr>
<tr>
<td>First Plan Blue - Gold Select</td>
<td>1-800-821-4795</td>
</tr>
<tr>
<td>HealthPartners-PharmaCare</td>
<td>1-800-777-1023</td>
</tr>
<tr>
<td>IM Care – Advance PCS</td>
<td>Help Desk: 1-800-345-5413</td>
</tr>
<tr>
<td></td>
<td>Medical Exception Requests/Service</td>
</tr>
<tr>
<td></td>
<td>Authorization: 1-888-413-2723</td>
</tr>
<tr>
<td>Medica – MEDIMPACT</td>
<td>1-800-788-2949</td>
</tr>
<tr>
<td></td>
<td>Medica Customer Service: 1-800-373-8335</td>
</tr>
<tr>
<td>MHP – Advance PCS</td>
<td>1-800-345-5413</td>
</tr>
<tr>
<td></td>
<td>Medical Exception Requests/Service</td>
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<tr>
<td></td>
<td>Authorization: 1-888-413-2723</td>
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<tr>
<td>PrimeWest Health System</td>
<td>Help Desk: 1-800-821-4795</td>
</tr>
<tr>
<td>Prime Therapeutics, Inc</td>
<td>Formulary Exception Requests/Service</td>
</tr>
<tr>
<td></td>
<td>Authorizations: (651) 286-4401 or</td>
</tr>
<tr>
<td></td>
<td>1-866-202-3474</td>
</tr>
<tr>
<td></td>
<td>Member Help Desk: 1-888-642-0447</td>
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<tr>
<td>SCHA – Advance PCS</td>
<td>Help Desk: 1-800-345-5413</td>
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<tr>
<td></td>
<td>Medical Exception Requests/Service</td>
</tr>
<tr>
<td></td>
<td>Authorization: 1-888-413-2723</td>
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<tr>
<td>UCare Minnesota – Advance PCS</td>
<td>Help Desk: 1-800-345-5413</td>
</tr>
<tr>
<td></td>
<td>Medical Exception Requests/Service</td>
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<tr>
<td></td>
<td>Authorization: 1-888-413-2723</td>
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Legal References

MS 256B.69; 256B.031; 256L.12
MS 256D.03
MS 62D; 62M; 62N; 62Q; 62T
Minnesota Rules 9500.1450 to 9500.1464
Minnesota Rules 9505.0285
Minnesota Rules 9506.0200; 9506.0300; 9506.0400
42 CFR 431
42 CFR 438
Chapter 4
Billing Policy

Minnesota Health Care Program (MHCP) fee-for-service providers must follow the billing policies described in this chapter. Providers must contact the appropriate health plan for billing policies for services provided to enrollees of prepaid health plans.

Minnesota Information Transfer System (MN-ITS)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care providers and payers nationwide to begin using a new universal set of standards for electronic billing and administrative transactions (e.g. health care claims, remittance advice (RA), eligibility verification requests, referral authorizations and coordination of benefits). Existing DHS claim submission tools, including the Information Transfer System (ITS) and National Standard Format (NSF), are not HIPAA-compliant. In order to meet HIPAA requirements and improve customer service to providers and electronic billers, DHS is grouping all current electronic claim submission processes in a new, federally mandated HIPAA-compliant electronic format called MN-ITS, or “minutes.”

MN-ITS is a Web-based, HIPAA-compliant billing and inquiry system for claim submission and other health care transactions for MHCP. MN-ITS consists of both an interactive (one-by-one, direct data entry) component and a batch component (to interface with non-DHS billing software). Individual, direct data entry claims can be submitted through MN-ITS Interactive and X12 format only batch claims can be submitted through MN-ITS Batch.

Anyone billing DHS for services provided to MHCP recipients may use MN-ITS. Providers and billers will use MN-ITS as the primary DHS electronic billing and inquiry tools as of October 1, 2003. Paper billers may switch to MN-ITS upon DHS HIPAA implementation or any other time thereafter. DHS will accept Interactive and Batch (X12 format) transactions through MN-ITS from all providers as of December 1, 2003. DHS will continue to accept all current electronic claim formats (including ITS and NSF) through March 31, 2004.

Note: This chapter provides additional information about the new billing systems and billing processes.

Eligibility

Eligibility Verification System (EVS)

DHS encourages providers to verify eligibility once per month per recipient. Recipient eligibility information can be accessed by using an automated telephone service or through the Internet. EVS reports the following information for each recipient:
• Major program
• Prepaid health plan enrollment
• Medicare coverage
• Third Party Liability (TPL)
• Spenddown*
• Benefit limitations*
• PCUR (restricted recipient) status*
• Special transportation*
• Elderly Waiver Obligation
• Eyeglass payment*

* Applies to fee-for-service only

Providers may verify ID numbers or dates of service up to one year prior to date of inquiry. To access EVS, call (651) 282-5354 or 1-800-657-3613, or visit the EVS Web site at www.mnevs.state.mn.us. Providers should contact the EDI Help Desk at (651) 282-5545 or 1-800-366-5411 to request PAS and authorization codes. To obtain eligibility information, providers must enter their 9-digit MHCP provider ID number and either the recipient’s 8-digit MHCP ID number or the recipient’s social security number and date of birth.

DHS also contracts with outside vendors who offer other options for verifying eligibility. For more information about their rates and options, contact them directly:

MediFAX
EDI
1283 Murfreeboro Road
Nashville, TN 37217
Marketing Services: 1-800-444-4336
e-mail: marketing@medifax.com

WebMD
WebMD Envoy
Rates and Options, Ste 601
26 Century Boulevard
Nashville, TN 37214
1-800-366-5716

HDX
HealthCare Data Exchange
467 Creamery Way
Exton, PA 19341
MN Rep: Dan Birch 610/219-1719
General Information: 610/219-1600
Retroactive Eligibility

Under certain conditions, some recipients may become eligible on a retroactive basis. Persons eligible for MA may receive three months retroactive eligibility from the date of application. Persons eligible for GAMC, effective October 1, 2003, no longer receive one month of retroactive eligibility. GAMC eligibility can begin no earlier than the date of application. Retroactive eligibility does not apply to all programs (e.g., MinnesotaCare, QMB, and the Prescription Drug Program). If a recipient received and paid for MHCP covered services during an eligible retroactive period and notifies the provider of the retroactive coverage, the provider must:

- Refund the recipient the full amount paid by the recipient; and
- Bill DHS their usual and customary charge for the service(s).

Pregnant women covered by MinnesotaCare are eligible for the MinnesotaCare Expanded Benefit Set retroactive to the date of diagnosis. If the pregnant woman has paid any MinnesotaCare copay amount on or after the date of diagnosis, the copay amount must be refunded to the woman. The provider may bill DHS for the copay amount.

If a recipient received and paid for covered services requiring authorization during a retroactive period and notifies the provider, the provider may request authorization and refund the recipient's payment if authorization is approved, or keep the recipient's payment if authorization is denied.

Services

Authorization Services

When a service requires authorization, the information submitted on the claim to DHS must match the information on the authorization, including procedure codes and modifiers. Authorized and unauthorized services must be billed separately. If authorized services are billed on the same claim as non-authorized services, the claim will deny. When a recipient has private health or dental insurance, authorization and other rules applicable to the primary insurance must also be followed. An approved authorization does not guarantee payment; all other MHCP requirements must be met.

Coordination of Services

It is the responsibility of the provider to ask the recipient if he/she is currently receiving the same health care services from another provider. In this case, the persons providing the services must coordinate services and document, in the recipient's record, that coordination occurred. DHS will not make this information available to providers.
Claims Submission

Fee-For-Service (FFS) Billing Chart

A complete listing of which services must be billed on which claim form is available at [http://edocs.dhs.state.mn.us/lfserver/legacy/MS-0641-ENG](http://edocs.dhs.state.mn.us/lfserver/legacy/MS-0641-ENG).

General Billing Requirements

MHCP providers who render or supervise services are responsible for claims submitted to DHS:

- Submit claims only after MHCP covered services have been rendered.
- Bill the provider's usual and customary charge (see Preferred Provider Agreements in this chapter for exception criteria).
- Bill only one calendar month of service per claim.
- Submit claims on paper or electronically.
- Paper claims must be typed.
- Mail paper claims to the correct address. See the Billing Chart for appropriate addresses, envelopes, and claim forms.
- Only original claim forms are accepted. Do not submit by fax, photocopy, or ITS screen prints.

Timely Billing Requirements

- Claims must be submitted correctly and received by DHS no later than 12 months from the date of service, including TPL (other insurance) and Medicare crossover claims.
- Replacement claims must be submitted and received by DHS within 6 months from the date of incorrect payment, or within 12 months from the date of service, whichever is greater.
- Claims that do not automatically cross over from Medicare must be submitted and received by DHS within 6 months from the Medicare payment date or within 12 months from the date of service, whichever is greater.
- Claims denied erroneously by DHS (due to system error or incorrect information from county) may be resubmitted within 12 months from date of service or up to 6 months from date of county correction, whichever is greater.
- Claims that are over one year old must be submitted on paper with appropriate, dated documentation attached. Documentation will be reviewed, but does not guarantee payment.
- Appropriate documentation may include, but is not limited to:
  - Explanation of erroneous denial;
  - County letter identifying recipient file changes, include effective date;
  - Copy of correct Medicare explanation of benefits; or
  - Third party payment information (see section titled Unsuccessful TPL Billing in this chapter).
- Claims that have been underpaid must be replaced within 12 months of the date of service or 6 months from the date of payment.
• Claims that have been overpaid can be replaced or refunded (see sections titled Replacement Claims and Refund of Payment for further information).

**Document Retention**

Providers must retain documentation of services provided and claims (paper and electronic) submitted for at least five years. Documentation of services provided must include all relevant information to support the services billed. Documentation of claims submitted must include payments, settlements, or denials, including those from other payers.

**Prompt Payment**

DHS is required to pay or deny clean claims within 30 days and complex claims within 90 days. Clean claims are electronic and paper claims without attachments. Complex claims are replacement claims, Medicare crossovers, third-party liability claims, or paper claims with attachments.

**Forms/Envelopes**

The DHS Forms Supply Unit supplies free, DHS only claim forms and pre-addressed envelopes for all claims. For more information call 651/296-9116, TTY: 1-800-627-3529, or FAX your request for forms/envelopes to 651/ 296-6244.

The following forms are not available from the DHS Forms Supply Unit, and must be obtained from a forms supplier:

- ADA
- CMS-1500
- UB-92

Forms must be mailed in either a DHS pre-addressed envelope or a plain 8 ½” x 11” envelope. Paper claims must not be folded nor stapled.

**Payment Cycle**

Providers are paid on a biweekly payment cycle. The MMIS Payment & Claim Cut-off Calendar is available on the Provider Web site at www.dhs.state.mn.us/provider/calendar/. The calendar identifies cut-off dates and times for paper and electronic claim submission, and the dates warrants (or checks) are mailed. Any changes to the payment cycle will be communicated through an RA message. Cut-off dates are the last date DHS will accept claims to be included on the next payment cycle.
MHCP Reimbursement is Payment in Full

A provider must accept MHCP reimbursement as payment in full for covered services provided to a recipient. This means that a provider may not request or accept payment in addition to the amount allowed under the MHCP programs from a recipient, the recipient’s relatives, the local human services agency, or any other source, except in the case of a spenddown or copay. An additional exception is made when the recipient has received an insurance payment designated for the service. In this case, the provider is allowed to bill the recipient directly to recover an insurance payment that the recipient has received. DHS is liable for the amount payable by MHCP minus the third party liability amount.

Claim Form/Remittance Advice Instructions

Instructions for completing claim forms and reading the DHS RA are available at www.dhs.state.mn.us/provider/training/.

Coding Schemes

Most providers are required to enter the most specific diagnosis code(s) on claims submitted to DHS. All providers are required to enter the appropriate procedure/service codes on claims identifying covered services. Providers must use applicable codes and follow the most current guidelines from the following manuals:

**ICD-9-CM** (International Classification of Diseases 9th Revision Clinical Modification) may be ordered by calling PMIC at 1-800-633-7467, or INGENIX at 1-877-464-3649 or www.ingenixonline.com.

**CPT** (HCPCS Level I: Physicians' Current Procedural Terminology) may be ordered from Book and Pamphlet Fulfillment, OP054191, American Medical Association, P.O. Box 2964, Milwaukee, WI 53201; or INGENEX at 1-877-464-3649 or www.ingenixonline.com.

**HCPCS Level II & III** (Healthcare Common Procedural Coding System) is available at www.dhs.state.mn.us/provider/ref; or Level II HCPCS code books may be purchased from a variety of medical book sources or the codes may be downloaded from the CMS website http://www.cms.hhs.gov/providers/pufdownload/anhpcd1.asp.

**NDC** (National Drug Codes) may be ordered by calling Red Book at 1-800-722-3062. NDC codes may be researched at http://www.fda.gov/cder/orange/.

**UB-92 Manual** may be ordered by calling the Minnesota Hospital & Healthcare Partnership at 651/641-1121.

**CDT-4** (Current Dental Terminology) may be ordered by calling ADA at 1-800-947-4746 or INGENIX AT 1-877-464-3649 or www.ingenixonline.com.

Providers are not required to purchase all of the manuals listed above. Providers should determine which manuals are appropriate for the services they provide.
Unlisted Codes

Providers may bill unlisted procedure codes only when a specific code cannot be found to define a service/procedure. When an unlisted code is billed, attach a written description and/or documentation to the claim defining the service/procedure.

Modifiers

HCPCS (levels I, II, III) include two-digit alpha, numeric, and alphanumeric modifiers. Use appropriate modifier(s) to identify:

- A service/procedure altered by a specific circumstances, but not changed in its definition or code;
- Rental, lease, purchase, repair, or alteration of medical supply; or
- The origin and destination for medical transportation.

Remittance Advice (RA)

The RA reports claim activity, and is issued biweekly to providers. The RA is divided into three sections:

**RA Message:** A message may appear on the cover sheet of the RA regarding the most current DHS billing or policy updates.

**Claims:** Claims are separated by type, and listed as paid, denied, or suspended in alphabetical order. Replacement claims are listed as adjustment claims. To have claims sorted by patient account number or transaction control number (TCN), contact DHS Provider Enrollment.

**Summary Section:** The summary section lists current and year-to-date claim totals. All alpha and numeric codes appearing on the RA are defined in this section. If an RA is not received, wait 10 working days from the warrant date before requesting a copy from the Provider Call Center. Effective February 1, 2003, the charges for duplicate RAs are: $5 fee plus $.10 per page: 1-99 page request; $10 fee plus $.10 per page: 100+ page request.

Explanation of Benefit (EOB) Codes

Refer to the Explanation of Benefit (EOB) Codes list

Replacement Claims

Use a replacement claim when all or a portion of a claim is paid incorrectly (e.g., due to a billing error) or a third party payment is received after MHCP payment. When replacement claims are received, DHS zeroes out the original claim. It is very important to include all lines on the claim,
regardless of whether or not all lines paid incorrectly. Denied claims cannot be replaced. Denied line items may be resubmitted. Two replacement claim options are available:

- Overpaid claims:
  - Replacement claims may be submitted electronically if the claim is within 12 months from date of service or six months from the warrant date.
  - Replacement claims over 12 months must be submitted on paper.

- Unpaid claims: Refer to section titled Timely Billing Requirements.

Refund of Payment

Providers may refund payments to DHS when the entire amount paid for a claim needs to be returned, or a portion of the payment needs to be returned due to an overpayment (receipt of third party payment, billing error, etc.). Two refund options are available:

- Send a check with a copy of the remittance advice (RA) highlighting the paid claim(s) and attach an explanation for the refund; or

- Send a copy of the RA highlighting the paid claim(s) and an attachment requesting the amount to be deducted from a future warrant (check).

Mail checks with RAs to:
DHS Benefit Recovery
PO Box 64836
St. Paul, MN 55164-0836

OR
Mail or FAX RAs only for credit adjustment to:
DHS Benefit Recovery
444 Lafayette Road
St. Paul, MN 55155-3850
FAX: (651) 296-9438

Spenddowns

Some MHCP recipients may have a spenddown. A spenddown is an amount the recipient is responsible to pay on the first day that they are eligible. Spenddowns may be paid by the recipient in one of the following ways:

- **Potluck Spenddown:** Providers may bill a recipient for the spenddown if it appears on the RA as a base rate reason/amount of “01.”

- **Designated Provider Spenddown:** Some recipients choose to designate a specific provider to pay their spenddown to each month. The base rate reason/amount of “01” and the dollar amount, to be paid by the recipient, will appear only on the designated provider’s RA.

- **Client Option Spenddown:** The recipient may choose to pay his/her spenddown directly to DHS each month. If a recipient fails to make his/her payment to DHS on any given month, his/her spenddown will revert to a potluck spenddown.
• **Elderly Waiver Obligations:** Certain recipients of the Elderly Waiver (EW) program are allowed to keep increased income while remaining eligible for MA. This means, some EW recipients will no longer have a medical spenddown. Instead, they will have to pay a portion or all of their EW service costs through a waiver obligation. The payment of the waiver obligation works the same as a "potluck" medical spenddown, except only EW services are applied to the obligation. Recipients may choose the "designated provider" option in order to pay their waiver obligations. The base rate reason/amount “18” and the dollar amount will appear on the provider’s remittance advice.

If the spenddown is retroactively reduced, the system will automatically reprocess the claim. If the spenddown was collected, reimbursement may be due to the recipient.

**Spenddowns and Copays**

If a copay applies to services in addition to the spenddown amount, a deduction will be made from the payment to the provider. Providers should bill the spenddown and copay amounts to the recipient.

**Medicare**

**Medicare:** The federal health insurance program for persons 65 or older, and certain people with disabilities, administered by the Center for Medicare and Medicaid Services (CMS).

Medicare is primary to MHCP. Services that are covered by Medicare must be provided by a Medicare enrolled provider and must be billed to Medicare first. Any balance remaining after Medicare payment must be billed to other liable third party payers. If the total amount received from Medicare and responsible third party payers is less than the MHCP allowable, a claim for the difference may be submitted to MHCP for payment of the coinsurance and/or deductible. If Medicare pays a claim and the claim fails to automatically cross over from Medicare, providers must bill MHCP in the same way Medicare was billed. If Medicare denies a claim, providers must bill DHS using MHCP guidelines. In both cases, copies of the Medicare EOMB must be attached to the paper claim or, if billing electronically using ITS, the Medicare attachment screen must be completed.

Services that are not covered by Medicare should be submitted to DHS in a timely manner. A denial from Medicare is not required.

The Medicare Revenue Enhancement Program (MREP) is responsible for the development of Medicare maximization in all areas where MHCP is the payer of last resort. Medicare maximization requires providers to bill Medicare prior to billing MHCP, if the recipient has Medicare benefits. Be sure to indicate when the recipient is not covered by Medicare.

If a recipient only has QMB eligibility, DHS will only cover the Medicare coinsurance and/or deductible, and Part B premium for Medicare covered services. If a recipient only has SLMB eligibility, DHS only pays their Medicare Part B premium.
Third Party Liability (TPL)

MHCP recipients may have other health coverage. If a recipient does not inform a provider of other health coverage, the provider can obtain the information by calling EVS or accessing EVS online.

Providers must bill liable third party payers (including Veteran's Benefits) and receive payment to the fullest extent possible before billing MHCP. Private accident and health care coverage, including HMO coverage held by or on behalf of an MHCP recipient, is considered primary and must be used according to the rules of the specific plan. A recipient with more than one level of private benefits must receive care at the highest level available. MHCP will not pay for services that could have been covered by the private payer if the applicable rules of that private plan had been followed.

TPL and Copays

Recipients with private health insurance primary to MHCP will be responsible to pay the MHCP copay for covered services. Providers must bill in the usual manner, reporting the insurance payment on the claim with the balance due of the private insurance copay amount. If the MHCP allowable would cover all or part of the balance billed, the MHCP copay will be deducted from the payment amount and reported as the copay amount.

Definitions

Assignment or Assignment of Benefits: The written authorization by a person, the person's authorized representative, a policy holder, or other authorized representative to transfer to another individual, entity, or agency their right or the rights of their dependents to medical care, support, or other third-party payments.

Private Insurer:

- Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated and indemnity contracts);
- Any profit or nonprofit prepaid plan offering either indirect services or full or partial payment for the diagnosis and treatment of an injury, disease, or disability; or
- Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employers, employee benefit plans, and any similar organization offering these payments for services, including self-insured and self-funded plans.

Third Party Payer: Any individual, entity, or program that is or may be liable to pay all or part of the health care costs incurred by recipients. This includes Medicare, an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), TriCare (formerly Champus), Workers' Compensation, and uncontested no-fault automobile insurance.

Third Party Liability (TPL): Payment resources available from both private and public health insurance and other liable third parties that can be applied toward a recipient's health care expenses.
Unsuccessful TPL Billing

Providers may bill MHCP in cases where three unsuccessful attempts have been made to collect from the third party payer within 90 days, except where the third party payer has already made payment to the recipient. A copy of the first claim sent to the third party payer, documentation of two further billing attempts, and any written communication the provider has received from the third party payer must be attached to the MHCP claim. Claims must be billed to MHCP within 12 months of the date of service to qualify for payment.

Preferred Provider Agreements

Providers may enter into agreements with third-party payers to accept payment for less than the amount of charges. These arrangements are often called "preferred provider agreements" or "preferred patient care agreements," and are to be considered payment in full for the service. The insured has no further responsibility. MHCP may be billed only if there is a recipient legal obligation to pay.

Provider charges that are reduced under contract by an insurance company (UC and R or withholding reductions) must be submitted to MHCP at the reduced rate. This can be done using one of two methods:

- Submit each line item charge at the reduced contract rate; or
- Submit the line items at the usual and customary charge and add the contract reduction to the insurance payment.

The second method may result in a lower payment by MHCP, but providers may prefer this method to avoid additional administrative effort. Providers must not bill MHCP for more than the amount that would be the patient's responsibility under their contract with the insurer.

TPL Partial Payment

When final payment from a third-party payer is for partial payment of the charges, an MHCP claim may be submitted. Payments from any third party payers must be indicated on any claims submitted to MHCP, including those payments for coinsurance or copay. If payment is less than 25% of total charges (50% for inpatient hospital claims), attach the TPL’s EOMB to the claim. If claims are denied by third party payers, insurance attachments must be submitted with paper claims or TPL reason codes may be used for electronic billing. Submit insurance-denied services on a separate claim from services partially paid by insurance. MHCP payment will be calculated as the lesser of:

- The difference between the MHCP maximum payment amount and the amount paid by all liable third-party payers;
- The difference between the provider submitted charge(s) and the amount paid by all liable third-party payers; or
- The total patient liability after the provider has accepted a reduced payment under an agreement with the insurer.
Cost Avoidance Requirements

DHS will pursue recovery of benefits where an accident settlement or contested Workers' Compensation benefits are pending, or where legal action may be required.

Providers are not required to bill third party payers in the following instances:

- Chemical dependency services.
- Prenatal care services for pregnant women. This exclusion does not apply to any inpatient hospital stay related to these services or to coverage provided by an HMO or PPO;
- Preventive pediatric care services for persons under age 21. This exclusion does not apply to coverage provided by an HMO or PPO.
- Prescription drugs, when the type of insurance is major medical or no-fault automobile insurance. Cost avoidance requirements do apply to prescription drug services provided to recipients with the following coverage types:
  - Private HMO;
  - Prescription drug plans;
  - PPOs;
  - Worker's Compensation; and
  - Immunosuppressive drugs covered by Medicare.

The following government health programs are not considered third party payers for the purpose of cost avoidance requirements:

- Head Start
- Comprehensive Health Service Projects
- Migrant Health Projects
- Appalachian Regional Commission (ARC)
- Health and Child Development Projects
- Health Under-served Rural Areas (HURA)
- Indian Health Services
- Crime Victims' Compensation Fund

Reporting Health Insurance Termination Dates

Notify DHS of health insurance terminations and denials for persons not covered by the policy. Send a copy of the termination notice/denial or include all of the following information on office letterhead:

- Insurance company name;
- Recipient's name;
- MHCP ID number;
- Termination date;
- Whether the termination applies to the policy or individual; and
• Name and phone number of the person contacted to obtain the termination information.

FAX or mail to:

DHS Benefit Recovery Section
444 Lafayette Road
St. Paul MN 55155-3850
FAX: (651) 296-9438

Prohibition Against Seeking Payment from Recipient

Providers must not request or accept payments from MHCP recipients, their families, or from others on behalf of the recipient for:

• Base rate changes made by DHS;
• Missed appointments;
• The difference between insurance payments and usual and customary charges; or
• Services otherwise covered by MHCP, except under MinnesotaCare, if a copay or dollar cap on the service exists.

If a third party payer sends a payment to the recipient, the provider may bill the recipient to recover the payment.

Request for Billing Statement

Billing statements submitted to recipients (upon their request) must clearly state that it is not a bill, and payment has been made or could be made by DHS. Providers must report the request in writing to the Benefit Recovery Section.

Prohibition Against Refusing to Furnish Services or Requiring Recipient to Bill Insurance

Providers must not refuse to furnish MHCP covered services to a recipient because of a third party payer's potential liability for payment of the service. Providers may not require MHCP recipients with primary insurance coverage to bill their insurance carrier. However, recipients must cooperate by completing and signing required forms.

Questions and Answers About Billing the Recipient

Q: How can a provider protect itself from financial responsibility for the care it provides to a Prepaid Medical Assistance Program (PMAP), Prepaid General Assistance Medical Care (PGAMC) or prepaid MinnesotaCare recipient when the provider is outside of the network of the recipient's health plan?

A: Out-of-network services that the recipient's health plan did not prior authorize (except for emergency services and family planning services) are non-covered services. While it is the
recipient's responsibility to know and follow program/health plan requirements, it is ultimately
the provider's responsibility to verify the recipient's eligibility for services and to notify the
recipient if the services are not covered. If the provider fails to inform the recipient (before
providing services) that he/she is responsible for payment because out-of-network services are
not covered, the provider cannot bill the recipient. (The provider could still attempt to obtain
payment from the recipient's health plan.) DHS encourages providers to use a written notification
form that includes the service in question, the date, and recipient's signature attesting he/she
understands he/she may be billed.

References:
MN Rules 9505.0225, Subpart 3
MN Rules 9505.0190

Q: A medical equipment/supply company provides a piece of equipment to a PMAP recipient. The
item is a covered item and the health plan pays its allowable. The provider is not satisfied with
the rate of reimbursement. May the provider bill the recipient for the difference between what the
health plan paid and what the provider normally charges?

A: No. DHS requires in its contracts with health plans that they must hold the enrollee harmless for
any charges (except for MinnesotaCare copays). Thus, health plans must ensure that their
contracted providers refrain from billing recipients in these circumstances. This is consistent
with the general fee-for-service requirement that MHCP-enrolled providers must accept MHCP
payment as payment in full and must not bill the recipient.

References:
DHS 2000 Model PMAP/PGAMC/MinnesotaCare Contract, Sections 6.12 & 9.2.11
42 CFR 447.15
MN Rules 9505.0225, Subpart 2
DHS Provider Agreement, Paragraph D

Q: A PMAP, PGAMC or prepaid MinnesotaCare recipient is on vacation in Florida when he/she has
a heart attack and must be taken to the emergency room. The hospital, doctors and lab are not
participating providers in the recipient's health plan. They bill the health plan and receive
payment but refuse to accept that as payment in full. Can the providers bill the recipient for the
difference between what the health plan paid and the provider's usual and customary charge?

A: No. DHS requires in its contracts with health plans that they must hold the enrollee harmless for
any charges (except for MinnesotaCare copays). The providers shouldn't bill the recipient, but
they could. Unless the providers are enrolled in MHCP, DHS lacks authority to prohibit them
from billing the difference in this case. DHS, however, requires health plans to ensure that the
enrollee is held harmless. One way they can ensure this is to condition their payment to an
out-of-state, out-of-network provider on the provider's agreement to accept payment as payment
in full. For example, the health plan could put a statement on its check to the provider that
acceptance of payment is payment in full.
Chapter 4: Billing Policy

References:
DHS 2000 Model PMAP/PGAMC/MinnesotaCare Contract, Sections 6.12 & 9.2.11
42 CFR 447.15
MN Rules 9505.0225, Subpart 2
DHS Provider Agreement, Paragraph D

Q: A recipient goes to a clinic enrolled in MHCP as a fee-for-service provider. When the clinic asks the recipient about coverage, the recipient says he/she does not have any. However, he/she is actually a PMAP recipient enrolled in a health plan. Can the provider bill the client for the services?

A: Yes. The provider has no obligation to check whether the recipient is eligible for an MHCP when the recipient informs the provider that he/she has no coverage. Otherwise, providers would be responsible to check MHCP coverage for every individual who indicates he/she has no coverage. There is no legal basis to require providers to do this.

References:
MN Rules 9505.0220

Q: A recipient goes to a provider who is a participating provider in the recipient's health plan for commercial and MA patients but not for MinnesotaCare patients. The recipient presents his/her health plan ID card (which does not indicate that he/she is a MHCP recipient). The recipient does not mention that he/she is on MinnesotaCare. The provider tells the recipient that it is a provider for his/her health plan and provides the service. The provider attempts to bill the health plan only to be denied because it is not a participating provider in the health plan's MinnesotaCare network. The provider says that, since it did not know the recipient was on MinnesotaCare, it should be able to bill the recipient. May the provider bill the recipient?

A: Since the 1998 contract, the health plan ID cards must now identify the enrollee as an MHCP recipient. The situation described in the question should not arise today. If recipient had shown an ID card identifying him/her as an MHCP recipient, the provider should have verified that he/she was on MinnesotaCare before providing the service through the Eligibility Verification System (EVS). In this example, the provider could not bill the recipient unless it informed the recipient before the specific service was provided, that he/she would be responsible for payment.

References:
2000 Model PMAP/GAMC/MinnesotaCare Contract, Section 3.2.3
MN Rules 9505.0225, Subpart 3

Q: A recipient wants an "upgrade" such as a porcelain dental crown instead of a metal dental crown. The recipient wants to pay the difference between what MHCP pays and what the upgrade costs. Can the provider accept payment for the "upgrade" from the recipient? What happens if the recipient wants an "add-on" such as anti-reflective coating for eyeglasses?

A: No, the provider cannot bill MHCP and also accept payment from the recipient for the difference related to an upgrade. If the provider chooses, it may provide the upgrade and agree to receive
payment for the basic service as payment in full for the upgrade. For example, a dentist would provide a porcelain crown, but would receive payment for a metal crown. If the recipient wants the upgrade and the provider will not accept MHCP payment for the basic service as payment in full for the upgrade, the recipient would be responsible for the entire charge as long as the provider informed him/her that he/she was responsible before providing the service.

There is a distinction between an "upgrade" and an "add-on." An upgrade is a non-covered service (and often a more desirable service) that substitutes for a covered service. An add-on is a non-covered service that the provider adds to a covered service, such as anti-reflective coating (which is non-covered) that an optical provider may add to eyeglasses (which are covered). In both fee-for-service and managed care, the provider may receive payment for the covered service and charge the recipient for the add-on.

References:
MN Rules 9505.0225, Subpart 3
42 CFR 447.15
DHS Provider Agreement, Paragraph "D"

Q: A provider provided a "non-covered" service to a recipient. The provider made it very clear to the recipient that the service was not covered and that the recipient would be responsible for payment. The recipient also signed a statement which clearly stated that the service would not be covered and that he/she would be responsible for payment. The provider has been trying to collect the bill for a year. The recipient is currently eligible for MA. Can the provider send the recipient's account to a collections agency?

A: Yes. The unpaid bill is a legally valid debt that may be referred to a collections agency. However, it is worth mentioning that the provider could not enforce a court judgment to collect the debt. Under Minnesota Statutes, section 550.37, subdivision 14, a court cannot issue an order for a creditor (such as the provider in this example) to attach, garnish, or impose a levy of execution on the welfare benefits, salary, and earnings of a recipient of a public assistance program, including MA and GAMC. This statute does not apply to MinnesotaCare. In addition, it only protects recipients while they receive public assistance and for a period of six months after their termination from public assistance programs.

Reference:
MN Statute 550.37, Subdivision 14

Recipient Uncooperative with TPL Billing

If a recipient fails to cooperate in the TPL billing process, by signing or completing forms, contact the financial case worker at the local human service agency or a MinnesotaCare representative to request assistance.
Assignment/Request for Direct Payment

Providers may obtain an assignment of benefits from the recipient to ensure direct payment for services. When a dependent child is insured under a group contract pursuant to a court order, providers should request that payment be made directly to them pursuant to Minnesota Statutes. If an MHCP recipient is insured by a plan approved in Minnesota, providers may request direct payment from the insurance plan pursuant to Minnesota statutes. The provider must indicate on the insurance claim form, that the person is receiving benefits through MHCP.

Liability Not Established or Benefits Not Payable

When probable liability is not established, or benefits are not available at the time a claim is submitted, MHCP will pay the maximum allowable except when Medicare has denied payment on the basis of secondary payer. The provider must accept MHCP payment as payment in full and must not continue to seek payment from third parties with pending liability. If MHCP learns of the existence of a liable third party, or benefits become available, MHCP may recover payment from the third party payer.

Fee-for-Service Payment Methodology

The following section describes how fee-for-service payment rates are calculated for MHCP services. Services provided to fee-for-service MHCP recipients, regardless of program, are paid at the same rate unless otherwise specified. Additional payment rate information can be accessed at www.dhs.state.mn.us/provider/ref/feeschedule.htm.

Audiologist, Chiropractor, Community/Public Health Clinic, Dentists Providing Medical Services, Family Planning Clinic, Individual Education Plan, Mental Health Clinic, Minnesota Children with Special Health Needs, Nurse Midwife, Occupational Therapist, Optician, Optometrist, Physical Therapist, Physician, Physician Clinic, Podiatrist, Psychologist, Rehabilitation Agency, Speech-Language Pathologist

Effective for services rendered on or after October 1, 1992, the payment rate is as follows:

- Payment for level I HCPCS codes titled:
  - "Office or Other Outpatient Services,"
  - "Preventive Medicine Services (new patient and established patient),"
  - "Delivery, Antepartum, and Postpartum Care,"
  - "Cesarean Delivery,"
  - "Critical Care Services,"

- "Pharmacological Management" provided to psychiatric patients, and HCPCS level III codes for enhanced services for prenatal at risk, will be paid at the lower of the:
  - Provider's submitted charge; or
25% above the rate in effect on June 30, 1992.

If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in Minnesota Statutes, section 256B.74, subdivision 2, then the larger rate shall be paid. All physician rates (except anesthesia, laboratory, medical supplies and equipment, orthotics and prosthetics, injections and immunizations) shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

Payments for all other services (except anesthesia, laboratory, medical supplies and equipment, orthotics and prosthetics, and injections and immunizations) shall be paid at the lower of the:

- Provider's submitted charge; or
- 15.4% above the rate in effect on June 30, 1992.

All physician rates (except anesthesia, laboratory, medical supplies and equipment, orthotics and prosthetics, injections and immunizations) shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

Services provided by a physician assistant shall be paid to the supervising enrolled provider at the lower of the:

- Provider's submitted charge; or
- 90% of the allowable.

Services provided by an enrolled advanced practice registered nurse shall be paid at the lower of:

- Provider's submitted charge; or
- 90% of the allowable.

Services provided by an enrolled clinical nurse specialist shall be paid at the lower of:

- Provider's submitted charge; or
- 90% of the allowable.

Services provided by non-psychiatric physician extenders shall be paid to the supervising enrolled provider at the lower of the:

- Provider's submitted charge; or
- 65% of the reference file allowable.
Anesthesiology Services

Effective July 1, 1991, rates paid for anesthesiology services provided by physicians and certified registered nurse anesthetists (CRNAs) are according to the formula utilized by Medicare. For physicians, a conversion factor "at percentile of calendar year set by legislature" is used.

Ambulatory Surgery Center Facility Fees

Effective for services rendered on or after October 1, 1992, the payment rate for ambulatory surgery center facility fees, shall be based on the lower of the:

- Provider's submitted charge; or
- 32% above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable. Services for which there is a federal maximum allowable payment shall be paid at the lower of the:
  - Provider's submitted charge; or
  - Federal maximum allowable payment.

Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit.

Child & Teen Checkups (EPSDT) Services

C&TC services payment rate will be the lower of the:

- Provider's submitted charge; or
- 75th percentile of the usual and customary fee based on billings submitted by all providers of service during the previous 12-month period of July 1 through June 30 and effective October 1.

Dental

Effective for services rendered on or after October 1, 1992, the payment rate shall be as follows:

- Dental services shall be paid at the lower of: the provider's submitted charge, or 25% above the rate in effect on June 30, 1992; and
- All dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

Effective for tooth sealant and fluoride treatments provided on or after October 1, 1999, the payment rate will be the lower of the:

- Providers submitted charge; or
- 80% of the 1997 median charge.
Effective for services provided on or after Jan. 1, 2002, the payment rate for diagnostic examinations and dental x-rays will be paid the lower of the:

- Providers submitted charge; or
- 85% of the 1999 median charge.

**Equipment and Supplies**

Medical supplies and equipment not subject to volume purchase are paid at the lower of the:

- Provider's submitted charge;
- Medicare fee schedule amount; or
- If Medicare has not established a payment amount for the medical supply or equipment, an amount will be determined using one of the following methodologies:
  - 50\(^{th}\) percentile of the usual and customary charges submitted for the code for the previous calendar year minus 20%;
  - If no information about usual and customary charges exists for the previous calendar year, payment is based upon the manufacturer's suggested retail price minus 20%; or
  - If no information exists about manufacturer's suggested retail price, payment is based on wholesale cost plus 20%.

**Prosthetics and Orthotics** are paid the lower of:

- Provider's submitted charge;
- Medicare fee schedule amount; or
- If Medicare has not established a payment amount, an amount will be determined using the criteria for supplies and equipment.

**Vaccines and Injections**

Vaccines available through the MnVFC program are paid as "administration only" at the lower of:

- Provider's submitted charge; or
- $8.50.

All other vaccines are paid the lower of:

- Provider’s submitted charge; or
- Average wholesale price minus 5%. Administration must be billed separately and is paid at $1.50.

All other injectibles are paid the lower of:

- Provider’s submitted charge; or
- Average wholesale price minus 5%. Administration must be billed separately and is paid at $1.50.

MHCP pays coinsurance and deductible on Medicare paid services.
Volume Purchase:

**Oxygen** is paid at the lower of the:
- Provider's submitted charge; or
- Negotiated contract rate.

**Hearing aids** are paid the lower of:
- Provider's submitted charge;
- Negotiated fee as agreed to in the contract; or
- If the hearing aid is a non-contract aid, the payment is at the single unit cost.

Dispensing fees for hearing aids are billed separately.

**Home Health Agency Services**

Home health agency services payment rate will be the lower of the:

- Provider's submitted charge; or
- Medicare cost per visit limits based on Medicare cost reports and submitted by freestanding home health agencies in the Minneapolis and St. Paul area in the calendar year specified in legislation governing maximum payment rates.

**Hospice Services**

Hospice services payment rate will be the lowest of the:

- Provider's submitted charge;
- Medicare maximum allowable; or
- State agency established rate.

**Hospitals (Critical Access)**

Effective July 1, 1999, Critical Access Hospitals (CAH) will no longer be paid on fee schedules for outpatient services. CAH will receive interim payments that will be based on an estimate of a hospital's cost as a percentage of that hospital's charges. Interim payments will be subject to upward or downward adjustments based on costs as determined under the cost-funding methods and allowable costs under the Medicare program.

**Hospitals (Outpatient Facility)**

Effective for services rendered on or after August 1, 2000, outpatient hospital facility services are paid in accordance with the most recent Ambulatory Payment Classification (APC) system rates published by CMS in the Federal Register, listed in the column titled "Payment Rate."
Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit.

**Indian Health Service Facility**

Indian Health Service facility payments are based on the methodology in Sections 321(a) and 322(b) of the Public Health Service Act.

**Laboratory Services**

Laboratory services for which Medicare upper limits apply shall be paid at the lower of the:

- Provider's submitted charge; or
- The Medicare rate.

If there is not a current Medicare rate, then the rate paid shall be the lower of the:

- Provider's submitted charge; or
- According to the methodology below.

Other services shall be paid the lower of the:

- Provider's submitted charge; or
- One of the following:
  - $50^{th}$ percentile of the charges submitted by all providers of the service in the calendar year specified in legislation governing maximum payment rates, less 25%;
  - $50^{th}$ percentile of the charges submitted by all providers of the service in years subsequent to the calendar year specified in legislation governing maximum payment rates backed down by the appropriate CPI formula, less 25%;
  - An average of the number of independent laboratory providers' charges, less 25%;
  - Payment rates for comparable services; or
  - The Medicare rate.

**Long Term Care Services**

Nursing facility and intermediate care facility services payment rates are established in Minnesota Rules, parts 9549.0010 to 9549.0080 and Minnesota Statutes 256B.431 and 256B.434. These rules and statutes establish per diem rates that are paid on behalf of the recipient. Private room rates are paid up to 115% of the recipient's current case mix, but only if the facility chooses to assign costs and MA has authorized a private room.

The 2003 legislative session made the following changes to nursing facility rates:

- Nursing facilities reimbursed under Minnesota Statutes, section 256B.431: The operating payment rate in effect the prior June 30 is the operating rate in effect on July 1.
• The number of days, for which a rate enhancement will be paid for nursing facility admissions on or after July 1, 2003, are reduced from 90 paid days to 30 calendar days. Rate enhancement for admissions prior to July 1, 2003, will cease on July 30, 2003.
• Nursing facility bed-hold day rates are reduced from 79% to 60% of the usual rate, when the facility meets occupancy standards.
• The amount paid by MA for Medicare coinsurance will be the lesser of the actual coinsurance amount, or the amount by which the MA case mix payment rate exceeds the Medicare payment rate less the coinsurance amount.
• The automatic inflation increase to the operating portion of the rate is eliminated for State Fiscal Years 2004-2005, for nursing facilities under contract through the Alternative Payment System (APS). The inflation factor is only applied to the property portion of the rate.
• For Rule 50 facilities, until otherwise specified in legislation, the operating portion of the rate will carry forward from one year to the next. The property portion of the rate will be recomputed based on the law, rule, and the cost report.
• For both APS and Rule 50 NFs, other non-operating portions of the rate will be recomputed as well.
• Requirements for advance notice of rate increases to nursing facility residents are clarified. Even in situations where the 30-day advance notice is not required, timely notice must be given before a rate increase can take effect.

**Skilled Nursing Facility:** Prior to July 1, 2003, DHS paid the Medicare Part A room and board coinsurance for MA eligible nursing facility residents. The Medicare Part A coinsurance rate is $105 per day for calendar year 2003. New legislation (MS 256B.431, subd. 2t) limits the amount of the Medicare Part A coinsurance that MA may pay.

For services rendered on or after July 1, 2003, DHS will pay the lesser of:
• The actual coinsurance amount, or
• The amount by which the MA RUGS III case mix payment rate exceeds the Medicare rate less the coinsurance amount. For coinsurance days occurring during a 30-day enhanced rate period for new admits, the enhanced MA rate will be used.

This legislative change may result in the amount of a recipient’s resources exceeding the obligation to the facility. To refund the excess payment made by the resident, send a check to DHS or request a deduction from a future warrant. Refer to the section titled **Refund of Payment** for instructions.

Nursing facilities may not apply an unpaid coinsurance amount to a recipient’s resources. The MA allowed amount for the coinsurance must be considered payment in full, even if it is a zero payment. Nursing facilities may consider coinsurance amounts that are not paid in full by MA to be a bad debt for Medicare purposes. Use the DHS RA for information to claim the bad debt from the Medicare Intermediary.

Requirements of the rate equalization law do not limit the amount of the Medicare copay that a nursing facility may collect from a private pay resident.

**ICF-MR Services:** Payment rates for intermediate care facility services for persons with mental retardation or related conditions are established in Minnesota Rules, parts 9553.0010 to 9553.0080.
• Payment rates for ICF/MR are reduced by decreasing their total operating payment rate by one percent (1%). The adjustment is applied by multiplying the total payment rate in effect on the proceeding June 30, excluding the property-related payment rate, by one percent.
• Facilities with receivership or closure agreements are excluded.
• ICF/MR facility rates increased $3.00 per day effective on June 1, 2003.
• DHS is authorized to designate up to 25 beds for the purpose of facilitating short-term admissions to an ICF/MR to meet short-term behavioral care needs or specialized medical care needs by providing occupancy adjustments of up to 15 days per month.
• ICF/MR residents have increased flexibility and choice in how they have their active treatment needs met during the day.
• Effective July 1, 2003 the facility is obligated to pay 1/12 of the $1040.00 total per licensed bed each month. It amounts to $86.67 per licensed bed per month. ICF/MR facilities will receive an invoice from DHS regarding the amount the facility needs to remit to meet the requirements of this legislation. These must be paid monthly, due on the 15th of each month, beginning July 15, 2003.

Swing Bed Services: The daily MHCP payment rate for swing bed services is set by law as the statewide average payment rate for all MA nursing facilities’ per diem. The swing bed payment rate is computed annually, effective each July 1. Eligible facilities are notified by mail of the new rate each year.

Mental Health Services

Effective July 1, 2001, Mental Health Services are paid the lower of:

• Provider’s submitted charge; or
• 75.6 percent of the median submitted charge of 1999

Masters-Prepared Mental Health Professionals

Enrolled masters-prepared mental health professionals (LP, CNS-MH, LICSW) are paid up to 80% of the MHCP allowed rate, unless their services are provided in an enrolled Community Mental Health Center (CMHC). Services provided at a CMHC and service of doctoral-prepared mental health professionals are paid up to 100% of the MHCP allowed rate.

Rule 79 Targeted Case Management for Seriously and Persistently Mentally Ill Services

Rule 79 Targeted Case Management for seriously and persistently mentally ill services payment rate will be as established in Minnesota Rules, part 9505.0491.

Nursing Services

Private Duty Nursing Services: Private duty nursing services payment rate will be the lower of the:
• Provider's submitted charge; or
• Maximum rate established by the legislature, effective July 1, 2001.

**Public Health Nursing**

Public health nursing services are paid at the lower of:

• Provider's submitted charge; or
• State agency established rate.

**Personal Care Assistant**

Personal Care Assistant services payment rate will be the lower of the:

• Provider's submitted charge; or
• The current maximum rate established by the legislature, effective July 1, 2001.

**Pharmacy Services**

Payment for a prescribed drug or compounded prescription is the lower of:

• Pharmacy's submitted charge;
• Maximum allowable cost for the drug as established by CMS or by the Commissioner plus a dispensing fee; or
• Estimated actual acquisition cost for the drug plus a dispensing fee.

Effective July 1, 2003, the pharmacy reimbursement is (AWP – 11.5%) plus $3.65 dispensing fee.

Exceptions include:

- Unit-dose blister card system (AWP – 11.5%) plus $3.95
- Intravenous drugs which require mixing (AWP – 11.5%) plus $8.00
- Cancer chemotherapy IVs (AWP – 11.5%) plus $14.00
- Total parental nutrition products which require mixing in volumes of 1 liter (AWP – 11.5%) plus $30.00
- Total parental nutrition products which require mixing in volumes of > 1 liter (AWP – 11.5%) plus $44.00

**Renal Dialysis Services**

The dialysis composite rate is the rate established by CMS for Medicare. MHCP will pay the lower of the:

• Provider’s submitted charge; or
• Composite rate.

**Rural Health Clinic and Federally Qualified Health Center Services**

Rural Health Clinic services payment rate will be based on the methodology in Code of Federal Regulations, title 42, section 447.371. If a rural health clinic other than a provider clinic offers ambulatory services other than rural health clinic services, maximum reimbursement for these ambulatory services will be at the levels specified in this part for similar services. For purposes of this item "provider clinic" means a clinic as defined in Code of Federal Regulations, title 42, section 447.371 (a); "rural health clinic services" means those services listed in Code of Federal Regulations, title 42, section 440.20 (b); "ambulatory services furnished by a rural health clinic" means those services listed in Code of Federal Regulations, title 42, section 440.20 (c).

Federally Qualified Health Center services including other ambulatory services as noted in the State Plan will have their payment rate based on the methodology in Section 6404 of the Omnibus Budget Reconciliation Act of 1989. Dental services are paid at a separate clinic specific rate.

**Transportation Services**

Life support transportation is paid the lower of the:

- Provider's submitted charge; or
- **MA allowable charge**

Special transportation is paid the lower of the:

- Provider's submitted charge; or
- MA allowable charge.

If a provider transports two or more persons simultaneously in one vehicle, the payment will be prorated. Payment for ancillary services to a recipient during life support transportation must be based on the type of ancillary service and is not subject to proration.

Air ambulance transportation will be paid at a rate consistent with the level of medically necessary services provided during the recipient's transport. Payment will be the lower of the:

- Provider's submitted charge; or
- 50th percentile of Medicare prevailing charges for 1982 plus a cumulative increase of 16.26% (a 7.5% increase effective July 1, 1990, a 3% increase effective July 1, 1993 and a 5% increase effective July 1, 1999).

Payment for air ambulance transportation of a recipient not having a life threatening condition requiring air ambulance transport will be at the level of medically necessary services that otherwise would have been appropriate for the recipient at the rates specified above.
### Ambulance and Special Transportation Proration Schedule

<table>
<thead>
<tr>
<th># of Riders</th>
<th>% of Allowed Base Rate Per</th>
<th>% of Allowed Mileage Vehicle</th>
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<tbody>
<tr>
<td>1</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>2</td>
<td>80</td>
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<td>4</td>
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<td>5 – 9</td>
<td>50</td>
<td>20</td>
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<tr>
<td>10 or more</td>
<td>40</td>
<td>10</td>
</tr>
</tbody>
</table>

**Waivered Services**

If a service provided under a waiver is comparable in type, amount, duration, and scope to an MA service, the reimbursable amount must be the same as if it were provided under the MA program. Payment for specific waivered services, or MA covered services that are different in amount, duration, or scope, will be determined in accordance with the rule established for the particular waiver program.

Effective July 1, 2003, provider payment rates are reduced by one percent (1%) for the following providers/programs:

- Home and community-based services for the elderly, except extended home care services;
- Alternative Care (AC) home and community-based services, except home health, personal care assistance, and private duty nursing services; and
- Day training and habilitation services for adults with mental retardation or related conditions (MR/RC).

Allocations to county agencies for home and community-based waivered services will be reduced one percent (1%) for the following. This reduction does not include home care, extended home care, or extended transportation services.

- Services provided to persons with MR/RC. The allowable budget will be reduced to assure savings for the biennium. Counties must make rate adjustments or changes in spending to achieve the total reduction required by the legislature. This reduction does not apply to home care or extended home care services.
- Waivered services under community alternatives for disabled individuals (CADI);
- Community alternative care (CAC) waivered services; and
- Traumatic brain injury waivered (TBIW) services.

MR/RC diversion allocations will not be available during FY04 and FY05. Conversion allocations for persons in ICF/MRs that downsize or close continue to be available.

Allocations for CADI are limited to an average monthly growth of 95 persons.

TBIW spending must be managed to the equivalent of limiting allocations to 150 per year.
Miscellaneous Rates

For health services not listed above, DHS may use competitive bidding, negotiate a rate, or establish a payment rate by other means consistent with statutes, federal regulations, and state rules.

Rate Variations/Legislative Changes

HCPCS Modifiers
DHS may increase or decrease payment when certain HCPCS/CPT modifiers are used.

Legislative Changes Related to Rates
The Commissioner, in the following situations, may estimate the 50th percentile of the prevailing charge for 1989, less the percent reduction:

- There were less than five billings in the calendar year specified in legislation governing maximum payment rates;
- The service was not available in the calendar year specified in legislation governing maximum payment rates;
- The payment amount is the result of a provider appeal;
- The procedure code description has changed since the calendar year specified in legislation governing maximum payment rates and, therefore, the prevailing charge information reflects the same code but a different procedure description;
- The 50th percentile, less the percent reduction, reflects a payment which is grossly inequitable when compared with payment rates for procedure or services which are substantially similar or when compared with payment rates for procedure codes or different levels of complexity in the same or substantially similar category; or
- The procedure code is for an unlisted service.

When one of the above situations occurs, the Commissioner will use the following methodology to reconstruct a rate comparable to the 50th percentile of the prevailing rate, less the percent reduction:

- Refer to information which exists for the first four billings in the calendar year specified in legislation governing maximum payment rates;
- Refer to surrounding or comparable procedure codes;
- Refer to the 50th percentile, less the percent reduction of years subsequent to the calendar year specified in legislation governing maximum payment rates and back-down the amount by applying an appropriate Consumer Price Index (CPI) formula;
- Refer to relative value indexes;
- Refer to payment information from other third parties, such as Medicare;
- Refer to a previous rate and add the aggregate increase to the previous rate; or
- Refer to the submitted charge and "back-down" the charge by a CPI formula.

If a procedure was authorized and approved prior to a DHS reference file rate change, the approved authorized payment rate may be paid rather than the new DHS reference file allowable.
Rates for certain services have been increased by the legislature as follows:

- 10% for obstetric services (October 1988)
- 15% for obstetric services in addition to 10% increase (July 1990)
- 7.5% for diagnostic and routine dental services (July 1989)
- 5% for all other dental services (July 1989)
- 20% for public health clinic and community health clinic services (July 1989)
- 15% for pediatric services (July 1990)
- 5% for physical therapy, speech-language therapy, respiratory therapy (July 1997)
- 5% for MA/GAMC dental (July 1997)
- 15% for MinnesotaCare dental (July 1997)
- 3% for MA/GAMC and MinnesotaCare dental (July 1998)
- 3% for physical therapy, speech-language therapy, respiratory therapy (July 1998)
- 3% for physician and professional services except home health (January 2000)
- 3% for dental (January 2000)
- 8% for outpatient hospital facility fees and emergency room facility fees that do not have a federal maximum allowable (January 2000)

Rates for certain services have been decreased by the legislature as follows:

- 6% for individual and group psychotherapy services (July 1990)
- 35% for therapy services provided by physical or occupational therapist assistant
- .5% for outpatient hospital facility services (July 2002)

Copay Guidelines

Billing Requirements for MA/GAMC/MLB Recipients

Non-emergency Visit to a Hospital-based Emergency Room
The non-emergency visit to a hospital-based emergency room copay will be deducted from the outpatient hospital facility claim. DHS will use the type of admission in conjunction with the revenue code to determine whether or not the visit was considered an emergency visit or a non-emergency visit. DHS will consider a type of admission equal to “1” in conjunction with a 45x revenue code to be an emergency.

Non-preventive Visit Copay
After the exclusions stated in Chapter 2 are taken into consideration, a combination of variables determines whether or not a copay is deducted from a claim. These variables include:

- Provider type
- Place of service code
- Diagnosis code
- Procedure code
- Modifier
Provider types, determined by header information based on pay-to provider, that are subject to the non-preventive copay deductions are:

<table>
<thead>
<tr>
<th>MA/GAMC</th>
<th>MLB</th>
</tr>
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<tbody>
<tr>
<td>• Audiologist</td>
<td>• Clinical Nurse Specialist</td>
</tr>
<tr>
<td>• Chiropractor</td>
<td>• Community Health Clinic</td>
</tr>
<tr>
<td>• Clinical Nurse Specialist</td>
<td>• Federally Qualified Health Center</td>
</tr>
<tr>
<td>• Community Health Clinic</td>
<td>• Hospital</td>
</tr>
<tr>
<td>• Federally Qualified Health Center</td>
<td>• Indian Health</td>
</tr>
<tr>
<td>• Hospital</td>
<td>• Nurse Practitioner</td>
</tr>
<tr>
<td>• Indian Health</td>
<td>• Physician</td>
</tr>
<tr>
<td>• Nurse Midwife</td>
<td>• Physician Assistant</td>
</tr>
<tr>
<td>• Nurse Practitioner</td>
<td>• Public Health Clinic</td>
</tr>
<tr>
<td>• Optician</td>
<td>• Public Health Nursing Organization</td>
</tr>
<tr>
<td>• Optometrist</td>
<td>• Rural Health Clinic</td>
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<tr>
<td>• Physician</td>
<td></td>
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<tr>
<td>• Physician Assistant</td>
<td></td>
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<tr>
<td>• Podiatrist</td>
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<tr>
<td>• Public Health Clinic</td>
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<tr>
<td>• Public Health Nursing Organization</td>
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<tr>
<td>• Rural Health Clinic</td>
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</tbody>
</table>

Within the provider types listed above, the following treating provider types are subject to the non-preventive copay deductions:

<table>
<thead>
<tr>
<th>MA/GAMC</th>
<th>MLB</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Audiologist</td>
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</tr>
<tr>
<td>• Chiropractor</td>
<td>• Nurse practitioner</td>
</tr>
<tr>
<td>• Clinical nurse specialist</td>
<td>• Physician (Some exclusions to “physician” provider type exist either directly or indirectly, based on the provider specialty, or the services provided. For example: due to the mental health exclusions, physicians who are enrolled as DHS providers with a psych specialty are excluded from copay deductions.)</td>
</tr>
<tr>
<td>• Nurse midwife</td>
<td>• Physician ancillary (WW, U7 modified services)</td>
</tr>
<tr>
<td>• Nurse practitioner</td>
<td>• Physician assistant</td>
</tr>
<tr>
<td>• Optician</td>
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<td>• Optometrist</td>
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<td>• Physician (Some exclusions to “physician” provider type exist either directly or indirectly, based on the provider specialty, or the services provided. For example: due to the mental health exclusions, physicians who are enrolled as DHS providers with a psych specialty are excluded from copay deductions.)</td>
<td></td>
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</tbody>
</table>
• Physician ancillary (WW, U7 modified services)
• Physician assistant
• Podiatrist

Unless the recipient or the service comes under one of the exemptions listed above, the following **place of service codes** are subject to a copay deduction (MA/GAMC and MLB):

- 05 - Indian Health Service free standing facility
- 06 - Indian Health Service provider based facility
- 07 - Tribal 638 free standing facility
- 08 - Tribal 638 provider based facility
- 11 - Office
- 20 - Urgent care
- 22 - Outpatient
- 24 - Ambulatory surgery center
- 50 - Federally Qualified Health Center
- 71 - State or local public health center
- 72 - Rural health center
- 99 - Other unlisted facility
- blank

**Diagnosis and Procedure Codes:** Refer to the “Non-preventive visit” definition and “Examples of services exempt from copays” (MA/GAMC and MLB).

**Modifiers:** When the following **modifiers** are billed by the providers types, in the place of service, etc., listed above, the non-preventive copay deduction does not apply to (MA/GAMC and MLB):

- 80 - Assistant surgeon
- 81 - Minimum assistant surgeon
- 82 - Assistant surgeon
- AS - Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
- ET - Emergency service. The “ET” modifier should be submitted for services that comply with the emergency services definition above. DHS will not deduct a copay, on the service date, on which an ET modifier is billed.
- G8 - Monitored anesthesia care
- G9 - Monitored anesthesia care

A copay deduction will be applied to the first “62” or “66” modifier on a claim processed by DHS. Subsequently processed “62” and “66” modified claims will not have a copay deducted, as only one copay is deducted per surgical procedure.
Inpatient Hospital Services

The Minnesota inpatient hospital payment system under MA and GAMC is authorized by Minnesota Statutes, section 256.9685 to 256.9695 and Minnesota Rules, parts 9500.1090 to 9500.1140. Payment rates are prospectively established on a per admission or per day basis under a diagnosis related group (DRG) system that condenses Medicare categories into Minnesota diagnosis categories. Rates are differentiated by eligibility (MA MFIP, MA NON-MFIP, GAMC) and specialty (Rehabilitation Distinct Part, Neonatal Transfer). Minnesota and local trade area hospitals are provided a notice of rates and relative values that are to be effective for the rate (calendar) year by the preceding December 1. The rate setting methodology is based on the cost finding and allowable cost principles of the Medicare program. The rates are established for each calendar year using hospital specific cost and MA/GAMC base year claims data that is trended for inflation to the rate year from a base year. Rates are re-based to more current data every two years.

Definitions

Adjusted Base Year Operating Cost: A hospital's allowable base year operating cost per admission or per day, adjusted by the hospital cost index.
Allowable Base Year Operating Cost: A hospital's base year inpatient hospital cost per admission or per day that is adjusted for case mix and excludes property costs.
Base Year: A hospital's fiscal year from which cost and statistical data are used to establish rates.
Case Mix: A hospital's distribution of admissions among the diagnostic categories.
Day Outlier: An admission whose length of stay exceeds the geometric mean length of stay for neonate and burn diagnostic categories by one standard deviation and all other diagnostic categories by two standard deviations.
Diagnosis Categories: The diagnosis classifications established under Minnesota Statutes, section 256.969, subdivision 2, containing one or more diagnosis related groups (DRGs) under Medicare.
Hospital Cost Index or HCI: The factor annually multiplied by the allowable base year operating cost to adjust for cost changes.
Inpatient Hospital Costs: A hospital's base year inpatient hospital service costs determined under the cost finding methods of Medicare without regard to adjustments in payments by Medicare.
Local Trade Area Hospital: A hospital with more than 20 combined MA and GAMC admissions in the base year that is located in a state other than Minnesota but in a county, contiguous to Minnesota and located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current re-based rate year.
Out-of-Area Hospital: A hospital located outside of Minnesota excluding local trade area hospitals.
Operating Costs: Inpatient hospital costs excluding property costs.
Property Costs: Inpatient hospital costs not subject to the HCI.
Rate Year: A calendar year from January 1 to December 31.
Transfer: The movement of a patient after admission from one hospital directly to another hospital, with a different provider number, or to or from a rehabilitation distinct part.
Trim Point: That number of inpatient days beyond which an admission is an outlier.
Determination of Payment

**MA Rate Per Admission** = \{[(adjusted base year operating cost per admission) multiplied by (relative value of the appropriate diagnostic category)] plus (property cost per admission)] multiplied by (disproportionate population adjustment).

**GAMC Rate Per Admission** = [(adjusted base year operating cost per admission) multiplied by (relative value of the appropriate diagnostic category) and multiplied by (the disproportionate population adjustment)] plus the property cost per admission.

**GAMC Mental Health and Chemical Dependency Admission payment** = \{[(adjusted base year cost per admission) multiplied by (relative value of the appropriate diagnostic category) multiplied by (disproportionate population adjustment)] plus (property cost per admission)] divided by (arithmetic mean length of stay of the diagnostic category) multiplied by two and multiplied by number of days of inpatient hospital services.

A hospital may not receive payment for a GAMC mental health or chemical dependency admission that exceeds the applicable rate per admission unless the admission is a day outlier.

**MA (non NICU) Transfer Payment** = \{[(adjusted base year operating cost per admission) multiplied by (relative value of the appropriate diagnostic category)] plus property cost per admission} multiplied by (disproportionate population adjustment) divided by (arithmetic mean length of stay of the diagnostic category) and multiplied by number of days of inpatient hospital services.

**GAMC Transfer Payment** = [(adjusted base year operating cost per admission) multiplied by (relative value of the appropriate diagnostic category) multiplied by (disproportionate population adjustment)] plus property cost per admission divided by (arithmetic mean length of stay of the diagnostic category) and multiplied by number of days of inpatient hospital services.

A hospital may not receive a transfer payment that exceeds the applicable rate per admission unless the admission is a day outlier.

Rehabilitation hospitals and Medicare designated rehabilitation distinct parts are exempt from the transfer payment methodology.

**NICU Transfer Payment** = \{[(adjusted base year neonatal operating cost per day) multiplied by (relative value of the appropriate diagnostic category)] plus neonatal property cost per day} multiplied by (disproportionate population adjustment) and multiplied by number of days of inpatient hospital services.

Hospitals with NICU's receiving transferred neonates are paid on a per day basis.

For MA admissions to be paid under respiratory distress syndrome (diagnostic category KK5), inpatient hospital services must be provided in either a level II or level III nursery. Otherwise, payment will be determined by taking into account respiratory distress but not the respiratory distress syndrome.

MA admissions for patients who are equal to or greater than the age of one at the time of admission, who are classified to diagnostic categories KK1 through NN3 with a length of stay less than 50% of the average length of stay for its diagnostic category, will be paid according to the MA transfer payment.

**Out-of-Area Rate Per Admission** = [(statewide average adjusted base year operating cost per admission) multiplied by (relative value of the appropriate diagnostic category)] plus statewide average property cost per admission.
Out-of-area payments may also be established based on a negotiated rate. Payments, including third-party liability, established for out-of-area hospitals may not exceed the charges on a claim-specific basis.

**MA MSA (Metropolitan Statistical Area) Rate Per Admission** = \([(\text{statewide average adjusted base year operating cost per admission for MSA hospitals}) \times (\text{relative value of the appropriate diagnostic category}) + (\text{property cost per admission})\] \times (\text{disproportionate population adjustment}).

**GAMC MSA Rate Per Admission** = \([(\text{statewide average adjusted base year operating cost per admission for MSA hospitals}) \times (\text{relative value of the appropriate diagnostic category}) \times (\text{disproportionate population adjustment}) + (\text{property cost per admission})\].

The rate per admission for Minnesota non-MSA hospitals is determined by substituting non-MSA hospitals' terms and data for the MSA hospitals' terms and data.

DHS will determine payment using the applicable MA or GAMC MSA rate per admission for Minnesota MSA and local trade area hospitals that do not have admissions in the base year.

Similarly, DHS will determine payment using the applicable MA or GAMC non-MSA rate per admission for Minnesota non-MSA hospitals that do not have admission in the base year.

**Long Term Hospital MA Rate Per Day** = \([(\text{adjusted operating cost per day}) + (\text{property cost per day}) \times (\text{disproportionate population adjustment}) \times (\text{number of days of inpatient services})\].

**Long Term Hospital GAMC Rate Per Day** = \([(\text{adjusted operating cost per day}) \times (\text{disproportionate population adjustment}) + (\text{property cost per day}) \times (\text{number of days of inpatient hospital services})\].

**Day Outlier Payment** = \([(\text{adjusted base year outlier cost per day}) \times (\text{relative value of the appropriate diagnostic category}) \times (\text{number of outlier days in excess of the diagnostic category arithmetic trim point}) \times (\text{disproportionate population adjustment})\].

DHS will pay a hospital for day outliers in addition to the applicable rate per admission.

**Disproportionate Population Adjustment (DPA) Eligibility**

For MA, a Minnesota or local trade area hospital that meets the following is eligible for an adjustment to the payment rate:

- A hospital that offers obstetric services must have at least two obstetricians (or any two physicians if the hospital is non-MSA) with staff privileges who have agreed to provide obstetric services to MA recipients.
- A hospital that did not offer non-emergency obstetric services as of December 21, 1987, or a hospital whose inpatients are predominately under 18 years of age is not subject to the requirement in the item above.
- A hospital must have an MA inpatient utilization rate that exceeds the mean for Minnesota and local trade area hospitals or a low-income inpatient utilization rate that exceeds 25%, determined as follows:

  **MA Inpatient Utilization Rate** = \(\frac{\text{MA days}}{\text{total inpatient days}}\).
  **Low Income Utilization Rate** = \(\frac{\text{MA revenues} + \text{any cash subsidies received by the hospital directly from state and local government}}{\text{total inpatient revenues} + \text{the cash subsidies amount}}\) plus \(\frac{\text{inpatient charity care charges minus the cash subsidies}}{\text{total inpatient revenues plus the cash subsidies amount}}\).
MA DPA for hospitals whose MA inpatient utilization rate exceeds the mean for Minnesota and local trade area hospitals = \([(\text{hospital’s MA inpatient utilization rate}) - (\text{mean MA inpatient utilization rate for Minnesota and local trade area hospitals})]\) plus one.

MA DPA for hospitals whose MA inpatient utilization rate exceeds the mean for Minnesota and local trade area hospitals plus one standard deviation = \([(\text{hospital’s MA inpatient utilization rate}) - (\text{mean MA inpatient utilization rate for Minnesota and local trade area hospitals})] \times 1.1\) plus one.

A hospital that does not meet the requirements of the first two points will receive a hospital payment adjustment equal to the DPA under MA.

For GAMC, a Minnesota or local trade area hospital is eligible for an adjustment to the payment rate if the hospital's MA inpatient utilization rate exceeds the mean for Minnesota and local trade area hospitals plus one standard deviation or the low income utilization rate exceeds 25%, the GAMC DPA is determined as follows:

GAMC DPA = \([(\text{hospital’s MA inpatient utilization rate}) - (\text{mean MA inpatient utilization rate for Minnesota and local trade area hospitals plus one standard deviation})]\) plus one.

**Other Payment Factors**

**Charge Limitation:** Individual hospital payments, excluding DPA payments, for covered inpatient services in addition to third party liability for admissions occurring in a rate year will not exceed, in aggregate, the charges for covered inpatient services paid for the same period of time to a hospital. The limitation will be calculated separately for MA and GAMC and separately from other services for a rehabilitation distinct part.

**Small Rural Hospital Adjustment:** Rural Minnesota hospitals with 100 or fewer licensed beds on March 1, 1988, and more than 100, but fewer than 250, Minnesota annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 15%. Rural Minnesota hospitals with 100 or fewer licensed beds on March 1, 1988, and 100 or fewer Minnesota annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 20%. Payments under this provision are reduced by the amount of the hospital’s DPA and hospital payment adjustment. This adjustment applies only to MA payments, not to GAMC.

**Re-basing Adjustment:** Payment for admissions occurring on or after October 25, 1993 include a re-basing adjustment that is designed to compensate for an effective date of July 1, 1992, under the rates and rules in effect on October 25, 1993. The method of compensating for this date occurs by adding to or subtracting from each claim the average difference in payments that would have resulted from the revised rates and rules from July 1, 1992 to the effective date of the changes. Amounts owed to the hospital are limited to 80% of the aggregate amount due. The adjustment will continue until the hospital or DHS is paid in full. The cash flow add-on provided to certain hospitals beginning July 1, 1992 is subtracted from the adjustment and, for purposes of case mix appeals, the adjustment is considered to have been made at the time of admission.
Appeals

A hospital may appeal a decision arising from the application of standards or methods of the payment system. An appeal can result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that result from the submission of appeals will be implemented. Regardless of any appeal outcome, relative values will not be recalculated.

The appeal will be heard by an administrative law judge according to Minnesota Statutes, chapter 14, or upon agreement by both parties, according to a modified appeals procedure established by the Commissioner and the office of administrative hearings. In any proceeding, the appealing party must demonstrate by a preponderance of the evidence that the Commissioner's determination is incorrect or not according to law.

To appeal a payment rate or payment determination or a determination made from base year information, the hospital must file a written appeal request to the Commissioner within 60 days of the date the payment rate determination was mailed. The appeal request must specify the:

- Disputed items;
- Authority in federal or state statute or rule upon which the hospital relies for each disputed item; and
- Name and address of the person to contact regarding the appeal.

To appeal a payment rate or payment change that results from a difference in case mix between the base year and the rate year, follow the procedures and requirements listed above apply. However, the appeal must be filed with the Commissioner within 120 days after the end of the rate year. A case mix appeal must apply to the cost of services to all MA and GAMC patients that received inpatient services from the hospital. The difference in case mix and the corresponding payment adjustment must exceed a threshold of five percent.

Department of Human Services
Appeals & Regulations
444 Lafayette Road No.
St. Paul, MN 55155-3813

Legal References

Minnesota Statutes, section 256B.03
Minnesota Statutes, section 256B.041
Minnesota Statutes, section 256D.03
Minnesota Rules, part 9505.0070, subp. 5
Minnesota Rules, part 9505.0110
Minnesota Rules, part 9505.0190
Minnesota Rules, part 9505.0225
Minnesota Rules, parts 9505.0450 to 9505.0475
Minnesota Rules, part 9505.5010
Minnesota Rules, part 9595.5030
Minnesota Rules, part 9505.2190
42 CFR 447.10
42 CFR 447.15
42 CFR 447.45
Chapter 5

Authorization

Some MHCP covered services require authorization. The authorization requirement is used to safeguard against inappropriate and unnecessary use of health care services governed by state law and federal regulations. MHCP covered services requiring authorization are listed annually in the State Register, with updates published as necessary. Information in this chapter pertains to fee-for-service MHCP recipients only. Providers must contact the appropriate health plan for authorization requirements for recipients in prepaid health plans.

Providers may obtain authorization prior to providing a service or, in some circumstances, after the service has been provided. Receiving an approval for an authorization request does not guarantee payment. Providers must follow MHCP billing policy guidelines, and the MHCP recipient must be eligible at the time the service is rendered. The prior authorization process for home care services can be found in the Home Care Services chapter (Ch. 24).

Definitions

Authorization: The written approval and issuance of an authorization number by a medical review agent under contract to DHS.

Fair Hearing: An administrative proceeding to examine facts concerning the matter in dispute and to advise the Commissioner if the decision to reduce or deny benefits are appropriate.

Investigative Health Service:

A procedure that has limited human application and trial, and lacks wide recognition as a safe and effective procedure in clinical medicine as determined by the National Blue Cross and Blue Shield Association, and utilized by Blue Cross and Blue Shield in Minnesota.

A drug or device (identified in the Food, Drug, and Cosmetic Act) the United States Food and Drug Administration has not yet declared safe and effective for the use prescribed.

Local Trade Area: The geographic area surrounding a recipient's residence commonly used by local residents to obtain similar health care services.

Medically Necessary or Medical Necessity: A health service that is consistent with the recipient's diagnosis or condition and:

Is recognized as the prevailing medical community standards or current practice by the provider's peer group; and
Is rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve community standards for diagnosis or condition; or is a preventive health service.

**Medical Review Agent:** The authorized representative of the Commissioner who is authorized to determine the medical appropriateness of procedures requiring authorization as stipulated in the terms of the contract.

**Out-of-state Provider:** A provider located outside of the State of Minnesota and the recipient's local trade area.

**Referee:** A person who conducts fair hearings and provides recommendations to the Commissioner.

### DHS Authorization Criteria

DHS requires authorization as a condition of MHCP payment if the health service:

- is of questionable medical necessity;
- requires monitoring to control the expenditure of MHCP funds;
- a less costly, appropriate alternative health service is available;
- is investigative or experimental;
- is newly developed or modified;
- is of a continuing nature and requires monitoring to prevent its continuation when it ceases to be beneficial;
- is comparable to a service provided in a skilled nursing facility or hospital but is provided in a recipient's home; or
- may be considered cosmetic.

### Medical Review Agent

DHS contracts with a medical review agent, Care Delivery Management, Inc. (CDMI), to process requests for authorization. CDMI accepts requests for authorization on paper, ITS, and in some instances over the telephone. Paper requests for authorization are accepted on the Medical Authorization form (DHS-3066), the Pharmacy/Supply invoice (DHS-3065), or the ADA form.
Appropriate documentation for medical necessity is required for all requests. Refer to the appropriate covered services chapter for more information about specific documentation requirements, or contact CDMI at:

CDMI
3535 Blue Cross Road
PO Box 64265, Route W1-01
St. Paul, MN 55164-0460
(651) 662-5275 or 1-888-878-0139, ext. 25275
FAX (651) 662-7459

If submitting requests using ITS, FAX or mail copies of the ITS screen prints and supporting documentation to CDMI.

**Documentation Requirements**

The criteria listed below are used by CDMI when processing requests for authorization.

The service must be:

- medically necessary, as determined by prevailing medical community standards or customary practice and usage;
- appropriate and effective for the recipient's medical needs;
- timely, considering the nature and present medical condition of the recipient;
- provided by a provider with appropriate credentials;
- the least expensive, appropriate alternative available; and
- an effective and appropriate use of MHCP funds.

**Modifiers**

If a modifier is required for a particular procedure code, the request for authorization submitted to CDMI must include the modifier. Information on the approved authorization, including the procedure code(s) and the modifier(s), must match claim information for the service, or the claim will be denied by DHS.
Out-of-state Providers

Except for emergency services, out-of-state providers must obtain prior authorization before providing MHCP covered services. Requests for prior authorization of services provided outside of Minnesota must include documentation establishing medical necessity and the unavailability of that service in Minnesota or the contiguous counties.

MHCP covered services provided to a Minnesota recipient by an out-of-state provider will be covered under the following circumstances:

- the provider must enroll in MHCP and follow all program guidelines;
- the services must be medically necessary;
- the services are provided in response to an emergency while the recipient is out of the state;
- the services are not available in Minnesota or the recipient's local trade area, and the attending physician has determined medical necessity and obtained prior authorization from CDMI. The county is responsible for travel expenses associated with obtaining the out-of-state services; or
- the services are required because the recipient's health would be endangered if he/she were required to return to Minnesota.

Notice of Action Taken

DHS will notify the provider and recipient, in writing, of action taken on an authorization request. CDMI will notify the provider if additional information is needed to decide medical necessity. If a request is denied, the recipient will receive a notice of recipient’s right to appeal.

Fair Hearings

If the request is denied or reduced, the recipient may appeal the decision and receive a fair hearing before a referee from DHS. To request a fair hearing, a recipient must contact the county agency or the Appeals Unit at DHS. Providers do not have the right to appeal a denied request under the department's fair hearing process.

Authorization List

The following is the current authorization list, which replaces any other list published in the State Register. This authorization list is effective on or after March 11, 2002.
As authorized by Minnesota Statutes, section 256B.0625, subdivision 25, the following list includes all health services that require authorization as a condition of MHCP payment. The list is presented in sections: Dental Services, Vision Care Services, Medical Supplies and Equipment, Prosthetics and Orthotics, Hearing Aids, Drugs, Rehabilitative Services, and All Other Services. The criteria used to develop this list are as follows:

A. The health service could be considered, under some circumstances, to be of questionable medical necessity.

B. Use of the health service needs monitoring to control the expenditure of program funds.

C. Less costly, appropriate alternatives to the health service are generally available.

D. The health service is investigative.

E. The health service is newly developed or modified.

F. The health service is of a continuing nature and requires monitoring to prevent its continuation when it ceases to be beneficial.

G. The health service is comparable to a service provided in a skilled nursing facility or hospital but is provided in a recipient's home.

H. The health service could be considered cosmetic.

**DENTAL SERVICES**

It is essential that requests submitted for authorization consideration be accompanied by adequate case information and appropriate diagnostic materials (i.e., x-rays, prosthesis information, teeth to be replaced, prognosis for remaining dentition, complete 6 point perio charting for cast metal partials).

**TESTS AND LABORATORY EXAMINATIONS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0999</td>
<td>Unspecified diagnostic procedure, by report (When no medical procedure is being done in addition to the dental procedure)</td>
</tr>
</tbody>
</table>

**CROWNS - SINGLE RESTORATIONS ONLY**

- D2720  Crown - resin with high noble metal
- D2721  Crown - resin with predominantly/base metal
- D2722  Crown - resin with noble metal
- D2740  Crown - porcelain/ceramic substrate
- D2750  Crown - porcelain fused to high noble metal
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2751</td>
<td>Crown - porcelain fused to predominantly/base metal</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown - porcelain fused to noble metal</td>
</tr>
<tr>
<td>D2780</td>
<td>Crown- 3/4 cast high noble metal</td>
</tr>
<tr>
<td>D2781</td>
<td>Crown-3/4 cast predominately base metal</td>
</tr>
<tr>
<td>D2782</td>
<td>Crown-3/4 cast noble metal</td>
</tr>
<tr>
<td>D2783</td>
<td>Crown- 3/4 porcelain/ceramic</td>
</tr>
<tr>
<td>D2790</td>
<td>Crown - full cast high noble metal</td>
</tr>
<tr>
<td>D2791</td>
<td>Crown - full cast predominantly base metal</td>
</tr>
<tr>
<td>D2792</td>
<td>Crown - full cast noble metal</td>
</tr>
<tr>
<td>D2810</td>
<td>Crown - 3/4 cast metallic</td>
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**OTHER RESTORATIVE SERVICES**

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>D2952</td>
<td>Cast post and core in addition to crown</td>
</tr>
<tr>
<td>D2953</td>
<td>Each additional post-same tooth</td>
</tr>
<tr>
<td>D2960</td>
<td>Labial veneer (laminate)</td>
</tr>
<tr>
<td>D2961</td>
<td>Labial veneer (resin laminate)-laboratory</td>
</tr>
<tr>
<td>D2962</td>
<td>Labial veneer (porcelain laminate)-laboratory</td>
</tr>
<tr>
<td>D2999</td>
<td>Unspecified restorative procedure, by report</td>
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**OTHER ENDODONTIC PROCEDURES**

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>D3460</td>
<td>Endodontic endosseous implant</td>
</tr>
<tr>
<td>D3960</td>
<td>Bleaching of discolored tooth</td>
</tr>
<tr>
<td>D3999</td>
<td>Unspecified endodontic procedure</td>
</tr>
</tbody>
</table>

**SURGICAL SERVICES** (including usual post-operative services)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty - per quadrant</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty - per tooth</td>
</tr>
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**PERIODONTICS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>D4220</td>
<td>Gingival curettage, surgical, per quadrant, by report</td>
</tr>
<tr>
<td>D4240</td>
<td>Gingival flap procedures, including root planning - per quadrant</td>
</tr>
<tr>
<td>D4245</td>
<td>Apically positioned flap</td>
</tr>
<tr>
<td>D4249</td>
<td>Crown lengthening - hard and soft tissue, by report</td>
</tr>
<tr>
<td>D4250</td>
<td>Mucogingival surgery - per quadrant</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery, including flap entry and closure per quadrant</td>
</tr>
<tr>
<td>D4263</td>
<td>Bone replacement graft - first site in quadrant</td>
</tr>
<tr>
<td>D4264</td>
<td>Bone replacement graft - each additional site in quadrant</td>
</tr>
<tr>
<td>D4266</td>
<td>Guided tissue regeneration - resorbable barrier, per site, per tooth</td>
</tr>
</tbody>
</table>
| D4267  | Guided tissue regeneration - nonresorbable barrier, per site, per tooth      | (includes membrane removal)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>D4268</td>
<td>Surgical revision procedure, per tooth</td>
</tr>
<tr>
<td>D4270</td>
<td>Pedicle soft tissue grafts</td>
</tr>
<tr>
<td>D4271</td>
<td>Free soft tissue grafts including donor site</td>
</tr>
<tr>
<td>D4273</td>
<td>Subepithelial connective tissue graft procedure (including donor site surgery)</td>
</tr>
<tr>
<td>D4274</td>
<td>Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)</td>
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**ADJUNCTIVE PERIODONTAL SERVICES**

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>D4320</td>
<td>Provisional splinting, intracoronal</td>
</tr>
<tr>
<td>D4321</td>
<td>Provisional splinting, extracoronal</td>
</tr>
<tr>
<td>D4341</td>
<td>Periodontal scaling, and root planning - per quadrant</td>
</tr>
<tr>
<td>D4381</td>
<td>Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, by tooth, by report</td>
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**OTHER**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>D4910</td>
<td>Periodontal maintenance procedures (following active therapy)</td>
</tr>
<tr>
<td>D4999</td>
<td>Unspecified periodontal service (by report)</td>
</tr>
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**PROSTHODONTICS, REMOVABLE DENTURES** *(Authorization required if provided more often than once in a three year period)*

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>D5110</td>
<td>Complete upper</td>
</tr>
<tr>
<td>D5120</td>
<td>Complete lower</td>
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**PARTIAL DENTURES** *(Authorization required if provided more often than once in a three year period)*

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>D5211</td>
<td>Upper partial - resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5212</td>
<td>Lower partial - resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5213</td>
<td>Upper partial - cast metal base with resin saddles (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5214</td>
<td>Lower partial - cast metal base with resin saddles (including any conventional clasps, rests and teeth)</td>
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**OTHER PROSTHETIC SERVICES**

<table>
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<tr>
<th>Code</th>
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<tbody>
<tr>
<td>D5860</td>
<td>Overdenture complete, by report</td>
</tr>
<tr>
<td>D5861</td>
<td>Overdenture partial, by report</td>
</tr>
<tr>
<td>D5862</td>
<td>Precision attachment, by report</td>
</tr>
<tr>
<td>D5867</td>
<td>Replacement of replaceable part of semi-precision attachment</td>
</tr>
<tr>
<td>D5875</td>
<td>Modification of removable prosthesis following implant surgery</td>
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</table>
D5899  Unspecified removable prosthodontics procedure, by report

MAXILLOFACIAL PROSTHETICS

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<tr>
<th>Code</th>
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<tbody>
<tr>
<td>D5951</td>
<td>Feeding aid</td>
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<tr>
<td>D5952</td>
<td>Speech aid prosthesis, pediatric</td>
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<tr>
<td>D5953</td>
<td>Speech aid prosthesis, adult</td>
</tr>
<tr>
<td>D5954</td>
<td>Palatal augmentation prosthesis</td>
</tr>
<tr>
<td>D5955</td>
<td>Palatal lift prosthesis, definitive</td>
</tr>
<tr>
<td>D5958</td>
<td>Palatal lift prosthesis, interim</td>
</tr>
<tr>
<td>D5959</td>
<td>Palatal lift prosthesis, modification</td>
</tr>
<tr>
<td>D5960</td>
<td>Speech aid prosthesis, modification</td>
</tr>
<tr>
<td>D5982</td>
<td>Surgical stent</td>
</tr>
<tr>
<td>D5983</td>
<td>Radiation carrier</td>
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<tr>
<td>D5984</td>
<td>Radiation shield</td>
</tr>
<tr>
<td>D5985</td>
<td>Radiation cone locator</td>
</tr>
<tr>
<td>D5986</td>
<td>Fluoride gel carrier</td>
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<tr>
<td>D5987</td>
<td>Commissure splint</td>
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</table>

IMPLANTS

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<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6055</td>
<td>Implant connecting bar</td>
</tr>
<tr>
<td>D6056</td>
<td>Prefabricated abutment</td>
</tr>
<tr>
<td>D6057</td>
<td>Custom abutment</td>
</tr>
<tr>
<td>D6058</td>
<td>Abutment supported porcelain/ceramic crown</td>
</tr>
<tr>
<td>D6059</td>
<td>Abutment supported porcelain fused to metal crown (high noble metal)</td>
</tr>
<tr>
<td>D6060</td>
<td>Abutment supported porcelain fused to metal crown (predominantly base metal)</td>
</tr>
<tr>
<td>D6061</td>
<td>Abutment supported porcelain fused to metal crown (noble metal)</td>
</tr>
<tr>
<td>D6062</td>
<td>Abutment supported cast metal crown (high noble)</td>
</tr>
<tr>
<td>D6063</td>
<td>Abutment supported cast metal crown (predominately base metal)</td>
</tr>
<tr>
<td>D6064</td>
<td>Abutment supported cast metal crown (noble metal)</td>
</tr>
<tr>
<td>D6065</td>
<td>Implant supported porcelain/ceramic crown</td>
</tr>
<tr>
<td>D6066</td>
<td>Implant supported porcelain fused to metal crown</td>
</tr>
<tr>
<td>D6067</td>
<td>Implant supported metal crown</td>
</tr>
<tr>
<td>D6068</td>
<td>Abutment supported retainer for porcelain/ceramic FPD</td>
</tr>
<tr>
<td>D6069</td>
<td>Abutment supported retainer for porcelain fused to metal FPD (high noble metal)</td>
</tr>
<tr>
<td>D6070</td>
<td>Abutment supported retainer for porcelain fused to metal FPD (predominately base metal)</td>
</tr>
<tr>
<td>D6071</td>
<td>Abutment supported retainer for porcelain fused to metal FPD (noble metal)</td>
</tr>
<tr>
<td>D6072</td>
<td>Abutment supported retainer for cast metal FPD (high noble metal)</td>
</tr>
<tr>
<td>D6073</td>
<td>Abutment supported retainer for cast metal FPD (predominately base metal)</td>
</tr>
<tr>
<td>D6074</td>
<td>Abutment supported retainer for cast metal FPD (noble metal)</td>
</tr>
<tr>
<td>D6075</td>
<td>Implant supported retainer for ceramic FPD</td>
</tr>
<tr>
<td>D6076</td>
<td>Implant supported retainer for porcelain fused to metal FPD</td>
</tr>
</tbody>
</table>
D6077  Implant supported retainer forcast metal FPD (titanium, titanium alloy, or high noble metal)
D6078  Implant/abutment supported fixed denture for completely edentulous arch

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6079</td>
<td>Implant/abutment supported fixed denture for partially edentulous arch</td>
</tr>
<tr>
<td>D6080</td>
<td>Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutment reinsertion of prosthesis.</td>
</tr>
<tr>
<td>D6095</td>
<td>Repair implant abutment, by report</td>
</tr>
</tbody>
</table>

**PROSTHODONTICS, FIXED BRIDGE PONTICS** (Only covered in situations when documented medical condition prohibits use of removable pontics)

D6210  Pontic - cast high noble metal
D6211  Pontic - cast predominantly base metal
D6212  Pontic - cast noble metal
D6240  Pontic - porcelain fused to high noble metal
D6241  Pontic - porcelain fused to predominantly base metal
D6242  Pontic - porcelain fused to noble metal
D6245  Pontic - porcelain/ceramic
D6250  Pontic - resin with high noble metal
D6251  Pontic - resin with predominantly base metal
D6252  Pontic - resin with noble metal

**RETAINERS**

D6545  Retainer - cast metal for acid etched fixed prosthesis
D6548  Retainer - porcelain ceramic-for resin bond fixed prosthesis

**CROWNS** (Only covered in situations when documented medical condition prohibits use of removable prostheses)

D6720  Crown - resin with high noble metal
D6721  Crown - resin with predominantly base metal
D6722  Crown - resin with noble metal
D6750  Crown - porcelain fused to high noble metal
D6751  Crown - porcelain fused to predominantly base metal
D6752  Crown - porcelain fused to noble metal
D6780  Crown - 3/4 cast high noble metal
D6781  Crown - 3/4 cast predominantly based metal
D6782  Crown - 3/4 cast noble metal
D6783  Crown - 3/4 porcelain/ceramic
D6790  Crown - full cast high noble metal
D6791  Crown - full cast predominantly base metal
D6792  Crown - full cast noble metal
OTHER FIXED PROSTHETIC SERVICES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6920</td>
<td>Connector bar</td>
</tr>
<tr>
<td>D6940</td>
<td>Stress breaker</td>
</tr>
<tr>
<td>D6950</td>
<td>Precision attachment</td>
</tr>
<tr>
<td>D6975</td>
<td>Coping metal</td>
</tr>
</tbody>
</table>

ORAL SURGERY EXTRACTION

D7241 Removal of impacted tooth - completely bone, with unusual surgical complications

OTHER SURGICAL PROCEDURES

D7272 Tooth transplantation
D7280 Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)
D7281 Surgical exposure of impacted or unerupted tooth to aid eruption
D7290 Surgical repositioning of teeth
D7291 Transseptal fiberotomy

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

D7880 Occlusal orthotic appliance
D7899 Unspecified TMD therapy, by report

LIMITED ORTHODONTIC TREATMENT

D8010 Limited orthodontic treatment of primary dentition
D8020 Limited orthodontic treatment of transitional dentition
D8030 Limited orthodontic treatment of adolescent dentition
D8040 Limited orthodontic treatment of adult dentition

INTERCEPTIVE ORTHODONTIC TREATMENT

D8050 Interceptive orthodontic treatment of primary dentition
D8060 Interceptive orthodontic treatment of transitional dentition

COMPREHENSIVE ORTHODONTIC TREATMENT

D8070 Comprehensive orthodontic treatment of transitional dentition
D8080 Comprehensive orthodontic treatment of adolescent dentition
D8090 Comprehensive orthodontic treatment of adult dentition
MINOR TREATMENT TO CONTROL HARMFUL HABITS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8210</td>
<td>Removal appliance therapy</td>
</tr>
<tr>
<td>D8220</td>
<td>Fixed or cemented appliance therapy</td>
</tr>
</tbody>
</table>

TREATMENT OF THE PERMANENT DENTITION/OTHER ORTHODONTIC SERVICES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8660</td>
<td>Pre-orthodontic treatment visit (PA required once every five years)</td>
</tr>
<tr>
<td>D8670</td>
<td>Periodic orthodontic treatment visit</td>
</tr>
<tr>
<td>D8680</td>
<td>Orthodontic retention</td>
</tr>
<tr>
<td>D8690</td>
<td>Orthodontic treatment</td>
</tr>
<tr>
<td>D8750</td>
<td>Post-treatment stabilization</td>
</tr>
<tr>
<td>X0515</td>
<td>Orthodontic full case study (PA required once every five years)</td>
</tr>
<tr>
<td>D8999</td>
<td>Unspecified orthodontic treatment</td>
</tr>
</tbody>
</table>

MISCELLANEOUS SERVICES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9940</td>
<td>Occlusal guards, by report</td>
</tr>
<tr>
<td>D9941</td>
<td>Fabrication of athletic mouth guards</td>
</tr>
<tr>
<td>D9951</td>
<td>Occlusal adjustment, limited</td>
</tr>
<tr>
<td>D9952</td>
<td>Occlusal adjustment, complete</td>
</tr>
<tr>
<td>D9971</td>
<td>Odontoplasty 1-2 teeth</td>
</tr>
<tr>
<td>D9972</td>
<td>External bleaching-per arch</td>
</tr>
<tr>
<td>D9973</td>
<td>External bleaching-per tooth</td>
</tr>
<tr>
<td>D9974</td>
<td>Internal bleaching-per tooth</td>
</tr>
<tr>
<td>D9999</td>
<td>Unspecified adjunctive procedure, by report - Inpatient anesthesia for dental services.</td>
</tr>
</tbody>
</table>

VISION CARE SERVICES

CONTACT LENS TREATMENT SERVICES (All contact lens services and supplies must be authorized except for recipients with a diagnosis of Aphakia, Aniseikonia, Keratoconus, or Bandage lenses.)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92070</td>
<td>Fitting of contact lens for treatment of disease, including supply of lens</td>
</tr>
<tr>
<td>92310</td>
<td>Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia</td>
</tr>
<tr>
<td>92325</td>
<td>Modification of contact lens (separate procedure), with medical supervision of adaptation</td>
</tr>
<tr>
<td>92391</td>
<td>Supply of contact lenses, except prosthesis for aphakia</td>
</tr>
</tbody>
</table>

VISION THERAPY SERVICES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92065</td>
<td>Orthoptic and/or pleoptic training, with continuing medical direction and evaluation</td>
</tr>
</tbody>
</table>
MATERIAL CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2500</td>
<td>Contact Lens - for diagnosis other than Aphakia, Keratoconus, or Aniseikonia, or to Bandage Lenses.</td>
</tr>
<tr>
<td>V2599</td>
<td>When submitting invoices for one of these three diagnosis, be sure to specify the diagnosis on the claim</td>
</tr>
</tbody>
</table>

MEDICAL SUPPLIES AND EQUIPMENT; PROSTHESES AND ORTHOSES

Medical Equipment/Supplies

Providers must get authorization for all procedure codes listed in the Equipment and Supplies code list, where authorization is indicated, and the following general areas:

All wheelchairs: When purchased, rented beyond three months, or for use in nursing facilities.

Repairs to equipment when combined parts and labor exceeds $400.00. Specify who owns the equipment.

E1399 is the unspecified equipment code. This code is to be used only when no specific, descriptive HCPCS or DHS code is assigned. Refer to equipment guide.

Nutritional Products (enteral)

All enteral nutrition products except those for treatment of phenylketonuria, hyperlysinemia, and maple syrup urine disease, and given through a feeding tube require authorization after the first 30 days. See the Minnesota Health Care Programs Provider Manual for coverage standards and the Authorization chapter for submission by FAX, I.T.S./FAX or mail.

Prostheses and Orthoses

Providers must get authorization for prostheses and orthoses when the purchase or projected cumulative rental cost exceeds $3,000.

HEARING AIDS

Services in the following categories require authorization:

- the purchase of a noncontract hearing aid, including pocket talkers. (Indicate model number and manufacturer on form.)
- the provision of more than one hearing aid or hearing aid dispensing fee in a five-year period.
- purchase of a hearing aid when pure-tone average is less than 25 dB HL in an adult and less than 20 dB HL in a child.
DRUGS

The following drugs require authorization through the FAX, I.T.S./FAX or mail from. The following drugs require authorization from the first day of service, or as indicated. For authorization contact Care Delivery Management Incorporated (CDMI), M-F 8:00 am - 4:30 pm, metro: 651-662-5275, outstate: 1-888-878-0139, fax; 651-662-7459 ext. 25275.

Aciphex (rabeprazole)
Anzemet (dolasetron) [for more than 4 consecutive weeks of continuous treatment]
Botulinum Toxin Type A (Botox)
Botulinum Toxin, Type B (Myobloc)
Celebrex (celecoxib) [authorization is required for anyone under the age of 65]
Ceredase (alglucerase)
Interferon Alfa-n3 (Alferon N)
InterferonGamma-1b (Actimmune)
Kytril (granisetron) [for more than 4 consecutive weeks of continuous treatment]
Lansoprazole (Prevacid)
Omeprazole (Prilosec)
Ondansetron (Zofran) [for more than 4 consecutive weeks of continuous treatment]
Nexium (esomeprazole)
Vioxx (rofecoxib) [authorization required for anyone under the age of 65]
Zoloft (sertraline) 25mg.
Zoloft (sertraline) 50mg.

For services performed in physician office: (Authorization comes from physician)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0205</td>
<td>Alglucerase</td>
</tr>
<tr>
<td>J0585</td>
<td>Botulinum Toxin Type A</td>
</tr>
<tr>
<td>J0587</td>
<td>Botulinum Toxin Type B</td>
</tr>
<tr>
<td>J1260</td>
<td>Dolasetron [for more than 4 consecutive weeks of continuous treatment]</td>
</tr>
<tr>
<td>J1626</td>
<td>Granisetron [for more than 4 consecutive weeks of continuous treatment]</td>
</tr>
<tr>
<td>J9215</td>
<td>Interferon Alfa-n3</td>
</tr>
<tr>
<td>J9216</td>
<td>Interferon Gamma -1b</td>
</tr>
<tr>
<td>J2405</td>
<td>Ondansetron [for more than 4 consecutive weeks of continuous treatment]</td>
</tr>
<tr>
<td>S0091</td>
<td>Granisetron [for more than 4 consecutive weeks of continuous treatment]</td>
</tr>
<tr>
<td>S0174</td>
<td>Dolasetron [for more than 4 consecutive weeks of continuous treatment]</td>
</tr>
<tr>
<td>S0181</td>
<td>Ondansetron [for more than 4 consecutive weeks of continuous treatment]</td>
</tr>
<tr>
<td>Q0166</td>
<td>Granisetron [for more than 4 consecutive weeks of continuous treatment]</td>
</tr>
<tr>
<td>Q0179</td>
<td>Ondansetron [for more than 4 consecutive weeks of continuous treatment]</td>
</tr>
<tr>
<td>Q0180</td>
<td>Dolasetron [for more than 4 consecutive weeks of continuous treatment]</td>
</tr>
</tbody>
</table>

Authorization requests will not be accepted by CDMI for drugs which do not appear on the above list. How about “CDMI will not accept requests for drugs that do not appear above.”?
REHABILITATIVE SERVICES

OCCUPATIONAL THERAPY

Any combination of the following codes that exceed six units (to be consistent with the ones below):

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97003</td>
<td>Occupational therapy evaluation, initial</td>
</tr>
<tr>
<td>97004</td>
<td>Occupational therapy reevaluation, periodic</td>
</tr>
</tbody>
</table>

The following occupational therapy codes always require authorization:

- X4511 Unlisted occupational therapy
- 97150 Occupational therapy group sessions
- 97750 Physical performance test, functional capacity

Occupational therapy code requiring authorization:

- X5511 Occupational therapy supplies that exceed $32.00 per calendar year

Any combination of the following codes that exceed 50 hours (200 units):

- X4515 Occupational therapy, motor skills
- X4524 Occupational therapy, preventive skills
- X4526 Occupational therapy, therapeutic adaptions
- 97532 Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training)
- 97533 Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands
- 97535 Self care home management training, (e.g., Activities of Daily Living [ADL’s] compensatory training, meal preparation, safety procedures, and instruction in use of adaptive equipment)
- 97537 Community work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis)

PHYSICAL THERAPY

Any combination of the following codes that exceed eight units:

- 97001 Physical therapy evaluation, initial
- 97002 Physical therapy evaluation, periodic
Any combination of the following codes that exceed 30 hours (120 units):

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032</td>
<td>Electrical stimulation</td>
</tr>
<tr>
<td>97033</td>
<td>Iontophoresis</td>
</tr>
<tr>
<td>97034</td>
<td>Contrast baths</td>
</tr>
<tr>
<td>97035</td>
<td>Ultrasound</td>
</tr>
<tr>
<td>97036</td>
<td>Hubbard tank</td>
</tr>
<tr>
<td>97110</td>
<td>Therapeutic procedure, exercises</td>
</tr>
<tr>
<td>97112</td>
<td>Therapeutic procedure, neuromuscular</td>
</tr>
<tr>
<td>97113</td>
<td>Therapeutic procedure, aquatic therapy</td>
</tr>
<tr>
<td>97116</td>
<td>Therapeutic procedure, gait training</td>
</tr>
<tr>
<td>97124</td>
<td>Massage</td>
</tr>
<tr>
<td>97140</td>
<td>Manual therapy techniques (e.g., mobilization/</td>
</tr>
<tr>
<td></td>
<td>manipulation, manual lymphatic drainage, manual</td>
</tr>
<tr>
<td></td>
<td>traction), one or more regions</td>
</tr>
<tr>
<td>97504</td>
<td>Orthotics fitting and training; upper and lower</td>
</tr>
<tr>
<td></td>
<td>extremity</td>
</tr>
<tr>
<td>97520</td>
<td>Prosthetics, initial</td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic activities</td>
</tr>
<tr>
<td>97542</td>
<td>Wheelchair management propulsion training</td>
</tr>
<tr>
<td>97703</td>
<td>Checkout for orthotic/prosthetic use</td>
</tr>
<tr>
<td>X5515</td>
<td>PT wound care</td>
</tr>
</tbody>
</table>

Any combination of the following modalities that exceed 30 treatment sessions:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90901</td>
<td>Biofeedback training by any modality</td>
</tr>
<tr>
<td>97010</td>
<td>Hot or cold packs</td>
</tr>
<tr>
<td>97012</td>
<td>Traction</td>
</tr>
<tr>
<td>97014</td>
<td>Electric stimulation</td>
</tr>
<tr>
<td>97016</td>
<td>Vasopneumatic devices</td>
</tr>
<tr>
<td>97018</td>
<td>Paraffin bath</td>
</tr>
<tr>
<td>97020</td>
<td>Microwave</td>
</tr>
<tr>
<td>97022</td>
<td>Whirlpool</td>
</tr>
<tr>
<td>97024</td>
<td>Diathermy</td>
</tr>
<tr>
<td>97026</td>
<td>Infrared</td>
</tr>
<tr>
<td>97028</td>
<td>Ultraviolet</td>
</tr>
</tbody>
</table>

Any combination of the following codes that exceed two treatment sessions:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95831</td>
<td>Muscle testing, manual extremity (excluding hand) or trunk, with report</td>
</tr>
<tr>
<td>95832</td>
<td>Hand, with or without comparison with normal side</td>
</tr>
<tr>
<td>95833</td>
<td>Total evaluation of body, excluding hands</td>
</tr>
<tr>
<td>95834</td>
<td>Total evaluation of body, including hands</td>
</tr>
</tbody>
</table>
Any combination of the following codes that exceed 12 treatment sessions:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95851</td>
<td>Range of motion measurements and report; each extremity (excluding hand) or each trunk section (spine)</td>
</tr>
<tr>
<td>95852</td>
<td>Range of motion measurements and report; - hand with comparison to normal side</td>
</tr>
</tbody>
</table>

The following codes always require authorization:

- 97039 Unlisted modality
- 97139 Unlisted therapeutic procedure
- 97150 Therapeutic procedures, group, two or more persons
- 97545 Work hardening/conditioning; initial 2 hours
- 97546 Work hardening, additional hour
- 97750 Physical performance test or measurement (functional capacity)
- 97799 Unlisted physical med/rehab service

**SPEECH-LANGUAGE PATHOLOGY**

The following codes always require authorization:

- 92599 Unlisted otorhinolaryngological services
- G0198 Patient adaptation and training for use of speech generating devices
- G0201 Modification or training in use of voice prosthetic

The following codes require authorization as listed:

- V5362 Speech screening (articulation) that exceed four units.
- V5363 Language screening (receptive or expressive) that exceed four units.
- V5364 Dysphagia screening that exceed four units
- 92506 Medical evaluation of speech that exceed six units
- 92525 Evaluation of swallowing or oral function for feeding that exceed four units

Any combination of the following codes that exceed two (2) treatment sessions.

- G0197 Evaluation of patient for prescription of speech generating device.
- G0199 Re-evaluation of patient using speech generating device
- G0200 Evaluation of patient for prescription of voice prosthetic

Any combination of the following codes that exceed 50 hours (200 units):

- 92507 Individual speech, language and hearing treatment
- 92508 Group speech language or hearing treatment
- 92510 Aural rehab following cochlear implant
- 92526 Treatment of swallowing dysfunction and/or oral function for feeding
ALL OTHER SERVICES

The following health services require authorization:

all air ambulance transportation that originates or is to a destination outside of Minnesota.

ALS or BLS non-emergency ambulance trips in excess of six trips per month.

scheduled ground transportation provided outside of Minnesota.

partial hospitalization programs.

investigative health services and procedures

procedures that may be considered cosmetic. If staged reconstructive surgery is being proposed for correction of a congenital anomaly the complete plan for future surgeries must be submitted with the first authorization.

all surgical or behavioral modification services aimed specifically at weight reduction.

services provided outside of Minnesota. This requirement for prior authorization does not include services provided in a recipient's local trade area that would not require prior authorization if provided within Minnesota, emergency services, services needed because the recipient's health would be endangered if the recipient was required to return to Minnesota or services provided to children placed outside of Minnesota through the subsidized adoption assistance program under Minnesota Statutes, Section 256B.055, subdivision 1 or 2. Includes any transportation costs.

In addition, the following specific procedures and investigative procedures require authorization. There are two lists: specific procedures with HCPCS codes and a list for which no HCPCS code has been assigned.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4301</td>
<td>Implantable access total system, catheter, port reservoir (venous, arterial or epidural), percutaneous access.</td>
</tr>
<tr>
<td>E0751</td>
<td>Implantable pulse generator</td>
</tr>
<tr>
<td>E0782</td>
<td>Infusion pump, implantable</td>
</tr>
<tr>
<td>E0783</td>
<td>Programmable infusion pump</td>
</tr>
<tr>
<td>E0784</td>
<td>External ambulatory pump, insulin</td>
</tr>
<tr>
<td>E0144</td>
<td>Enclosed, framed folding walker, wheeled, with posterior seat</td>
</tr>
<tr>
<td>J1660</td>
<td>Histamine up to 2.75 Mg.</td>
</tr>
<tr>
<td>J9070</td>
<td>Cyclophosphamide, 100 Mg</td>
</tr>
<tr>
<td>J9092</td>
<td>Cyclophosphamide, 2.0 Gram</td>
</tr>
<tr>
<td>K0454</td>
<td>Nonpowered pressure mattress</td>
</tr>
<tr>
<td>L8614</td>
<td>Cochlear Device/system</td>
</tr>
<tr>
<td>Q0134</td>
<td>Collagen implant material</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>S0800</td>
<td>Laser in situ keratomileusis (lasik)</td>
</tr>
<tr>
<td>S0810</td>
<td>Photorefractive keratectomy (PRK)</td>
</tr>
<tr>
<td>S2109</td>
<td>Autologous chondrocyte transplantation (preparation of autologous cultured</td>
</tr>
<tr>
<td></td>
<td>chondrocytes)</td>
</tr>
<tr>
<td>S2052</td>
<td>Transplantation of small intestine allograft</td>
</tr>
<tr>
<td>S2053</td>
<td>Transplantation of small intestine and liver allografts</td>
</tr>
<tr>
<td>S8035</td>
<td>Magnetic source imaging (only used for pre-operative)</td>
</tr>
<tr>
<td>S9085</td>
<td>Medical Allograft transplantation</td>
</tr>
<tr>
<td>X0691*9</td>
<td>Day treatment, nervous and mental</td>
</tr>
<tr>
<td>X5254*22</td>
<td>Level I Mental Health Behavioral Aide</td>
</tr>
<tr>
<td>X5255*22</td>
<td>Level II Mental Health Behavioral Aide</td>
</tr>
<tr>
<td>X5257*22</td>
<td>Mental Health Crisis Intervention and Mental Health Stabilization</td>
</tr>
<tr>
<td>X5241*22</td>
<td>Therapeutic Components of Preschool Programs</td>
</tr>
<tr>
<td>X5317*15</td>
<td>Cognitive remediation training (1 to 3 clients)</td>
</tr>
<tr>
<td>X5318*15</td>
<td>Cognitive remediation training (4 to 9 clients)</td>
</tr>
<tr>
<td>X5330</td>
<td>Partial hospitalization program - adult</td>
</tr>
<tr>
<td>X5331</td>
<td>Partial hospitalization program - adolescent</td>
</tr>
<tr>
<td>X5535*16</td>
<td>Neuropsychological rehabilitation (individual)</td>
</tr>
<tr>
<td>X5536*17</td>
<td>Neuropsychological rehabilitation (group)</td>
</tr>
<tr>
<td>X5528*22</td>
<td>Crisis assistance in a family community support service program</td>
</tr>
<tr>
<td>X5538*22</td>
<td>Individual skills training in a home-based mental health, therapeutic</td>
</tr>
<tr>
<td></td>
<td>support of foster care, and family community support service program.</td>
</tr>
<tr>
<td>X5539*22</td>
<td>Family skills training in a home-based mental health, therapeutic support</td>
</tr>
<tr>
<td></td>
<td>of foster care, and family community support service program.</td>
</tr>
<tr>
<td>X5540*22</td>
<td>Group skills training in a home-based mental health, therapeutic support of</td>
</tr>
<tr>
<td></td>
<td>foster care, and family community support service program.</td>
</tr>
<tr>
<td>X5541*22</td>
<td>Travel in a home-based mental health, therapeutic support of foster care and</td>
</tr>
<tr>
<td></td>
<td>family community support service program</td>
</tr>
<tr>
<td>X5641*2</td>
<td>Private duty nursing by RN</td>
</tr>
<tr>
<td>X5642*2</td>
<td>Private duty nursing by LPN</td>
</tr>
<tr>
<td>X7010</td>
<td>ICF-MR and DAC special needs - service (review by Long-term Care Division)</td>
</tr>
<tr>
<td>X7020</td>
<td>ICF-MR and DAC special needs - equipment (review by Long-term Care Division)</td>
</tr>
<tr>
<td>11920</td>
<td>Tattooing, intradermal introduction of insoluble opaque pigments to correct color</td>
</tr>
<tr>
<td></td>
<td>defects of skin, including micro pigmentation; 6.0 sq cm or less</td>
</tr>
<tr>
<td>11921</td>
<td>6.1 to 20.0 sq cm</td>
</tr>
<tr>
<td>11922</td>
<td>Each additional 20.0 sq cm</td>
</tr>
<tr>
<td>11950</td>
<td>Subcutaneous injection of &quot;filling&quot; material (e.g., collagen); 1 cc or less</td>
</tr>
<tr>
<td>11951</td>
<td>1.1 to 5 cc</td>
</tr>
<tr>
<td>11952</td>
<td>5.1 to 10 cc</td>
</tr>
<tr>
<td>11954</td>
<td>Over 10 cc</td>
</tr>
<tr>
<td>11450</td>
<td>Excision of skin and subcutaneous tissue for hidradenitis, axillary; with</td>
</tr>
<tr>
<td></td>
<td>simple or intermediate repair</td>
</tr>
<tr>
<td>11451</td>
<td>With complex repair</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>11462</td>
<td>Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair</td>
</tr>
<tr>
<td>11463</td>
<td>With complex repair</td>
</tr>
<tr>
<td>11470</td>
<td>Excision of skin and subcutaneous tissue for hidradenitis; perianal, perineal, or umbilical; with simple or intermediate repair</td>
</tr>
<tr>
<td>11471</td>
<td>With complex repair</td>
</tr>
<tr>
<td>15775</td>
<td>Punch graft for hair transplant; 1 to 15 punch grafts</td>
</tr>
<tr>
<td>15776</td>
<td>More than 15 punch grafts</td>
</tr>
<tr>
<td>15780</td>
<td>Dermabrasion of skin</td>
</tr>
<tr>
<td>15781</td>
<td>Less than total face</td>
</tr>
<tr>
<td>15782</td>
<td>Regional</td>
</tr>
<tr>
<td>15783</td>
<td>Superficial, any site (e.g., tattoo removal)</td>
</tr>
<tr>
<td>15786</td>
<td>Abrasion; single lesion</td>
</tr>
<tr>
<td>15787</td>
<td>Each additional four lesions or less</td>
</tr>
<tr>
<td>15788</td>
<td>Chemical peel, facial; epidermal</td>
</tr>
<tr>
<td>15789</td>
<td>Facial; dermal</td>
</tr>
<tr>
<td>15792</td>
<td>Non-facial; epidermal</td>
</tr>
<tr>
<td>15793</td>
<td>Non-facial; dermal</td>
</tr>
<tr>
<td>15810</td>
<td>Salabrasion; 20 sq. cm or less</td>
</tr>
<tr>
<td>15811</td>
<td>Over 20 sq. cm</td>
</tr>
<tr>
<td>15819</td>
<td>Plastic surgery neck cervicoplasty</td>
</tr>
<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid</td>
</tr>
<tr>
<td>15821</td>
<td>With extensive herniated fat pad</td>
</tr>
<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid</td>
</tr>
<tr>
<td>15823</td>
<td>With excessive skin weighing down lid</td>
</tr>
<tr>
<td>15824</td>
<td>Rhytidectomy; forehead</td>
</tr>
<tr>
<td>15825</td>
<td>Neck with platysmal tightening (platysmal flap, &quot;P-flap&quot;)</td>
</tr>
<tr>
<td>15826</td>
<td>Glabellar frown lines</td>
</tr>
<tr>
<td>15828</td>
<td>Cheek, chin and neck</td>
</tr>
<tr>
<td>15829</td>
<td>Removal of skin wrinkles RHYTIDECTOMY</td>
</tr>
<tr>
<td>15831</td>
<td>Excision, excessive skin and subcutaneous tissue (including lipectomy), abdomen (abdominoplasty)</td>
</tr>
<tr>
<td>15832</td>
<td>Thigh</td>
</tr>
<tr>
<td>15833</td>
<td>Leg</td>
</tr>
<tr>
<td>15834</td>
<td>Hip</td>
</tr>
<tr>
<td>15835</td>
<td>Buttock</td>
</tr>
<tr>
<td>15836</td>
<td>Arm</td>
</tr>
<tr>
<td>15837</td>
<td>Forearm or hand</td>
</tr>
<tr>
<td>15838</td>
<td>Submental fat pad</td>
</tr>
<tr>
<td>15839</td>
<td>Other area</td>
</tr>
<tr>
<td>15876</td>
<td>Suction assisted lipectomy, head and neck</td>
</tr>
<tr>
<td>15877</td>
<td>Trunk</td>
</tr>
<tr>
<td>15878</td>
<td>Suction assisted lipectomy, upper extremity</td>
</tr>
<tr>
<td>15879</td>
<td>Lower extremity</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17106*24</td>
<td>Destruction of cutaneous vascular proliferative lesions (e.g. laser technique); less than 10 sq. cm</td>
</tr>
<tr>
<td>17107*24</td>
<td>10.0 - 50.0 sq. cm</td>
</tr>
<tr>
<td>17108*24</td>
<td>Over 50.0 sq. cm</td>
</tr>
<tr>
<td>17380</td>
<td>Electrolysis epilation, each 1/2 hour</td>
</tr>
<tr>
<td>19140</td>
<td>Mastectomy for gynecomastia through circumareolar or other incision</td>
</tr>
<tr>
<td>19182</td>
<td>Subcutaneous mastectomy</td>
</tr>
<tr>
<td>19316</td>
<td>Mastopexy</td>
</tr>
<tr>
<td>19318</td>
<td>Reduction mammaplasty</td>
</tr>
<tr>
<td>19324</td>
<td>Mammaplasty, augmentation without prosthetic implant</td>
</tr>
<tr>
<td>19325</td>
<td>With prosthetic implant</td>
</tr>
<tr>
<td>19328</td>
<td>Removal of intact mammary implant</td>
</tr>
<tr>
<td>19355</td>
<td>Correction of inverted nipples</td>
</tr>
<tr>
<td>20550*25</td>
<td>Injection, tendon sheath, ligament, trigger point or ganglion cyst</td>
</tr>
<tr>
<td>20975</td>
<td>Electrical stimulation to bone healing invasive (operative)</td>
</tr>
<tr>
<td>21010</td>
<td>Arthrotomy, temporomandibular joint</td>
</tr>
<tr>
<td>21050</td>
<td>Condylectomy, temporomandibular joint (separate procedure)</td>
</tr>
<tr>
<td>21060</td>
<td>Meniscectomy, temporomandibular</td>
</tr>
<tr>
<td>21070</td>
<td>Coronoidectomy (separate procedure)</td>
</tr>
<tr>
<td>21085</td>
<td>Impression and custom preparation; oral surgical splint</td>
</tr>
<tr>
<td>21110</td>
<td>Application of interdental fixation device, includes removal</td>
</tr>
<tr>
<td>21137</td>
<td>Reduction forehead; contouring only</td>
</tr>
<tr>
<td>21138</td>
<td>Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)</td>
</tr>
<tr>
<td>21139</td>
<td>Reduction forehead; contouring and setback of anterior frontal sinus wall</td>
</tr>
<tr>
<td>21141</td>
<td>Reconstruction midface, Lefort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft</td>
</tr>
<tr>
<td>21142</td>
<td>Two pieces, segment movement in any</td>
</tr>
<tr>
<td>21143</td>
<td>Three or more pieces, segment movement in any direction, without bone graft</td>
</tr>
<tr>
<td>21145</td>
<td>Reconstruction midface, Lefort I; single piece, any direction, requiring bone grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21146</td>
<td>Reconstruction midface, Lefort I; two pieces, any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)</td>
</tr>
<tr>
<td>21147</td>
<td>Reconstruction midface, Lefort I; three or more pieces, any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)</td>
</tr>
<tr>
<td>21150</td>
<td>Reconstruction midface, Lefort II; anterior intrusion (e.g., Treacher-Collins syndrome)</td>
</tr>
<tr>
<td>21151</td>
<td>Reconstruction midface, Lefort II; any direction, requiring bone grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21154</td>
<td>Reconstruction midface, Lefort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without Lefort I</td>
</tr>
<tr>
<td>21155</td>
<td>Reconstruction midface, Lefort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with Lefort I</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>21159</td>
<td>Reconstruction midface, Lefort III (extra and intracranial), with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without Lefort I</td>
</tr>
<tr>
<td>21160</td>
<td>Reconstruction midface, Lefort III (extra and intracranial), with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); with Lefort I</td>
</tr>
<tr>
<td>21172</td>
<td>Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21175</td>
<td>Reconstruction bifrontal, superior-lateral orbital rims and lower forehead, advancement or alternation (e.g. plagioccephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21179</td>
<td>Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)</td>
</tr>
<tr>
<td>21180</td>
<td>Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)</td>
</tr>
<tr>
<td>21181</td>
<td>Removal by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial</td>
</tr>
<tr>
<td>21182</td>
<td>Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra-and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 cm²</td>
</tr>
<tr>
<td>21183</td>
<td>Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra-and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 cm², but less than 80 cm²</td>
</tr>
<tr>
<td>21184</td>
<td>Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra-and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 cm²</td>
</tr>
<tr>
<td>21188</td>
<td>Reconstruction midface, osteotomies (other than Lefort type) and bone grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21193</td>
<td>Reconstruction of mandibular ramus, horizontal, vertical, &quot;c&quot; or &quot;l&quot; osteotomy; without bone graft</td>
</tr>
<tr>
<td>21194</td>
<td>Reconstruction of mandibular ramus, horizontal, vertical, &quot;c&quot; or &quot;l&quot; osteotomy; with bone graft</td>
</tr>
<tr>
<td>21195</td>
<td>Reconstruction of mandibular ramus, sagittal split; without internal rigid fixation</td>
</tr>
<tr>
<td>21196</td>
<td>Reconstruction of mandibular ramus, sagittal split; with internal rigid fixation</td>
</tr>
<tr>
<td>21198</td>
<td>Osteotomy, mandible, segmental</td>
</tr>
<tr>
<td>21206</td>
<td>Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)</td>
</tr>
<tr>
<td>21208</td>
<td>Osteoplasty, facial bones; augmentation (autograft, or prosthetic implant)</td>
</tr>
<tr>
<td>21209</td>
<td>Osteoplasty, facial bones; reduction</td>
</tr>
<tr>
<td>21240</td>
<td>Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>21242</td>
<td>Arthroplasty, temporomandibular joint, with allograft</td>
</tr>
<tr>
<td>21243</td>
<td>Arthroplasty, temporomandibular joint with prosthetic joint replacement</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>21244</td>
<td>Reconstruction of mandible, extraoral, with transosteal bone plate</td>
</tr>
<tr>
<td>21245</td>
<td>Reconstruction of mandible or maxilla, subperiosteal implant, partial</td>
</tr>
<tr>
<td>21246</td>
<td>Reconstruction of mandible or maxilla, subperiosteal implant, complete</td>
</tr>
<tr>
<td>21247</td>
<td>Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)</td>
</tr>
<tr>
<td>21248</td>
<td>Reconstruction of mandible or maxilla, endosteal implant, partial</td>
</tr>
<tr>
<td>21249</td>
<td>Complete</td>
</tr>
<tr>
<td>21255</td>
<td>Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)</td>
</tr>
<tr>
<td>21256</td>
<td>Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., microphthalmia)</td>
</tr>
<tr>
<td>21299</td>
<td>Unlisted craniofacial and maxillofacial procedure</td>
</tr>
<tr>
<td>21260</td>
<td>Periorbital osteotomies for orbital hypertelorism</td>
</tr>
<tr>
<td>21261</td>
<td>Combined intra and extracranial approach</td>
</tr>
<tr>
<td>21263</td>
<td>With forehead advancement</td>
</tr>
<tr>
<td>21267</td>
<td>Orbit repositioning</td>
</tr>
<tr>
<td>21268</td>
<td>Combined intra and extracranial approach</td>
</tr>
<tr>
<td>21270</td>
<td>Malar augmentation, prosthetic material</td>
</tr>
<tr>
<td>21275</td>
<td>Secondary revision of orbitocraniofacial reconstruction</td>
</tr>
<tr>
<td>21462*7</td>
<td>Open treatment of closed or open mandibular fracture, with interdental fixation</td>
</tr>
<tr>
<td>21485</td>
<td>Complicated manipulative treatment of TMJ dislocation, initial or subsequent</td>
</tr>
<tr>
<td>29800</td>
<td>Arthoscopy/Arthroscopic Surgery for treatment of TMJ (when used for diagnosis only)</td>
</tr>
<tr>
<td>29804</td>
<td>Arthoscopy/Arthroscopic Surgery for treatment of TMJ (when used for diagnosis only)</td>
</tr>
<tr>
<td>30120</td>
<td>Excision or surgical planing of skin of nose</td>
</tr>
<tr>
<td>30400</td>
<td>Rhinoplasty, primary</td>
</tr>
<tr>
<td>30410</td>
<td>Complete</td>
</tr>
<tr>
<td>30420</td>
<td>Including major septal repair</td>
</tr>
<tr>
<td>30430</td>
<td>Rhinoplasty, secondary</td>
</tr>
<tr>
<td>30435</td>
<td>Intermediate</td>
</tr>
<tr>
<td>30450</td>
<td>Major revision</td>
</tr>
<tr>
<td>32491</td>
<td>Removal of lung other than pneumonectomy; excision/pliction of emphysematous lung(s) (bullous or non bullous) for lung volume reduction. Sternal split or transthracic approach with or without any pleural.</td>
</tr>
<tr>
<td>32851</td>
<td>Lung transplant, single; without cardiopulmonary bypass</td>
</tr>
<tr>
<td>32852</td>
<td>With cardiopulmonary bypass</td>
</tr>
<tr>
<td>32853</td>
<td>Double (bilateral sequential or en bloc); without cardiopulmonary bypass</td>
</tr>
<tr>
<td>32854</td>
<td>Double (bilateral sequential or en bloc); with cardiopulmonary bypass</td>
</tr>
<tr>
<td>33140</td>
<td>Transmyocardial laser recvascularization (a laser probe is used to create a channel through the heart muscle into the left vent.)</td>
</tr>
<tr>
<td>33935</td>
<td>Heart-lung transplant with recipient cardiectomy, pneumonectomy</td>
</tr>
<tr>
<td>33945</td>
<td>Heart transplant</td>
</tr>
<tr>
<td>33975</td>
<td>Implantation of ventricular assist device, single ventricle</td>
</tr>
<tr>
<td>33976</td>
<td>Implantation of ventricular assist device, biventricular support</td>
</tr>
<tr>
<td>33999</td>
<td>Unlisted cardiac procedure</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>35400</td>
<td>Angioscopy</td>
</tr>
<tr>
<td>36468</td>
<td>Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk</td>
</tr>
<tr>
<td>36469</td>
<td>Face</td>
</tr>
<tr>
<td>36470</td>
<td>Injection of sclerosing solution; single vein</td>
</tr>
<tr>
<td>36471</td>
<td>Multiple veins, same leg</td>
</tr>
<tr>
<td>36520</td>
<td>Therapeutic apheresis, plasma and/or cell exchange</td>
</tr>
<tr>
<td>36530</td>
<td>Insertion of implantable intravenous infusion pump</td>
</tr>
<tr>
<td>37788</td>
<td>Penile revascularization, artery</td>
</tr>
<tr>
<td>37790</td>
<td>Penile venous occlusive procedure</td>
</tr>
<tr>
<td>38230</td>
<td>Bone Marrow harvesting for transplant</td>
</tr>
<tr>
<td>38231</td>
<td>Blood-derived peripheral stem cell harvesting for transplantation per collection</td>
</tr>
<tr>
<td>38240</td>
<td>Bone marrow transplant, allogenic</td>
</tr>
<tr>
<td>38241</td>
<td>Bone marrow transplant, autologous</td>
</tr>
<tr>
<td>42140</td>
<td>Uvulectomy, excision of uvula</td>
</tr>
<tr>
<td>42145</td>
<td>Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty)</td>
</tr>
<tr>
<td>43842</td>
<td>Gastroplasty, vertical-banded, for morbid obesity</td>
</tr>
<tr>
<td>43843</td>
<td>Gastroplasty, other than vertical-banded, for morbid obesity</td>
</tr>
<tr>
<td>43846</td>
<td>Gastric restrictive procedure, with gastric bypass for morbid obesity with short limb (less than 100 cm) Roux-en-Y gastroenterostomy</td>
</tr>
<tr>
<td>43847</td>
<td>Gastric restriction procedure, with gastric bypass for morbid obesity</td>
</tr>
<tr>
<td>43848</td>
<td>Revision of gastric restriction procedure for morbid obesity (separate procedure)</td>
</tr>
<tr>
<td>43850</td>
<td>Revision of gastroduodenal anastomosis with reconstruction; without vagotomy</td>
</tr>
<tr>
<td>43855</td>
<td>With vagotomy</td>
</tr>
<tr>
<td>43860</td>
<td>Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction; without vagotomy</td>
</tr>
<tr>
<td>43865</td>
<td>With vagotomy</td>
</tr>
<tr>
<td>44130</td>
<td>Enterenterostomy, anastomosis of intestine; with or without cutaneous enterostomy (separate procedure)</td>
</tr>
<tr>
<td>44132</td>
<td>Donor enterectomy, open, with preparation and maintenance of allograft; from cadaver donor</td>
</tr>
<tr>
<td>44133</td>
<td>Donor enterectomy, open, with preparation and maintenance of allograft; from cadaver donor</td>
</tr>
<tr>
<td>44135</td>
<td>Intestinal allotransplantation; from cadaver donor</td>
</tr>
<tr>
<td>44136</td>
<td>Intestinal allotransplantation; from living donor</td>
</tr>
<tr>
<td>47135</td>
<td>Liver transplant, with or without recipient heptectomy</td>
</tr>
<tr>
<td>47136</td>
<td>Liver allotransplantation, heterotoxic, partial or whole, from cadaver or living donor any age</td>
</tr>
<tr>
<td>47620</td>
<td>Cholecystectomy with transduodenal sphincterotomy or sphincteroplasty,</td>
</tr>
<tr>
<td>48160</td>
<td>Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islets</td>
</tr>
<tr>
<td>48554</td>
<td>Transplantation of pancreatic allograft</td>
</tr>
<tr>
<td>51715</td>
<td>Endoscopic injection of implant material into submucosal tissues of the urethra</td>
</tr>
<tr>
<td>52510</td>
<td>Transurethral balloon dilation of prostatic urethra, any method</td>
</tr>
<tr>
<td>54400</td>
<td>Insertion of penile prosthesis; non-inflatable, semi-rigid.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>54401</td>
<td>Inflatable, self contained</td>
</tr>
<tr>
<td>54405</td>
<td>Insertion of inflatable penile prosthesis</td>
</tr>
<tr>
<td>54660</td>
<td>Insertion of testicular prosthesis</td>
</tr>
<tr>
<td>55970</td>
<td>Intersex surgery; male to female</td>
</tr>
<tr>
<td>55980</td>
<td>Female to male</td>
</tr>
<tr>
<td>58345</td>
<td>Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography. Investigative when used for performing assisted reproductive procedures and managing ectopic pregnancy.</td>
</tr>
<tr>
<td>61770</td>
<td>Stereotactic localization, or any method, including burr hole(s), with insertion of catheter(s) for brachytherapy (for Parkinsonism)</td>
</tr>
<tr>
<td>61850</td>
<td>Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cerebral; cortical</td>
</tr>
<tr>
<td>61855</td>
<td>Subcortical</td>
</tr>
<tr>
<td>61860</td>
<td>Cranietctomy or craniotomy for implantation of neurostimulator electrodes; cerebral; cortical</td>
</tr>
<tr>
<td>61862</td>
<td>Twist drill, burr hole, craniotomy, or craniectomy for stereo tactic implantation of one neurostimulator array in subcortical site (e.g. thalamus, globus palliduis, subthalamic nucleus, preiventricular, periaqueductal gray)</td>
</tr>
<tr>
<td>61865</td>
<td>Subcortical</td>
</tr>
<tr>
<td>61870</td>
<td>Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical</td>
</tr>
<tr>
<td>61875</td>
<td>Subcortical</td>
</tr>
<tr>
<td>61885</td>
<td>Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling.</td>
</tr>
<tr>
<td>61886</td>
<td>Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays.</td>
</tr>
<tr>
<td>62350</td>
<td>Implantation, revision or repositioning of intrathecal or epidural catheter</td>
</tr>
<tr>
<td>62351</td>
<td>Insertion or replacement, subarachnoid or epidural catheter, with resevoir and/or pump for intermittent or continuous infusion of drug, including laminectomy</td>
</tr>
<tr>
<td>62360</td>
<td>Implantation or replacement of device for intrathecal or epidural drug</td>
</tr>
<tr>
<td>62361</td>
<td>Implantation or replacement of device for intrathecal epidural drug</td>
</tr>
<tr>
<td>62362</td>
<td>Implantation or replacement of programmable pump for intrathecal or epidural,</td>
</tr>
<tr>
<td>63185</td>
<td>Laminectomy with rhizotomy; 1 or 2 segments</td>
</tr>
<tr>
<td>63190</td>
<td>Laminectomy with rhizotomy; more than 2 segments</td>
</tr>
<tr>
<td>63650</td>
<td>Percutaneous implantation of neurostimulator electrodes; epidural</td>
</tr>
<tr>
<td>63655</td>
<td>Laminectomy for implantation of neurostimulator electrodes</td>
</tr>
<tr>
<td>63685</td>
<td>Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling</td>
</tr>
<tr>
<td>64553</td>
<td>Percutaneous implantation of neurostimulator electrodes; cranial nerve</td>
</tr>
<tr>
<td>64555</td>
<td>Peripheral nerve</td>
</tr>
<tr>
<td>64560</td>
<td>Autonomic nerve</td>
</tr>
<tr>
<td>64561</td>
<td>Percutaneous implantation of neurostimulator electrodes; sacral nerve</td>
</tr>
<tr>
<td>64565</td>
<td>Neuromuscular</td>
</tr>
<tr>
<td>64573</td>
<td>Incision for implantation of neurostimulator electrodes; cranial nerve</td>
</tr>
<tr>
<td>64575</td>
<td>Peripheral nerve</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>64577</td>
<td>Autonomic nerve</td>
</tr>
<tr>
<td>64580</td>
<td>Neuromuscular</td>
</tr>
<tr>
<td>64581</td>
<td>Implant neuroelectrodes</td>
</tr>
<tr>
<td>64590</td>
<td>Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling</td>
</tr>
<tr>
<td>64612*8</td>
<td>Destruction by neurolytic agent (chemodenervation of muscle endplate); muscles enervated by facial nerve</td>
</tr>
<tr>
<td>64613*8</td>
<td>Cervical spinal muscles</td>
</tr>
<tr>
<td>65760</td>
<td>Keratomileusis PA is B with specific ICD-9 coding</td>
</tr>
<tr>
<td>65765</td>
<td>Keratophakia PA is B with specific ICD-9 coding</td>
</tr>
<tr>
<td>65767</td>
<td>Epikeratoplasty PA is B with specific ICD-9 coding</td>
</tr>
<tr>
<td>65770</td>
<td>Keratoprosthesis</td>
</tr>
<tr>
<td>65771</td>
<td>Radial keratotomy</td>
</tr>
<tr>
<td>65772</td>
<td>Corneal relaxing incision for correction of surgically induced astigmatism</td>
</tr>
<tr>
<td>65775</td>
<td>Corneal wedge resection for correction of surgically induced astigmatism</td>
</tr>
<tr>
<td>67345</td>
<td>Chemodenervation of extraocular muscle</td>
</tr>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
</tr>
<tr>
<td>67901</td>
<td>Repair blepharoptosis, frontalis muscle technique with suture</td>
</tr>
<tr>
<td>67902</td>
<td>Frontalis muscle technique with fascial sling</td>
</tr>
<tr>
<td>67903</td>
<td>(Tarso) levator resection or advancement, internal approach</td>
</tr>
<tr>
<td>67904</td>
<td>(Tarso) levator resection or advancement, external approach</td>
</tr>
<tr>
<td>67906</td>
<td>Superior rectus technique with fascial sling</td>
</tr>
<tr>
<td>67909</td>
<td>Reduction of overcorrection of ptosis</td>
</tr>
<tr>
<td>67911</td>
<td>Correction of lid retraction</td>
</tr>
<tr>
<td>69300</td>
<td>Otoplasty, protruding ear, with or without size reduction</td>
</tr>
<tr>
<td>69710</td>
<td>Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone</td>
</tr>
<tr>
<td>69711</td>
<td>Removal or repair of electromagnetic bone conduction hearing device in temporal bone.</td>
</tr>
<tr>
<td>69714</td>
<td>Implantation, osseointegrated implant, temporal bone, with percutaneios</td>
</tr>
<tr>
<td>69715</td>
<td>Implantation, osseointegrated implant temporal with percutaneous</td>
</tr>
<tr>
<td>69717</td>
<td>Replacement (including removal of existing device), osseointegrated implant</td>
</tr>
<tr>
<td>69718</td>
<td>Replacement (including removal of existing device), osseointegrated implant</td>
</tr>
<tr>
<td>69930</td>
<td>Cochlear implant</td>
</tr>
<tr>
<td>G0032</td>
<td>PET myocardial perfusion imaging, (following rest spect, 78464); single study, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0033</td>
<td>PET myocardial perfusion imaging, (following rest spect, 78464); multiple studies, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0034</td>
<td>PET myocardial perfusion imaging, (following rest spect, 78465); single study, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0035</td>
<td>PET myocardial perfusion imaging, (following rest spect, 78465); multiple studies, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0036</td>
<td>PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); single study, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
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<td>----------</td>
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</tr>
<tr>
<td>G0037</td>
<td>PET myocardial perfusion imaging. (Following coronary angiography, 93510-93529); multiple studies, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0038</td>
<td>PET myocardial imaging, (following stress planar myocardial perfusion, 78460); single study, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0039</td>
<td>PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460); multiple studies, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0040</td>
<td>PET myocardial perfusion imaging, (following stress echocardiogram, 93350); single study, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0041</td>
<td>PET myocardial perfusion imaging, (following stress echocardiogram, 93350.)</td>
</tr>
<tr>
<td>G0042</td>
<td>PET myocardial perfusion (following stress ventriculogram, 78481 or 78483); single study, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0043</td>
<td>PET myocardial perfusion imaging, (following stress ventriculogram, 78481 or 78483); multiple studies, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0044</td>
<td>PET myocardial perfusion imaging, (following rest ECG, 93000); single study, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0045</td>
<td>PET myocardial perfusion imaging (following rest ECG,93000); multile studies, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0046</td>
<td>PET myocardial perfusion imaging, (following rest ECG, 93015); single study, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0047</td>
<td>PET myocardial perfusion imaging (following rest ECG, 93015); multiple studies, rest or stress (exercise and/or pharmacologic).</td>
</tr>
<tr>
<td>G0125</td>
<td>PET lung imaging of solitary pulmonary nodules following CT (7125, 71260 or 71270)</td>
</tr>
<tr>
<td>G0126</td>
<td>PET lung imaging of solitary pulmonary nodules using 2 fluoro (FD6) following CT (71250, 71260, 71270) initial staging of pathologically diagnosed non-small cell lung cancer.</td>
</tr>
<tr>
<td>G0160</td>
<td>Cryosurgical ablation of localized prostate cancer, primary treatment only (post operative irrigations and aspiration of sloughing tissue included)</td>
</tr>
<tr>
<td>G0166</td>
<td>External counterpulsation, per treatment session</td>
</tr>
<tr>
<td>71555</td>
<td>Magnetic resonance angiography chest</td>
</tr>
<tr>
<td>72159</td>
<td>Magnetic resonance angiography spinal canal and contents</td>
</tr>
<tr>
<td>72198</td>
<td>Magnetic resonance angiography pelvis</td>
</tr>
<tr>
<td>73225</td>
<td>Magnetic resonance angiography, upper extremity, with or without contrast materials.</td>
</tr>
<tr>
<td>73725</td>
<td>Magnetic resonance angiography lower extremity, with or without contrast materials.</td>
</tr>
<tr>
<td>74185</td>
<td>Magnetic resonance angiography abdomen, with or without contrast materials.</td>
</tr>
<tr>
<td>75552</td>
<td>Cardiac magnetic resonance imaging for function, complete study</td>
</tr>
<tr>
<td>76070*26</td>
<td>Computerized tomography, bone density study.</td>
</tr>
<tr>
<td>76075*27</td>
<td>Dual energy X-ray absorptiometry (DEXNA), bone density study.</td>
</tr>
<tr>
<td>76076*28</td>
<td>Dual energy X-ray absorptiometry (DEXA), bone density study, one or more sites.</td>
</tr>
<tr>
<td>76390</td>
<td>Magnetic resonance spectroscopy (for magnetic resonance imaging, use appropriate MRI body site code)</td>
</tr>
<tr>
<td>77605</td>
<td>Hyperthermia, externally generated , superficial deep</td>
</tr>
<tr>
<td>77610</td>
<td>Hyperthermia generated by intestinal probe, 5 or fewer</td>
</tr>
<tr>
<td>77615</td>
<td>Hyperthermia generated by intestinal probe, 5 or greater</td>
</tr>
<tr>
<td>77620</td>
<td>Hyperthermia generated by intracavitary probes</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>78459</td>
<td>MRI, positron emission tomography (PET), metabolic evaluation</td>
</tr>
<tr>
<td>78491</td>
<td>MRI, positron emission tomography (PET), perfusion; single study at rest or stress</td>
</tr>
<tr>
<td>78492</td>
<td>MRI, positron tomography (PET), perfusion; multiple studies at rest or stress</td>
</tr>
<tr>
<td>78496</td>
<td>Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique.</td>
</tr>
<tr>
<td>78608</td>
<td>PET scan; metabolic evaluation</td>
</tr>
<tr>
<td>78609</td>
<td>Brain Imaging (PET) positron emission tomography</td>
</tr>
<tr>
<td>78810</td>
<td>Tumor imaging, positron emission tomography (PET), metabolic evaluation</td>
</tr>
<tr>
<td>82175</td>
<td>Arsenic</td>
</tr>
<tr>
<td>83015</td>
<td>Heavy metal screen</td>
</tr>
<tr>
<td>83018</td>
<td>Heavy metal screen, quantitative, each</td>
</tr>
<tr>
<td>86343</td>
<td>Leukocyte histamine release test (LHR)</td>
</tr>
<tr>
<td>90799</td>
<td>Unlisted Therapeutic, Prophylactic or Diagnostic Injection</td>
</tr>
<tr>
<td>90802*14</td>
<td>Interactive diagnostic assessment</td>
</tr>
<tr>
<td>90804*4</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, 20-30 minutes face to face with patient.</td>
</tr>
<tr>
<td>90805*4</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, 20-30 minutes face to face with patient; with medical evaluation and management services</td>
</tr>
<tr>
<td>90806*4,22</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, 45-50 minutes face to face with patient</td>
</tr>
<tr>
<td>90807*4,22</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, 45-50 minutes face to face with patient; with medical evaluation and management services</td>
</tr>
<tr>
<td>90808*4,22</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, 75-80 minutes face to face with patient;</td>
</tr>
<tr>
<td>90809*4,22</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, 75-80 minutes face to face with the patient; with medical evaluation and management services</td>
</tr>
<tr>
<td>90810*14</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communications, in an office or outpatient facility, 20-30 minutes face to face with patient</td>
</tr>
<tr>
<td>90811*14</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, 20-30 minutes face to face with patient; with medical evaluation and management services</td>
</tr>
<tr>
<td>90812*14</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, 45-50 minutes face to face with patient</td>
</tr>
<tr>
<td>90813*14</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, 45-50 minutes face to face with patient, with medical evaluation and management services</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<td>----------</td>
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</tr>
<tr>
<td>90814*14</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, 75-80 minutes face to face with patient</td>
</tr>
<tr>
<td>90815*14</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, 75-80 minutes face to face with patient with medical evaluation and management services</td>
</tr>
<tr>
<td>90816*29</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face to face with the patient;</td>
</tr>
<tr>
<td>90817*29</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face to face with the patient; with medical evaluation and management services;</td>
</tr>
<tr>
<td>90818*29</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face to face with the patient;</td>
</tr>
<tr>
<td>90819*29</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face to face with the patient; with medical evaluation and management services;</td>
</tr>
<tr>
<td>90821*29</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face to face with the patient;</td>
</tr>
<tr>
<td>90822*29</td>
<td>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face to face with the patient; with medical evaluation and management services;</td>
</tr>
<tr>
<td>90823*29</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient, partial hospital or residential care setting, approximately 20 to 30 minutes face to face with the patient;</td>
</tr>
<tr>
<td>90824*29</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient, partial hospital or residential care setting, approximately 20 to 30 minutes face to face with the patient; with medical evaluation and management services</td>
</tr>
<tr>
<td>90826*29</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient, partial hospital or residential care setting, approximately 45 to 50 minutes face to face with the patient;</td>
</tr>
<tr>
<td>90827*29</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient, partial hospital or residential care setting, approximately 45 to 50 minutes face to face with the patient; with medical evaluation and management services</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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</tr>
<tr>
<td>90828*29</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient, partial hospital or residential care setting, approximately 75 to 80 minutes face to face with the patient;</td>
</tr>
<tr>
<td>90829*29</td>
<td>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient, partial hospital or residential care setting, approximately 75 to 80 minutes face to face with the patient; with medical evaluation and management services</td>
</tr>
<tr>
<td>90846*4,22</td>
<td>Family psychotherapy (without the patient present)</td>
</tr>
<tr>
<td>90847*4,22</td>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present)</td>
</tr>
<tr>
<td>90853*14</td>
<td>Group therapy (other than of a multiple-family group)</td>
</tr>
<tr>
<td>90857*14</td>
<td>Interactive group psychotherapy</td>
</tr>
<tr>
<td>90875*4</td>
<td>Individual psychophysiological therapy incorporating biofeedback training by any modality (face to face) with the patient and, with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 20-30 minutes</td>
</tr>
<tr>
<td>90899</td>
<td>Unlisted psychiatric service or procedure</td>
</tr>
<tr>
<td>90911</td>
<td>Biofeedback training, perineal muscle, anorectal or urethral sphincter, including EMG.</td>
</tr>
<tr>
<td>92065</td>
<td>Orthoptic and/or pleoptic training, with continue medical direction</td>
</tr>
<tr>
<td>92512</td>
<td>Nasal function studies (rhinomanometry)</td>
</tr>
<tr>
<td>92598</td>
<td>Modification of voice prosthetic or augmentative/alternative communication device</td>
</tr>
<tr>
<td>92599</td>
<td>Unlisted otorhinolaryngological services</td>
</tr>
<tr>
<td>92987</td>
<td>Percutaneous Transluminal Coronary Angioplasty mitral valve</td>
</tr>
<tr>
<td>92982</td>
<td>Angioplasty Laser</td>
</tr>
<tr>
<td>92984</td>
<td>Angioplasty Laser</td>
</tr>
<tr>
<td>93278</td>
<td>Signal-Averaged ECG</td>
</tr>
<tr>
<td>93760</td>
<td>Thermography</td>
</tr>
<tr>
<td>93762</td>
<td>Thermography</td>
</tr>
<tr>
<td>93784</td>
<td>Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording scanning analysis, interpretation and report</td>
</tr>
<tr>
<td>93786</td>
<td>Recording only</td>
</tr>
<tr>
<td>93788</td>
<td>Scanning analysis with report</td>
</tr>
<tr>
<td>93790</td>
<td>Physician review with interpretation and report</td>
</tr>
<tr>
<td>95078</td>
<td>Provocative testing</td>
</tr>
<tr>
<td>95805*23</td>
<td>Multiple sleep latency testing</td>
</tr>
<tr>
<td>95807*23</td>
<td>Sleep study, 3 or more parameters...</td>
</tr>
<tr>
<td>95808*23</td>
<td>Polysomnography; sleep staging with 1-3 additional parameters...</td>
</tr>
<tr>
<td>95810*23</td>
<td>Polysomnography; sleep staging with 4 or more additional parameters...</td>
</tr>
<tr>
<td>97780*20</td>
<td>Acupuncture, one or more needles; without electrical stimulation</td>
</tr>
<tr>
<td>97781*20</td>
<td>Acupuncture, one or more needles; with electrical stimulation</td>
</tr>
<tr>
<td>98940*1</td>
<td>Chiropractic manipulative treatment (CMT); spinal, one to two regions</td>
</tr>
<tr>
<td>98941*1</td>
<td>Spinal, three to four regions</td>
</tr>
<tr>
<td>98942*1</td>
<td>Spinal, five regions</td>
</tr>
<tr>
<td>99199</td>
<td>Unlisted special services or procedures</td>
</tr>
</tbody>
</table>
Services for which no HCPCS Code is assigned

Alpha-1 Antitrypsin Deficiency Replacement Therapy - investigative except when used in patients satisfying the following criteria (90799, 90784):

inherited alpha-1 antrypsin deficiency;
nonsmoking;
forced expiratory volume (FEV1) should be less than 65% of the normal value;
patients waiting for lung transplantation.

Angel Wings Occluder
Angioplasty, Laser
Apheresis - For LDL
  - Hypercholesterolemia: Familial type IIA homozygous form (P)
Apnea Appliance, Oral
Artificial Heart Implant
Autograft skin culture and culture transplants for severe burns and patients with giant hairy nevus
Autologous Chondrocyte Implantation
Balloon transurethral divulsion of prostate gland
Bone grafts from animal sources
Bullectomy (laser)
Caroid angioplasty with/without stenting
Cardiomyoplasty
Cervigram - (considered not medically necessary)
Cold laser treatment
Coma stimulation
Cranial sacral therapy
Cryoglobulinemia: refractory (P)
Cryosurgical Ablation of Prostate
Contact Dissolution Therapy
Chronic electrostimulation of the pallidum for Parkinson’s disease
Cytoxan for Neurological Disorders - investigative except in patients with progressive MS who have failed standard therapy. (J9070 - J9092)
Diastasis Recti Abdominus repair
Electrostimulated Gracilis Neosphinctor
Energy Emission Analysis
Epikeratophakia Lens (authorization required for eligible indications). (65760, 65765, 65767)
Hair Analyses
Epidural access:
  Administration of analgesia for control of severe, intractable pain of the terminally ill secondary to malignancy;
  Control of spasticity with low dose morphine;
  Control of physically disabling spasticity of spinal origin (i.e., resulting from Multiple Sclerosis or spinal cord injury) with intrathecal baclofen (Lioresal) in patients who:
    are refractive to various pharmacologic (i.e., oral baclofen) and exercise therapies, and
    have a significant functional component that is expected to improve with this therapy.
We will pay for services associated with infusion pumps only when the pump is FDA approved. These associated services include implantation surgery and hospitalization. Infusion pumps provided on an outpatient basis require prior authorization. Infusion pumps associated with inpatient services are covered as part of the DRG payment and cannot be billed separately.

Fetal Tissue transplantation
Gravity lumbar reduction
Growth Hormone Treatment
Gunderson Lyme Test - test is considered investigative.
Homeopathy & Homeopathic Gene Therapy Treatment Drugs
Homeopathic Medicine, Electrodiagnostic Machine
Hyperhomocysteinemia
Immunoglobulin Therapy - investigative for the treatment of multiple sclerosis, chronic fatigue syndrome, and chronic sinus infections. Not considered investigative for acute inflammatory demyelinating polyneuropathy (Guillan Barre).
Impedance Cardiography
Impotence - Vascular Surgery
Intravaginal Conception (IVC)
Interleukin 2 - for malignant melanoma - considered investigative for all indications except renal cell carcinoma.
Iontophoresis Devices for Hyperhidrosis
IV Vitamins and Minerals - investigative when administered in the office setting for allergies, candidiasis, chronic fatigue syndrome, Epstein-Barr virus, and multiple sclerosis.
Knee Cartilage ((Meniscus) Transplants including autologous chondrocyte implementation
LASIK
Laser Assisted Uvulopalatopharyngoplasty (LAUP)
Laser Corneal Sculpturing
Lyme Borreliosis Antigen Testing
Lymphokine Activated Killer Cells (LAK)
Magnetic Source Imaging
Methyl Test - Butyl Ether (MTBE)
Nerve Expansion
Nephrectomy (Percutaneous)
Neurometric encephalogram
Omental Transposition to Spinal Cord
Perfusion- isolated limb
Phototherapeutic Keratectomy
Platelet Derived Wound Healing Factor (PDWHF)
Posturography
Prolastin - see alpha- 1 antitrypsin deficiency for indications for coverage.
Promontory Test
Protropin
Red blood cell substitutes
Rotating Chair Test
Scanning laser technologies for glaucoma testing and monitoring
Seismocardiogram
Somatostatin Analog - investigative except for the treatment of metastatic carcinoid tumors and vasoactive intestinal peptide-secreting (VIP) tumors, and pancreatic fistulas.

Spiral (helical) CT or electron beam (EBCT) CT
Therastim
Tissue Engineering
Topographic Brain Mapping
Transmyocardial Laser Revasculization
Transmyocardial revascularization adjunct to CABG
Transurethral Cryosurgical removal of prostate
Topographic Brain Mapping
Ultra Fast CT
Uterine Lavage for Preembryo Transfer
Vagal Nerve Stimulator using Neralcybernetics Prosthesis (NCP)
Vascular Surgery for Impotence - surgical correction of organic impotence by either venous or arterial procedures
Ventricular reduction surgery
Vertebral Axial Compression

Footnotes

*1  For any combination of the CMT codes authorization is required for treatments in excess of 6 per month and 24 per calendar year.

*2  All hours of private duty nursing provided in a hospital or facility certified as an ICF, SNF, or ICF-MR.

*4. A.  Authorization is required for more than twenty-six (26) hours (52 visits/units of 90804, 90805) or 90875 (when billed in one unit increments) and twenty (20) hours of 90806 or 90807 or 40 units of 90875 (when billed in two-unit increments) per calendar year. Note: The 90875 when billed as one unit and 90804 or 90805 combined decrements from the total 26 hours per calendar year. There is not a separate benefit level for each code. Likewise, 90875 when billed as two units and 90806 or 90807 combined decrement from the total 20 hours per calendar year. There is not a separate benefit level for each code.
B.  PA is required either when more than three (3) hours of 90853 are provided within a five (5) calendar day period, or when more than seventy-eight (78) hours per calendar year has been reached.
C. PA is required for 90847 in excess of 26 hours per calendar year. (Note: 90846 must be used when the family member being treated is not present during the family therapy session. CPT 90846 is subject to the same P.A. requirements and limitations as those imposed on CPT 90847. Use of this code does not result in an additional benefit level but counts against the benefit level available for 90847.

*7 Authorization is required if this code is used more than 30 days after documented fracture.

*8 Authorization is required for chemodenervation of any area.

*9 Authorization is required for day treatment in excess of 390 hours.

*14 Authorization is required for 90802, 90810-90814, 90857 when the thresholds of 90801, 90806 or 90807, 90853 have been used. These codes will be included in the thresholds of codes 90801, 90806 or 90807, 90853. (The provider cannot bill both a 90806 or 90807 and 90810-90814. They must choose one or the other.)

*15 Authorization is required for cognitive remediation training (X5317, or X5318, or a combination of X5317 and X5318) in excess of 390 hours.

*16 Authorization is required for neuropsychological rehabilitation (X5535) prior to service initiation and for more than 20 hours.

*17 Authorization is required for neuropsychological rehabilitation (X5536) prior to service initiation and for more than 78 hours.

*19 Authorization is required for neuropsychological testing and assessment (96117) a) to exceed 7 hours (or 28 units) of CPT code 96117 services per calendar year. A maximum of 10 hours (or 40 units) may be approved with prior authorization for a single assessment; and/or if multiple assessments (i.e., re-evaluation) are requested and determined to be medically necessary, a maximum of 15 hours (or 60 units) of CPT code 96117 may be allowed with authorization for the calendar year.

*20 Acupuncture is covered for chronic pain. Authorization is required in excess of 10 sessions, and must be performed by an M.D or a licensed acupuncturist employed and supervised by an M.D. or; provided through a hospital pain management program by an M.D. or a licensed acupuncturist who is supervised by M.D.

*22 A child under age 21 eligible for home-based mental health, therapeutic support of foster care, family community support services may exceed the payment limitations for this package with authorization.

*23 Authorization is required for persons 18 years of age and under.

*24 Authorization is not required for port wine stain birthmarks.

*25 Authorization needed after three sessions, up to five injections per session within thirty days.

*26 Authorization is required after 1 per calendar year

*27 Authorization is required after 1 per calendar year.

*28 Authorization is required after 1 per calendar year.

*29 Codes 90816 through 90829 when provided in other than an inpatient place of service shall be subject to the same practice parameters and service coverage limitations as other outpatient, individual psychotherapy codes (90804 through 90815) unless authorized.
Legal References

MS 256B.02
MS 256B.04
MS 256B.093
MS 256B.0625
MS 256B.0627
Minnesota Rules 9505.0175, 9505.0215; 9505.0500 to 9505.0540
Minnesota Rules 9505.5000 to 9505.5105
42 CFR 431.52
42 CFR 440.230
Chapter 6

Physician and Professional Services

The following sections are included in this chapter:

- General physician service;
- Evaluation and management service;
- Physician services in a group setting;
- Medical supplies provided by a physician's office;
- Casting provided in a physician's office;
- Immunization and vaccination;
- Laboratory service;
- EKG interpretation;
- Acupuncture;
- Allergy immunotherapy-allergy testing;
- Surgical service;
- Locum tenens;
- Reciprocal billing;
- Telemedicine;
- Physician extender;
- Advanced practice registered nurse;
- Physician assistant;
- Outpatient hospital service;
- Urgent care clinic service;
- Authorization standards (penile prosthesis, gastric restrictive surgery, sleep studies, breast reduction, panniculectomy, breast implant, gynecomastia, and botulinum toxin A);
- Transplant service;
- Nutritional counseling;
- Diabetic education;
- Nutritional product; and
- Podiatry service.

Physician Services

Physician: A person who is licensed to provide health services within the scope of his/her profession under MS 147. For purposes of this section, a physician means a licensed doctor of medicine or osteopathy.

Enrollment Requirements

Physicians must enroll with DHS to receive payment. Physicians must receive an individual MHCP provider ID number even if they are a member of a group, clinic, employed by an
outpatient hospital, or other organized health care delivery system that employs physicians. (Refer to the Locum Tenens section of this chapter.)

**Covered Services**

Services provided by a physician are not restricted to a specific place of service unless specified by CPT or HCPCS code description. Physicians may provide services in the patient's home, nursing home, outpatient hospital, inpatient hospital, or other facility.

Physicians may not bill separately for performing administrative or medical functions that are paid through an institution's per diem rate.

A health service must be medically necessary in order to be a covered service. Services listed as provided by a physician in this chapter may be provided by other health care professionals if the service is within the scope of their practice as defined in the Minnesota Statues.

**Evaluation and Management Services (E/M)**

**New vs. Established Patient**

MHCP follows CPT guidelines.

**Concurrent Care**

**Concurrent Care Services:** The provision of similar services (e.g., hospital visits to the same patient by more than one physician on the same day). If a consulting physician subsequently assumes the responsibility for a portion of patient management, it is considered concurrent care.

MHCP pays concurrent care when the medical condition of the patient requires the services of more than one physician. Generally, a patient's condition that requires physician input in more than one specialty area establishes medical necessity for concurrent care.

**Non-covered Concurrent Care Services**

MHCP will not pay for concurrent care when:

- The physician makes a routine call at the request of the patient and family or as a matter of personal interest; or
- Available information does not support the medical necessity of concurrent care.

**Billing Concurrent Care**

If the patient's condition requires concurrent care, bill the appropriate E/M code and modifier.
Consultation

When the treating physician or other qualified health care professional asks the advice or opinion of another physician or qualified health care professional. A consulting physician or qualified health care professional has a wide degree of latitude in providing services, but does not assume care or provide treatment plans.

The request for consultation from the attending physician or other appropriate source must be documented in the patient's medical record. The consultant's opinion and any services ordered or performed must also be documented in the patient's medical record and communicated to the requesting physician.

If the consulting physician assumes responsibility for the continuing care of the patient, any subsequent services rendered will cease to be a consultation.

Critical Care

Use CPT E/M codes to report critical care, designed to include:

- All diagnostic and therapeutic services listed; and
- Direction of care provided by the physician during the period for which this procedure code is billed.

Follow CPT guidelines to determine which services are included in reporting critical care codes.

Physicians must not bill separately for procedures included in the code and performed during the critical care hour. Physicians may bill separately for services performed that are not included in the critical care codes.

Observation Services

MHCP observation policy has changed. Report E/M observation codes and follow CPT guidelines:

- Observation services are covered with or without being preceded by a medical emergency.
- Observation services are paid for up to 48 hours and in some circumstances up to 72 hours.

Physician Services in Long Term Care (LTC) Facilities

Payment for physician and professional services in an LTC facility must be medically necessary. Refer to the Physician Extender section of this chapter for use of physician extender services.
provided in LTC facilities. Refer to the Long Term Care chapter (Ch. 27) for additional information on covered services in LTC facilities.

**Prolonged Physician Services**

Prolonged services involving direct (face-to-face) patient contact are covered. Report the total duration of face-to-face time spent providing care on a given date.

**Physician Standby Services**

Standby services are covered when requested by another physician and involve prolonged attendance without direct (face-to-face) patient contact. Standby services are covered only in the case of a documented existing risk or distress, such as documented fetal distress.

**Physician Case Management (Team Conferences)**

A medical team conference conducted for the purpose of coordinating the activities of a patient's care with an interdisciplinary team of health professionals or a representative of community agencies is a covered service.

The medical record must document the contents of the conference and the amount of time spent in the conference.

Bill the appropriate CPT E/M code.

**Medical Conference/Counseling (as part of E/M code)**

Physician services related to counseling are covered as part of the E/M codes if the counseling is conducted face-to-face with the patient, relative, or guardian.

When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter, time may be considered the key or controlling factor to qualify for a particular level of E/M service. Medical record documentation must reflect the content of the counseling, coordination of care, and the amount of time spent in counseling/coordination.

**Telephone Calls**

Telephone calls are not covered by MHCP.

**Care Plan Oversight**

Care plan oversight services are not covered by MHCP.
Preventive Medicine Services

**Preventive Health Service:** A health service provided to a patient to avoid or minimize the occurrence or recurrence of illness, infection, disability, or other health condition. Preventive health services are covered if the service:

- Is provided in person;
- Affects a health condition rather than the physical environment;
- Is not otherwise available to the recipient without cost as part of another preventive health program funded by a government or private agency;
- Is not part of another covered service;
- Avoids or minimizes an illness, infection, or disability that will respond to treatment;
- Is generally accepted by the provider's professional peer group as a safe and effective means to avoid or minimize the illness; and
- Is ordered in writing by a physician, advanced practice registered nurse (APRN), physician assistant (PA), and included in the plan of care approved by the primary care provider.

Non-covered Preventive Services

The following services are not covered as a preventive service:

- Services that are only for vocational or educational purposes that are not health related; and
- Services that deal with external, social, or environmental factors that do not directly address the patient's physical or mental health.

Preventive Medicine Services/Counseling and/or Risk Factor Reduction

Preventive health counseling to promote health and prevent illness or injury is a covered service. These services should be billed with the appropriate E/M code for preventive medicine, individual counseling, and group counseling.

Physician Services in a Group Setting

**Eligible Providers**

Eligible providers include: enrolled physicians, physician clinics, community clinics, outpatient hospitals, public health clinics, family planning agencies, certified nurse practitioners, physician assistants, clinical nurse specialists, certified nurse midwives, community mental health centers, and physician extenders.
Covered Services

Group services are covered when provided on a scheduled basis, and are divided into two areas:

- Services to healthy individuals include: educational counseling and/or risk reduction intervention provided to healthy individuals for the purpose of promoting health and preventing illness or injury (e.g., CPR instruction, abuse prevention, smoking cessation, and prenatal classes). Refer to Reproductive Health – Obstetrics and Gynecology (Ch. 10) for information about maternal health classes.

- Services provided to individuals who have symptoms, a diagnosis or established illness. Services are provided with the purpose of dealing with the diagnosed condition (e.g., self-care for chronic disease such as joint care, depression, or back pain).

Nutritional counseling, diabetic education, and weight reduction have separate sections in this chapter.

Non-covered Services

Services provided as part of a day treatment program, partial hospitalization, or other similar health care programs may not be billed as physician services provided in a group setting.

Documentation

A physician order for group services is required. Documentation of the individual's participation, number of participants in the group, name and credentials of person who provided the service, and topic content must be in the medical record or class record.

Billing

- If a group is advertised as "free," it cannot be billed to MHCP.
- The cost of educational materials is included in the payment; no additional payment will be made for handouts, textbooks, or other materials.
- Physician extenders must modify their services using the appropriate modifier. (Refer to the Physician Extender section in this chapter.)

Medical Supplies Provided by a Physician Office

Eligible Providers

For the purpose of this chapter: physicians, APRNs, PAs, and physician clinics.

Payment Limitations

Payment limitations for medical supplies provided by a physician’s office are the same as for medical supplies. Refer to Equipment and Supplies (Ch. 23). Routine supplies are not paid
separately. Supplies applied or used in the physician’s office or clinic in direct relationship to an illness or injury are generally considered incident to the service and are not separately billable to DHS.

**Non-covered Services**

Supplies sent home with recipients are not covered by MHCP.

The following list of routine physician office supplies cannot be billed separately. This is not an all-inclusive list:

- Adhesive tape, all sizes
- Alcohol or peroxide, per pint
- Alcohol wipes
- Autolet
- Band-Aids
- Betadine, Iodine, Providine swabs/wipes
- Betadine, Phisohex, per pint
- Chux pads
- Cold packs
- Cotton balls
- Cotton tip application (sterile/non-sterile)
- Culturette
- Emesis basins
- Enema kits
- Gauze pads, sterile or non-sterile
- Gelfoam
- Gloves (latex, plastic, rubber, sterile, etc.)
- Gowns
- Hemostatic cellulose (e.g., surgical, any size)
- IVP dyes
- Kerlix, Kling bandages
- Masks
- Microporous tape
- Needles, sterile
- OpSite
- Patient electrode pads
- Razor
- Sanitary belt/napkins, tampons
- Silver nitrate stick
- Specimen collection
- Steri-strips
- Sterile saline, 30cc
- Sterile water, 30cc
- Suction tubing
- Surgical drapes
- Suture removal tray
- Syringe (with/without needles)
- Thermometer (any size)

**Casting Provided in a Physician Office**

If no surgery or manipulation is done, bill the appropriate E/M code and HCPCS casting supply code.

If surgery or manipulation is done, bill the appropriate CPT surgery code and HCPCS casting supply code.

If recasting is done, bill the appropriate CPT casting code and HCPCS casting supply code.
Immunizations and/or Vaccinations

MHCP covers vaccines, toxoids, and an administration fee.

MHCP covers only the administration fee for vaccines and toxoids provided free by the Minnesota Vaccines for Children (MnVFC), available through the Minnesota Department of Health (MDH). Most routine childhood vaccines and some adult vaccines are available through the MnVFC program. Refer to the Immunization section of Children's Services (Ch. 9).

Laboratory Services

Refer to the Laboratory/Pathology, Radiology, and Diagnostic Services chapter (Ch. 11) for specific information regarding laboratory/pathology, radiologic, diagnostic services, laboratory handling, and specimen collection fees.

Billing

When a physician or physician clinic bills for CLIA certified lab services and the equipment used is owned by the physician or clinic, the services cannot be separated into a professional and technical component. Bill the appropriate code without a modifier.

Physician or physician clinics may choose to bill laboratory services sent out to a hospital or free standing laboratory by indicating the lab's MHCP provider number in box 24K on the CMS-1500 or Treating Provider Number field on ITS. The claim line must include the lab procedure code, place of service, (where the specimen was sent) and modifier 90.

Physician or physician clinics may also have the hospital or free standing lab bill MHCP directly; modifier 90 is not required.

A physician clinic laboratory granted CLIA Waiver Certification may only perform waiver tests. Refer to Laboratory/Pathology, Radiology, and Diagnostic Services chapter (Ch. 11).

EKG Interpretations

EKG interpretation services may be billed in addition to the E/M service. MHCP covers one physician interpretation for each EKG.

Acupuncture

Acupuncture is covered for chronic pain. Authorization is required in excess of 10 sessions and must be performed by: 1) an MD or licensed acupuncturist employed and supervised by an MD; or 2) provided through a hospital pain management program by an MD or licensed acupuncturist who is
supervised by an MD. Bill using the Physician Extender modifier for non-physician services. (Refer to the Physician Extender section of this chapter for instructions on billing these services.)

Allergy Immunotherapy-Allergy Testing

The preparation of allergenic extracts and the administration of allergy immunotherapy are covered services.

**Antigen:** The raw form of pollen, (venom, stinging insect, etc.) prior to refinement for administration to humans.

**Allergenic Extract:** The refined injectible form of antigen either commercially prepared or refined in the physician's office under his/her supervision.

**Immunotherapy:** The parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy.

**Professional Services:** Physician ordered allergen immunotherapy and services either performed by the physician or qualified personnel under the physician.

**Covered Services**

- Providing the raw pollen;
- Professional services to prepare raw antigen to a refined state that will become an allergenic extract;
- Professional services to administer the allergenic extract;
- Providing the injectible allergenic extract;
- Professional services to monitor the recipient's injection site and observe for anaphylactic reaction;
- Allergy testing; and
- Provision of inhalants (a pharmaceutical). Refer to the Pharmacy Services chapter (Ch. 22).

**Non-Covered Services**

The following allergy testing and treatments have not been proven to be effective, and therefore are not covered:

**Testing:**

- Cytotoxic leukocyte testing (Brian's test);
- Leukocyte histamine release testing;
• Provocation-neutralization testing (sublingual, subcutaneous, intradermal, or
  intracutaneous);
• Re buck skin window test;
• Passive transfer or P-K Test (Prausnitz-Kustner) - this has been replaced by RAST;
• Candidiasis hypersensitivity syndrome testing;
• IgG level testing (IgG level testing for all antibiotics except penicillin);
• General volatile organic screening test (volatile aliphatic panel);
• Allergy antibiotic skin testing for all antibiotics except penicillin (penicillin testing is
done using penicillin G, Pre-Pen and penicillin minor determinants); and
• ELISA/ACT immunotherapy (Serammune Physician Lab, Reston VA).

Treatment:

• Provocation-neutralization treatment (sublingual, subcutaneous, intradermal, or
  intracutaneous);
• Oral and sublingual immunotherapy (includes oral drops, solutions, oral capsules, and
  tablets);
• Rinkel immunotherapy (serial dilution endpoint titration) Note: Allergy testing using this
  method is eligible as a variant of conventional intradermal skin testing;
• Autologous urine immunizations;
• Clinical ecology urine immunizations;
• Candidiasis hypersensitivity syndrome treatment and related services;
• IV vitamin C therapy; and
• Enzyme potentiated desensitization.

Coverage Limitations

Allergenic extracts may be administered with either one or multiple injections. Documentation in
the medical record must support the number of injections administered.

Preparation of Raw Antigen to Allergenic Extract: Only physicians who perform the
refinement of raw antigens to allergenic extract may bill for this service. This service involves:

• Sterile preparation of an allergenic extract by titration, filters, etc.; and
• Checking the integrity of the extract by cultures or other qualitative methods.

Purchasing refined antigens, measuring dosages and adding diluent is not refining raw antigens.

Adding Diluent: As in any other medication administration, it is not a separately covered
service. This service is an integral part of the professional services for providing an allergenic
extract.
Additional Visits: Payment for injection administration will be adjusted and reflect monitoring of the injection site and observation of the patient for anaphylactic reaction.

A separate visit charge for the provision of allergy services is not allowed unless other identifiable services are performed such as physical examination, review of systems, obtaining a history of current symptoms or illness, laboratory services, and blood pressures, etc.

Identifiable services **not** included in an office visit may be billed separately.

Surgical Services

Global Surgery Package

**The global surgical package period:** Surgery and the time following surgery during which routine care by the physician is considered postoperative and included in the surgical fee. Office visits or other routine care related to the original surgery cannot be separately reported if the care occurs during the global period. Global periods may be referred to as “follow-up-days”.

MHCP covers medically necessary surgical services. MHCP reimbursement for all surgeries is based on a global surgery package, which follows Medicare's global surgery guidelines and includes pre, post, and intraoperative work related to the surgical procedure. MHCP starts the global surgery the day of surgery and follows Medicare guidelines for the number of days in the global package. Preoperative physicals by a primary physician are not included in the global package.

The visit identifying the need for surgery is not included in the global fee even if occurring on the preoperative day, or on the day of surgery. Use CPT modifier 57 to bill the E/M service for established patient visit or consultation the day before or the day of major surgery when the decision for surgery is made during the visit.

For global surgery purposes, surgeries are classified into three categories: exempt/endoscopic, minor, and major. The global surgery package for each category includes the following services:

- **Exempt/Endoscopic (0 days)**
  - Physician visit on the same day as surgery;
  - The surgical procedure; and
  - No postoperative days.
  
  E/M services provided on the same day as the procedure are generally not payable unless they are significant, separately identifiable, and billed with modifier 25.

- **Minor Surgery (10 days)**
  - Physician visit on the same day as surgery;
  - The surgical procedure; and
10 days of postoperative care.
E/M services provided on the same day as the procedure are generally not payable unless they are significant, separately identifiable, and billed with modifier 25.

- Major Surgery (90 days)
  - Preoperative exam on the day of, or the day before surgery;
  - The surgical procedure; and
  - 90 days of postoperative care.

Postoperative care includes:

- Evaluation and management services;
- Pain management;
- Treatment of complications (e.g., treatment of infection related to the surgery); and
- Miscellaneous service: dressing changes and local incisional care; removal of operative pack, cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes/removal of tracheostomy tubes.

Complications

Complications requiring additional services from the surgeon that do not require a return trip to the operating room are included in the global payment. Surgical complications requiring a return to the operation room are not included in the global fee. Report complications requiring a return trip to the operating room with modifier 78 appended to the original procedure code.

Services not included in the global package:

- Initial (new patient) E/M visit;
- Diagnostic tests and procedures;
- Surgical trays;
- Recasting;
- Casting supplies;
- Dialysis;
- Immunosuppressive therapy;
- Radiation oncology services;
- Physical therapy;
- Silicone punctual plugs (A4263) when reported with code 68761 and POS 11 (office);
• Implantable vascular access device (A4300), when reported with code 36533 and POS 11 (office); and
• Catheter used for treatment of a temporary obstruction and POS 11 (office).

If further detail is required, refer to the Medicare global surgery guidelines.

**Exceptions: Global Surgery Rules**

For certain circumstances, services may be billed and paid outside of the global surgery package. When these circumstances exist, the service must be billed along with the appropriate modifier.

**Starred (*) Procedures**

MHCP covers starred (*) procedures using CPT guidelines.

**Assistant-at-Surgery**

MHCP follows Medicare’s assistant-at-surgery guidelines. MHCP does not cover assistant-at-surgery services provided by surgical technicians, surgical assistants, RN first assists (RNFA), clinical nurse specialists, or certified nurse practitioners.

MD assistant surgeons or physician assistants are covered for assistant-at-surgery. MD assistant surgeons must bill using modifier 80 or 81, and physician assistants must use modifier AS.

**Billing**

• Claims for physician services at surgery must be submitted on the CMS-1500 or the electronic equivalent.
• Physician services provided in an FQHC or RHC must be submitted on the UB-92 or the electronic equivalent.
• Physician services provided in an IHS, refer to [Federal Indian Health Services](Ch. 31).

**Locum Tenens Physicians**

MHCP recognizes that physicians often retain a substitute physician to take over their professional practices while they are absent for reasons such as illness, vacations, continuing medical education and pregnancy. MHCP further recognizes locum tenens arrangements and pays the regular physician for the services provided by the substitute physician if:

• The substitute physician generally does not maintain a practice and travels from area to area as needed.
• The regular physician is unavailable to provide services.
• The recipient has arranged or seeks to receive the services from the regular physician.
• The regular physician pays the locum tenens physician on a per diem or a fee-for-service basis.
• The locum tenens physician does not provide services over a continuous period of longer than 60 days.

Coverage

MHCP covers locum tenens physician services using Medicare guidelines.

Documentation

The regular physician must keep a record of each service provided by the locum tenens physician along with the substitute physician’s UPIN.

Billing

• The patient's regular physician bills and receives payment for locum tenens physician covered services. Compensation paid by a medical group is considered paid by the physician.
• The locum tenens physician does not have to be identified on the claim or need to enroll with DHS.
• Bill with modifier Q6 in box 24D on the CMS-1500 or the Mod field on ITS, and the regular physician's MHCP provider ID number in box 24K on the CMS-1500 or the Treating Provider field on ITS.
• Postoperative services performed by the locum tenens physician during the global surgery period do not require a Q6 modifier (if the services are only in connection with the surgery).

Reciprocal Billing

Reciprocal Billing Arrangements: A recipient’s regular physician may submit a claim for a covered service which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if:

• The regular physician is unavailable to provide the visit services.
• The recipient has arranged or seeks to receive services from the regular physician.
• The substitute does not provide services over a continuous period of longer than 60 days.

These requirements do not apply to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who actually performed the services must be identified as the rendering physician.
Coverage

MHCP covers substitute physician services using Medicare guidelines.

Documentation

The regular physician must keep a record of each service provided by the substitute physician along with the substitute physician’s UPIN.

Billing

- The regular physician bills and receives payment for substitute physician covered services.
- The substitute physician does not have to be identified on the claim or need to enroll with DHS.
- Bill with modifier Q5 in box 24D on the CMS-1500 or the Mod field on ITS, and the regular physician's MHCP ID number in box 24K on the CMS-1500 or the Treating Provider field on ITS.
- Postoperative services performed by the substitute physician during the global surgery period do not require a Q5 modifier (if the services are in connection with the surgery).

Telemedicine

**Distant site:** The site where the physician or practitioner, providing the professional service, is located at the time the service is provided via a telecommunications system.

**Telemedicine:** The use of telecommunications to furnish medical information and services. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology.

**Two-way Interactive Video:** A type of technology that permits a "real time" consultation to take place. This is used when a consultation involving the patient, the primary caregiver, and a specialist is medically necessary. Video-conferencing equipment at two different locations permits a live non-face-to-face consultation to take place.

"Store and Forward": The asynchronous transmission of medical information to be reviewed at a later time by a physician or practitioner at the distant site. Medical information may include, but is not limited to, video clips, still images, x-rays, MRIs, EKGs, laboratory results, audio clips and text. The physician at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time.

**Hub Site:** A medical facility telemedicine site where the medical specialist is located.
**Spoke Site:** A remote site where the referring health professional and patient are located.

**Consultation:** A type of service provided by a physician whose opinion or advice is requested by another provider.

Asynchronous telecommunications systems in single media format do not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the recipients (electronic mail). Photographs must be specific to the recipient’s condition and adequate for rendering or confirming a diagnosis or treatment plan.

**Eligible Providers**

The "spoke," or referring provider, may be any enrolled MHCP provider including a physician, nurse practitioner, clinical nurse specialist, physician assistant, certified nurse midwife, podiatrist or mental health professional.

The "hub," or consulting provider, is limited to a specialty physician or an oral surgeon.

**Eligible Recipients**

Telemedicine coverage applies to MHCP recipients in fee-for-service programs. Prepaid health plans may or may not choose to pay for services delivered in this manner.

**Covered Services**

Coverage includes payment for physician consultations that are performed via two-way interactive video, or via store and forward technology.

**General**

- Telemedicine consultation coverage is limited to physician services;
- A consultation (as defined by CPT) must take place;
- A request for a consultation and the need for a consultation must be documented in the patient's medical record. The consultation opinion must be documented in the patient's medical record and communicated to the requesting provider;
- Out-of-state coverage policy applies to services provided via telemedicine. Consultations performed by providers who are not located in Minnesota and contiguous counties, require authorization prior to the service being provided; and
- Consultations must be billed with the appropriate modifier indicating services were performed via telemedicine.

**Two-Way Interactive Video Consultations in an Office, Outpatient, or Inpatient Setting:**

- Payment is made to both the referring provider and consulting physician;
- The referring provider bills an office or outpatient E/M code; and
• The consulting physician bills an office, outpatient, or inpatient E/M consultation code with the GT modifier, indicating the service was performed via two-way interactive video.

Two-Way Interactive Video Consultation in an Emergency Room (ER):
Two-way interactive video consultation may be billed when there is no physician in the ER and the nursing staff is caring for the patient at the "spoke" site. The ER physician at the "hub" site bills the ER CPT codes with the GT modifier. Nursing services at the "spoke" site would be included in the ER facility code.

If the ER physician requests the opinion or advice of a specialty physician at a "hub" site, the ER physician bills the ER CPT codes without the GT modifier. The consulting physician bills the consultation E/M code with the GT modifier.

"Store and Forward" Telemedicine:
• CPT definition of a consultation must be met as above; and
• Consultation E/M codes are billed by the consulting physician with the GQ modifier, used to indicate that the consult was done via store and forward technology.

Payment Limitations:
• Payment for telemedicine consultation services is limited to three per week per recipient; and
• Payment will be made for only one reading or interpretation of diagnostic tests such as x-rays, lab tests, and diagnostic assessments.

Physician Extenders
MHCP covers health services provided by a physician extender under the supervision of the physician. Physician extender services are not covered unless they replace or substitute for the physician service.

Physician Extender: Physician Assistants and Advanced Practice Registered Nurses who choose to not enroll with DHS. Genetic counselor, registered nurse and licensed acupuncturist who are:
• Employed by the physician provider;
• Employed by the same provider organization that employs the physician; or
• Supervised by a physician.

Advanced Practice Registered Nurse (APRN): An individual licensed as a registered nurse by the Minnesota Board of Nursing and certified by a national nurse certification organization acceptable to the Minnesota Board of Nursing to practice as a clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner.
Clinical Nurse Specialist Practice (CNS): The provision of patient care in a particular specialty or subspecialty of advanced practice registered nursing within the context of collaborative management, and includes: (1) diagnosing illness and disease; (2) providing nonpharmacologic treatment, including psychotherapy; (3) promoting wellness; and (4) preventing illness and disease. The certified clinical nurse specialist is certified for advanced practice registered nursing in a specific field of clinical nurse specialist practice.

Registered Nurse (RN): A nurse licensed under and within the scope of Minnesota statutes.

Physician Assistant (PA): A person who is qualified by academic or practical training or both to provide patient services under a supervising physician, pursuant to MS 147A.

Genetic Counselor or Geneticist: An individual who is board certified by the American Board of Genetic Counseling (ABGC).

Supervision of Physician Extenders (Except for Physician Assistants)

The process of control and direction by which the physician accepts full professional responsibility for the supervisee, instructs the supervisee in their work, and oversees or directs the work of the supervisee. The process must meet the following conditions:

- The physician must be present, available, and on the premises more than 50% of the time when the supervisee is providing health services;
- The diagnosis must be made by or reviewed, approved, and signed by the physician;
- The plan of care for a condition other than an emergency may be developed by the supervisee, but must be reviewed, approved, and signed by the physician before care is begun; and
- The supervisee may carry out the treatment, but the physician must review and countersign the record of a treatment within five working days after the treatment.

Supervision of Physician Assistants

The 1995 legislation allows for off-site or remote supervision, provided the terms of the physician/physician assistant agreement are being met and the physician/physician assistant are, or can be, easily in contact with one another by radio, telephone, or other communication device.

This exclusion does not apply to Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC). In both of these settings, federal regulations require that a physician is present for sufficient periods of time, at least once in every two week period (except in extraordinary circumstances which must be documented in the records of the clinic) to provide:

- Medical direction;
- Medical services;
- Consultation; and
• Supervision.

The physician must be available through direct telecommunication for consultation, assistance with medical emergencies, and patient referral.

**Role of Physician Extenders in Long Term Care (LTC) Facilities**

Physician services provided by a physician extender in an LTC facility must be provided under the direction of a physician who is an enrolled MHCP provider. This means the physician has authorized and is personally responsible for the physician services performed by the physician extender and has reviewed and signed the record of the service no more than five days after the service was performed.

Physician extenders may provide any service within their scope of practice and as delegated and directed by a physician.

As permitted by Minnesota rules, licensure, and facility policy, APRN, or a physician assistant who is not enrolled with DHS and is not an employee of the facility (but is working in collaboration with a physician) may provide the following physician services in an LTC facility:

• Develop a written plan of care as required by federal regulation; and
• Conduct a periodic visit as required by federal regulations. At the option of the physician, and in accordance with facility policy, required visits (after the initial visit) may alternate between personal visits by the physician and visits by a physician assistant, or APRN.

**Genetic Counselor or Geneticist**

A genetic counselor or geneticist may conduct a consultation to render an opinion and/or advice.

• The genetic counselor or geneticist may only initiate diagnostic or therapeutic services at the request of the attending physician.
• Follow-up consultations may be performed if it is medically necessary to reevaluate a patient on whom an opinion previously has been rendered.
• Consultations provided by a genetic counselor must be billed with the appropriate E/M code, and use the WW modifier.

**Use of Modifiers**

The minimal service E/M code, as defined in CPT, represents a level of service supervised by a physician but does not necessarily require his/her immediate ongoing presence. Thus, this code does **not** need to be modified if a physician extender provides the services.
Modifier U7 (WW before 1/1/04 service dates) must be used with all other E/M codes when the physician extender provides services, unless the physician is directly involved more than 50% of the time required to provide the health service.

Physician extender services associated with the enhanced prenatal care services for "at risk" pregnancies do not require modification. Do not use the WW modifier for these services. Refer to the Family Planning and Obstetrics & Gynecology Services sections of the Reproductive Health – Obstetrics and Gynecology chapter (Ch. 10).

Billing Physician Extender Services

- Enter the provider number of the physician who supervised the service in box 24K on the CMS-1500 or Treating Provider Number field on ITS.
- Enter the appropriate procedure code for the level of care provided in box 24D on the CMS-1500 or the CPT/HCPCS field on ITS.
- Enter the appropriate modifier in box 24D on the CMS-1500 or Mod field on ITS.

Non-covered Services

Services provided by personnel such as office and clerical workers, lab workers, assistants (e.g., surgical and ophthalmic) and aides are not considered physician extender services. These services are considered part of a physician’s overhead and cannot be billed separately.

Advanced Practice Registered Nurse (APRN) Services

**Advanced Practice Registered Nurse:** An individual licensed as a registered nurse by the Minnesota Board of Nursing and certified by a national nurse certification organization acceptable to the Minnesota Board of Nursing to practice as a clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner. The practice of advanced practice registered nursing also includes accepting referrals from, consulting with, cooperating with, or referring to all other types of health care providers, including but not limited to physicians, chiropractors, podiatrists, and dentists, provided that the advanced practice registered nurse and the other provider are practicing within their scopes of practice as defined in state law. The advanced practice registered nurse must practice within a health care system that provides for consultation, collaborative management, and referral as indicated by the health status of the patient.

**Registered nurse anesthetist practice:** The provision of anesthesia care and related services within the context of collaborative management, including selecting, obtaining, and administering drugs and therapeutic devices to facilitate diagnostic, therapeutic, and surgical procedures upon request, assignment, or referral by a patient's physician, dentist, or podiatrist.

**Clinical Nurse Specialist Practice (CNS):** The provision of patient care in a particular specialty or subspecialty of advanced practice registered nursing within the context of collaborative management, and includes: (1) diagnosing illness and disease; (2) providing nonpharmacologic
treatment, including psychotherapy; (3) promoting wellness; and (4) preventing illness and disease. The certified clinical nurse specialist is certified for advanced practice registered nursing in a specific field of clinical nurse specialist practice.

**Nurse practitioner practice:** Practice within the context of collaborative management: (1) diagnosing, directly managing, and preventing acute and chronic illness and disease; and (2) promoting wellness, including providing nonpharmacologic treatment. The certified nurse practitioner is certified for advanced registered nurse practice in a specific field of nurse practitioner practice.

**Nurse-midwife practice:** The management of women's primary health care, focusing on pregnancy, childbirth, the postpartum period, care of the newborn, and the family planning and gynecological needs of women and includes diagnosing and providing nonpharmacologic treatment within a system that provides for consultation, collaborative management, and referral as indicated by the health status of patients.

**Eligible Providers**

Historically DHS has enrolled nurse practitioners certified in pediatric, family, adult, OB/GYN, neonatal, geriatric, or certified clinical nurse specialist in mental health. Effective April 1, 2000, DHS enrolls all advanced practice registered nurses. Those enrolled will receive 90% of the physician rate and should not use modifier U7 (WW before 1/1/04 service dates) modifier when billing DHS. The services of those who choose not to enroll will be paid through the supervising physician at 65% of the physician rate and will require a WW modifier when billing DHS. **Registered nurse certified (RN, C) are not eligible to enroll.**

**Covered Services**

Services performed by a nurse practitioner or clinical nurse specialist are covered if the services are a covered service and if the service is within the scope of practice for an APRN as described in MS 148.171 through 148.285.

**Billing**

Services must be billed on the CMS-1500 using HCPCS/CPT codes, and follow MHCP requirements for covered physician and professional services.

- Enrolled certified nurse practitioners or clinical nurse specialist: enter their individual MHCP provider number in box 33 or the Physician GRP# field on ITS (leave box 24K blank); or
- Employers of nurse practitioners or clinical nurse specialist, if the employer is enrolled with MHCP: enter the individual provider number of the nurse practitioner or clinical nurse specialist in box 24K on the CMS-1500 or the Treating Provider field on ITS.
Physician Assistants (PA)

Physician Assistant: A person registered pursuant to MS 147A who is qualified by academic or practical training or both to provide patient services as specified in MS 147A under the supervision of a supervising physician.

Eligible Providers

Effective April 1, 2000, DHS accepts physician assistants as eligible providers for MHCP. Those who enroll will receive 90% of the physician rate and should not use the physician extender modifier when billing DHS. The services of those who choose not to enroll will be paid through the supervising physician at 65% of the physician rate and requires modifier U7 (WW before 1/1/04 dates of service) when billing DHS.

Covered Services

Services performed by a PA are covered if the services are within the scope of practice for a PA as described in MS 147A, and meet all required criteria by the appropriate certifying, regulatory, or licensing entities. PAs are enrolled as "treating providers" not "pay-to-providers." Refer to the Physician Extender section of this chapter for supervision of physician assistants.

Billing

Bill services on the CMS-1500 using the appropriate CPT/HCPCS codes. Follow MHCP requirements for covered physician services.

- Enter the 9-digit individual MHCP provider number in box 24K or Treating Provider field on ITS.
- Enter the 9-digit clinic/group MHCP provider number in box 33 or the Physician GRP# field on ITS.
- Non-enrolled PAs must use modifier U7 (WW before 1/1/04 dates of service) when billing.
- Physician assistants should continue to use modifier AS when assisting-at-surgery.

Non-covered

Nurse practitioners and clinical nurse specialists are not covered for assistant-at-surgery.

Outpatient Hospital Services

Billing Requirements

Outpatient Hospital Clinic: For clinic services provided in the outpatient hospital setting, physicians must bill the appropriate HCPCS/CPT code and use place of service "22." Failure to
identify the place of service could be considered fraudulent or abusive billing, subject to monetary recovery or program sanctions.

DHS has designated specific HCPCS codes in which the individual code may be separated into professional and technical components. Providers billing and delivering professional services in outpatient hospitals will be paid for the professional component. The outpatient hospital will receive the technical component in the form of a "facility fee."

**Urgent Care in Emergency Department:** Non-emergency care rendered in an emergency department is urgent care and should be billed as urgent care services.

**Emergency Department:** If in a physician's professional opinion, treatment for a patient's diagnosis or condition cannot be provided on an outpatient basis, a physician may seek inpatient admission certification. Refer to Inpatient Hospital Authorization chapter (Ch. 13).

### Hospital Physician Services

**Eligible Providers**

Physicians, APRNs, and PAs under the supervision of the physician in accordance with the physician/physician assistant agreement and in accordance with the hospital by laws, may provide inpatient hospital services.

**Billing**

- Bill physician services provided in an inpatient hospital setting on the CMS-1500.
- Enter the dates of hospital admission and discharge in box 18 on the CMS-1500 or Hospitalization Dates field on ITS. If the recipient has not been discharged, leave the "To" box blank.

**Urgent Care Clinic Services**

- Urgent care clinic services are covered for MHCP recipients in an outpatient hospital setting.
- Urgent care services in a freestanding facility (including physician clinics) must be billed as an office visit.
- No facility fee is paid in a physician's clinic for after hours care.
Authorization Standards

Authorization Standards for Surgery, Including Cosmetic and Reconstructive Surgery Definitions:

Investigative: A health service/procedure that has progressed to limited human application and trial, lacks wide recognition as a proven and effective procedure in clinical medicine as determined by the National Blue Cross and Blue Shield Association Medical Advisory Committee, and used by Blue Cross and Blue Shield of Minnesota in the administration of their program using the following criteria:

- The technology must have final approval from the appropriate government regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternatives.
- Improvement must be attainable outside the investigational settings.
- A drug or device that the United States Food and Drug Administration (FDA) has not yet declared safe and effective for the use prescribed. For purposes of this definition, drugs and devices are those identified in the Food and Drug Act.

Plastic Surgery: The alteration, replacement, or restoration of visible parts of the body performed to correct a structural defect, or cosmetic effect.

Cosmetic Surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve appearance and self-esteem. The procedure is done for decorative purposes rather than functional, medical, or mental health reasons.

Reconstructive Surgery: Performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. Procedures are done in order to replace, rebuild, restore, or to create one or more body parts or functions.

Authorization Policy

Authorization is required for all investigative procedures and procedures that may be considered cosmetic. The authorization request originates with the surgeon and must be submitted to Care Delivery Management, Inc. (CDMI). A list of procedures including investigative procedures requiring authorization is listed in the Authorization chapter (Ch. 5).

It is the responsibility of the provider requesting authorization to submit sufficient documentation to establish that coverage standards have been met.
If an investigative or cosmetic surgical procedure is performed without an authorization, payment will not be made to the surgeon, the anesthesiologist, or the hospital. In addition to authorization, certification of inpatient admission (if applicable) must be obtained and properly indicated on the CMS-1500.

Cosmetic surgery aimed at beautification only, is not covered.

A provider may choose to submit a summary letter in lieu of submitting reports from diagnostic and specialized services noted in the following standards. This will be accepted only if the letter addresses each element of the standard and the information is current.

If staged plastic and reconstructive surgery is being proposed for correction of a congenital anomaly, the complete plan for future surgeries must be submitted with the first authorization.

The procedure will be authorized, when in the opinion of the medical review agent, the following standards are documented:

- Medical and psychiatric contraindications to the surgery have been ruled out;
- The timing for the procedure has been assessed and found to be medically appropriate for the particular condition, age, and stage of development of the individual;
- Appropriate treatment which is nonsurgical, less intrusive, or less expensive has been tried and was not successful, was contraindicated, not applicable, or not available for the given condition;
- An assessment has been made to determine that the surgical procedure will cause significant improvement of the condition;
- The recipient, parent, or guardian fully understands the surgical procedure, the risks involved, and the possible side effects of the surgery;
- If the reconstruction procedure requires the insertion of an implant, the implant must be FDA approved; and
- Information submitted is sufficient to establish that the standards listed above have been met. This information must include:
  - A statement indicating medical necessity is based on significant medical problems, functional impairment, or is a jeopardy to physical or mental health;
  - Specify diagnosis, date of onset, symptoms, severity, duration, treatment results, and effects on the performance of activities of daily living;
  - When jeopardy to mental health is claimed, an evaluation by a psychologist or a psychiatrist, and an MMPI and interpretation are also required;
  - A summary of past clinical history which relates to the current condition including previous procedures, if any, to correct the condition (include surgical reports);
  - A description of the proposed procedure and the expected results;
Specify exact surgical site including right, left, upper, lower, unilateral or bilateral (if bilateral, bill two line items with the modifier reported on the second line item) as appropriate;
Specify primary and secondary procedures, if applicable;
Photographs for situations that are difficult to describe must be submitted. Several different views of the affected part are helpful (photographs should be limited to the affected part); and
Additional information requested by the medical review agent on behalf of DHS.

Authorizations are reviewed on a case-by-case basis. Certain situations may require a unique piece of information that will aid the medical review agent in the decision-making process. Since it is impossible to identify all of the diverse information necessary for each case, a request will be made for additional information as the situation requires. For example, for a blepharoplasty, in addition to documentation required in these standards, visual field studies and ophthalmology reports are necessary.

Authorization Standards for Insertion of Penile Prosthesis

Implantation of a penile prosthesis requires authorization from the medical review agent. It is the responsibility of the surgeon to submit the authorization request, with the following information:

- Medical history: history of penile dysfunction and report of physical examination;
- Results of related diagnosis, laboratory tests, and x-rays;
- Past treatments and results for erectile dysfunction; and
- Summary of evaluation of suitability for implant.

Authorization to implant a penile prosthesis for urinary drainage will be approved when, in the opinion of the medical review agent, the following standards have been met:

- Other less invasive methods of urine drainage and collection have proven to be inadequate; and
- Information submitted is sufficient to determine the standard is met. The information must include:
  - Medical history and report of physical exam;
  - Reports of related laboratory tests and x-rays; and
  - Summary of approaches to the problems of urinary drainage, with dates indicating periods of time used and when problems began.
Authorization Standards for Gastric Restrictive Surgery Coverage

Gastric restrictive surgery is an option for carefully selected individuals with clinically severe obesity (e.g., a body mass index [BMI] of 40 or higher) when less invasive methods of weight loss have failed, and the individual is at risk for obesity-associated morbidity and mortality.

The individual and the surgeon both have pre and postoperative responsibilities to assure that the outcome is successful. The following standards have been developed to assure the individual meets requirements that have been established as a standard of practice in the community and in nationally known groups.

Patient's Responsibility:

A "self report" is required from the individual. Coverage of gastric restrictive surgery will be considered when documentation is received from the surgeon addressing each of the following standards:

- The recipient is clinically obese with a body mass index (BMI) of 40 or higher;
- All co-morbid conditions are listed and described;
- The recipient has made serious attempts to lose weight in the past; and
- The recipient is motivated and committed to losing weight, has realistic expectations of the surgical outcome, and postoperatively is willing to make permanent life-style changes in the areas of eating behaviors, other behaviors, and exercise therapy.

Surgeon's Responsibility:

- To fully appraise the individual's description of how he/she meets the above standard;
- To refer the individual preoperatively to qualified professionals for diet counseling and a medically supervised weight loss program if prior attempts are deemed inadequate or are absent;
- Medical contraindications to the surgical procedure have been ruled out;
- To perform a history and physical;
- Psychiatric contraindications to the surgery have been ruled out (applicable if the individual is currently receiving psychiatric care and on a case-by-case basis for those individuals currently not receiving psychiatric care, but for whom the surgeon has determined a need). Individuals with the following psychiatric disorders: active substance abuse, psychosis, uncontrolled depression, and borderline personality disorder must have a current psychiatric/psychological assessment. There is a possibility that these individuals will be denied authorization;
- To certify that the individual's psychiatric profile is such that the individual is able to understand, tolerate, and comply with all phases of care, and is committed to long term follow-up requirements;
• To refer the individual at any time as deemed necessary for a consultative interaction with a licensed consulting psychologist or psychiatrist for assessment, treatment and/or follow-up care for psychosocial needs;
• To insure that the individual receives (from the surgeon) a thorough explanation about risks, benefits, and uncertainties involved, and the necessity for a long term commitment to follow a dietary regime;
• Provisions have been made for a long term program of postoperative care which consists of a weight loss program with three main components: diet therapy, behavior modification, and activity/exercise; and
• To submit (on a one-time basis) a written description of the post surgical follow-up program. This description will be kept on file with the medical reviewer for each surgeon.

Documentation Requirements

From the Surgeon:

• Height, weight, and BMI;
• Any co-morbid conditions;
• A written statement regarding the individual's past weight loss attempts, eating habits, commitment to lose weight, expectations of the surgical outcome, and the willingness to make permanent life-style changes; each part must be addressed;
• Medical contraindications, if applicable;
• Psychiatric contraindications, if applicable;
• Copy of the psychiatric/psychological assessment, if applicable;
• Statement that the risks, benefits, and uncertainties involved and the necessity for a long term commitment was explained to the individual; and
• Description of the long-term follow-up weight loss program with three main components: diet therapy, behavior modification, and activity/exercise.

From Individual Requesting the Surgery:

A Self Report Addressing: weight loss, exercise, and behavior modification efforts with approximate dates, feelings about making a long term commitment to diet therapy, exercise and behavior modification, knowledge about the surgery, and why there is an interest in having this surgery.

Required Documentation for Revision of Gastric Restrictive Surgery

• Date and type of the initial surgery;
• Weight loss history after the surgery;
• Present height and weight;
• Dietary assessment regarding current eating habits;
• X-ray or endoscopic report that demonstrates the staple line has failed or the pouch has enlarged; and
• Psychiatric contraindications to the surgery have been ruled out. If the patient is currently receiving psychiatric treatment, a current diagnostic assessment must be submitted.

Authorization Standards for Sleep Testing Children

Authorization is required for patients under the age of 18 years. The following information must be submitted with the authorization request:

• Current history and physical examination (within last 60 days) from the referring physician, including lab results and medications;
• Diagnosis and how it relates to the need for a sleep study;
• Specific examples of how symptoms impact health, well-being, and functional status; and
• Documentation of recent prior conservative interventions.

Authorization Standards for Breast Reduction

The following documentation must be submitted with the authorization request:

• Chart notes from the referring or primary physician, including:
  ▪ Clinical history/case summary documenting patient complaints; and
  ▪ Severity and duration of complaints;
• Height and weight;
• Bra size;
• Previous treatment;
• Number of grams to be removed from each breast;
• Photograph; and
• Schnur scale.

Authorization Standards for Panniculectomy

Panniculectomy is considered medically necessary when ALL (A-C) of the following are met:

A. The panniculus hangs to or below the level of the pubis (front and lateral view photo required) and,
B. The panniculus causes functional impairment, such as back pain documented by an orthopedic consult; or the pannus itself causes interference with ADL performance, and
C. Chronic, recurrent intertriginous rash, cellulitis, or skin necrosis that has failed to respond to medical management in six months (photo required).

OR
D. Incidental to intra-abdominal surgery to improve surgical access and wound healing and ONE of criteria A-C.

OR

E. Incidental to ventral hernia repair to improve wound healing and ONE of criteria A-C.

Authorization Standards for Breast Implant Removal

The following information must be submitted with the authorization request:

- Reason for initial implantation;
- Chart notes/test results documenting leakage/rupture, if present; and
- If rupture is not present, chart notes from the primary or referring physician documenting any medical reasons/symptoms for implant removal (history/case summary, severity and duration, previous treatment).

Authorization Standards for Gynecomastia

The following information must be submitted with the authorization request:

- Current history and physical examination from the primary care physician;
- History of medication or drug use;
- Results of lab tests, to rule out endocrine abnormalities;
- Evidence that other diseases (which can cause this condition) have been ruled out;
- Height and weight;
- Photograph; and
- Pathology report documenting removal of breast tissue rather than fat.

Authorization Standards for Botulinum Toxin

- Botox (Type A)
- Myobloc (Type B)

Authorization for use of botulinum toxin, Type A or Type B, will be granted solely for the treatment of approved conditions or for spasticity. This includes spasticity in cerebral palsy. The current approved conditions for Type A are blepharospasm, strabismus and spasmodic torticollis (cervical dystonia).

Use of botulinum toxin, Type A or Type B, will not be approved for cosmetic purposes such as removal of facial wrinkles or for the treatment of migraines or headaches.

Initial authorization only requires providing an acceptable diagnosis, which can be granted for up to 12 months.
Subsequent authorizations can be granted for up to 12 months. Each subsequent authorization requires documentation verifying the patient’s response to the treatment. The prior authorization is only granted if the documentation shows a positive response to the treatment. A comprehensive treatment is not required.

Transplant Services

Organ and Tissue Transplants

Transplant procedures approved by Medicare are automatically covered by MHCP. The legislature created a 12 member Transplant Advisory Committee whose role is to provide advice and recommendations to the Commissioner. Additional transplant procedures are covered only if they are covered by the DHS consulting contractor, are recommended by the Transplant Advisory Committee, approved by the Commissioner, and submitted to CMS in the State Plan and published in the State Register.

Covered Services

MHCP coverage for organ and tissue transplant procedures is limited to those procedures covered by the Medicare program or approved by the Advisory Committee on Organ and Tissue Transplants.

Types of Transplants:

- Autologous pancreatic islet cell transplant (after pancreatectomy)
- Heart
- Cornea
- Heart-lung
- Intestine
- Intestine-liver
- Kidney
- Liver
- Lung
- Pancreas
- Pancreas-kidney
- Stem Cell

Transplant coverage includes: preoperative evaluation, recipient and donor surgery, follow-up care for the recipient and live donor, and retrieval of organs, tissues. All transplant-related services are billed under the recipient’s MHCP ID number.

Effective January 1, 1996, upon the recommendation of the Transplant Advisory Committee, the Commissioner authorized coverage of autologous stem cell transplants for breast cancer.

Effective December 20, 1996, upon the recommendation of the Transplant Advisory Committee, the Commissioner authorized conditional coverage of allogeneic stem cell transplant for coverage of sickle cell disease. Conditional coverage for this diagnosis means the transplant must be limited to an investigational setting under research protocol and the criteria be adopted which is listed in the article "Bone Marrow Transplantation for Sickle Cell Disease," page 370, published in volume 335, Number 6, August 8, 1996 issue of the New England Journal of Medicine.
Effective April 1, 1997, upon recommendation of the Transplant Advisory Committee, the Commissioner authorized coverage for autologous stem cell transplants for multiple myeloma and authorized conditional coverage for allogeneic stem cell transplants for multiple myeloma. Conditional coverage for this diagnosis means the procedures must be performed in an investigational setting under research protocol.

Effective October 1, 1997, upon the recommendation of the Transplant Advisory Committee, the Commissioner authorized coverage for living donor lung lobe transplants.

Effective after April 4, 1998, upon the recommendation of the Transplant Advisory Committee, the Commissioner authorized coverage for allogeneic stem cell transplants for the diagnosis of myelodysplastic syndrome.

Effective after August 20, 1998, upon the recommendation of the Transplant Advisory Committee, the Commissioner authorized coverage for:

- Intestinal transplant using live donor or a cadaveric organ;
- Intestinal-liver transplants using cadaveric organs; and
- Liver transplant for a diagnosis of hepatocellular carcinoma (HCC) for patients who meet the United Network for Organ Sharing (UNOS) criteria in their policy (June 1988 3.6.4.4).

Effective November 19, 1998, upon the recommendation of the Transplant Advisory Committee, the Commissioner authorized coverage for:

- Liver transplants for patients with end stage liver disease who have a diagnosis of hepatitis B;
- Liver transplants using live donors for diagnoses listed in Minnesota's State Plan; and
- Autologous pancreatic islet cell transplant (after pancreatectomy).

Effective July 1, 1999, Medicare coverage of pancreas transplants, when performed simultaneously with or after a Medicare covered kidney transplant, is covered with prior authorization.

Eligible Providers

Cornea and kidney transplants must be performed in a facility that is a participating provider of the Medicare program.

All organ transplants must be performed at transplant centers meeting United Network for Organ Sharing Criteria (UNOS) or be Medicare Approved Heart, Lung, Heart-Lung, Liver, and Intestinal Transplant Centers.

Stem cell transplants must be performed in a tissue transplant center which is certified by and meets the Foundation for the Accreditation of Hematopoietic Cell Therapy (FAHCT) for stem
cells or bone marrow transplants, or be approved by the Advisory Committee on Organ and Tissue Transplants.

All transplant procedures must comply with all applicable laws, rules, and regulations governing (1) coverage by the Medicare program, (2) federal financial participation by the Medicaid program, and (3) coverage by the MA program. All transplants performed out of state must have prior authorization.

It is the responsibility of the transplant center to submit their certification documentation to provider enrollment.

**Eligible Recipients**

Transplant coverage applies to MA, GAMC, and MinnesotaCare recipients. GAMC recipients and MinnesotaCare recipients should be referred to their county human services agency for application to MA. If a recipient is not eligible for MA, any maximum benefit limits applicable to the MinnesotaCare recipient will apply. Refer to the MinnesotaCare section of the Health Care Programs and Services chapter (Ch. 2) for further information.

Persons eligible for EMA are **not** eligible for organ transplant coverage, or care services related to the transplant procedure.

**Authorization**

Authorization is required for the following transplant procedures: stem cell, heart-lung, lung, pancreas, pancreas-kidney, intestine, intestine-liver, and autologous pancreatic islet cell transplant (after pancreatectomy). The transplant facility must submit the authorization request to CDMI with a medical report. The medical report must include the following information:

- Diagnosis, including ICD-9-CM diagnosis code;
- Proposed treatment; and
- Sufficient information that is pertinent.

Out-of-state hospitals must include evidence of meeting the requirements of Medicare, UNOS, and Foundation for the Accreditation of Hematopoietic Cell Therapy (FAHCT).

If a transplant is to be performed out-of-state, the provider must obtain authorization **prior** to the service being rendered. Refer to the instructions in the Authorization chapter (Ch. 5) for out-of-state services.

**Heart Transplant**

Heart transplants are covered when performed in a facility on the Medicare list of approved heart transplant centers.

Artificial heart transplants are **not** covered.
Heart-Lung Transplant Coverage

Heart-lung transplants for persons with primary pulmonary hypertension, are covered when performed in a Minnesota facility that meets UNOS criteria to perform heart-lung transplants. Heart-lung transplants require authorization (except for those performed on recipients with Medicare coverage).

Lung Transplant Coverage

Lung transplants using cadaveric donors and lung lobe transplants from living donors are covered when performed in a Minnesota facility that meets UNOS criteria to perform lung transplants. All lung transplants require authorization (except for those performed on recipients with Medicare coverage).

Kidney Transplant Coverage

Kidney transplants must be performed in a hospital that is a participating provider of the Medicare program. If performed in an out-of-state facility, kidney transplants require authorization prior to the service being rendered.

Pancreas and Pancreas-Kidney Transplant Coverage

Pancreas transplants for uremic diabetic recipients of kidney transplants and persons with hypoglycemic unawareness, are covered when performed in a Minnesota facility which meets UNOS criteria to perform pancreas and pancreas-kidney transplants. All pancreas and pancreas-kidney transplants require authorization.

Liver Transplant Coverage

Liver transplants in children (under age 18 years) with extrahepatic biliary atresia, or other forms of end-stage liver disease are covered.

Liver transplants for children with a malignancy extending beyond the margins of the liver, or those with persistent viremia are not covered.

Liver transplants using live donors are covered.

Liver transplants are covered for adults with the following conditions:

- Primary biliary cirrhosis;
- Primary sclerosing cholangitis;
- Post necrotic cirrhosis, hepatitis B surface antigen negative;
- Alpha-1 antitrypsin deficiency disease;
- Wilson's disease or primary hemochromatosis;
• Alcoholic cirrhosis;
• Any other end-stage liver disease other than hepatitis B;
• Hepatocellular carcinoma; or
• End-stage liver disease with the diagnosis of hepatitis B.

In cases involving alcoholic cirrhosis:

• The facility must state its criteria for the period of abstinence required prior to surgery;
• Documentation which shows how the patient meets that criteria; and
• Documentation showing evidence of social support to assure assistance in alcohol rehabilitation and immunosuppressive therapy following the surgery.

Liver transplants require authorization, including those covered by other third-party payers. Transplants for recipients with Medicare coverage do not require authorization.

**Intestine Transplant Coverage**

Intestine transplants for a patient with a diagnosis of short bowel syndrome, parenterally dependent and experiencing life-threatening or potentially life-threatening complications due to the original disease or to complications of total parenteral nutrition (TPN), are covered. Intestine transplants must be performed in a facility that meets UNOS criteria to perform this transplant. All intestine transplants require authorization.

**Intestine-liver Transplant Coverage**

Intestine-liver transplants are covered for persons who develop liver disease secondary to TPN treatment. Intestine transplants must be performed in a facility that meets UNOS criteria to perform this transplant. Intestine-liver transplants require authorization.

**Stem Cell Transplant Coverage**

**Stem Cell Transplantation:** A procedure where stem cells are obtained from a donor's or recipient's bone marrow or peripheral blood, and prepared for intravenous infusion. DHS follows Medicare guidelines and is replacing references to bone marrow with stem cell transplantation.

**Policy**

Transplant centers must be participating providers of the Medicare program and meet Foundation for the Accreditation of Hematopoietic Cell Therapy (FAHCT) criteria for stem cell transplants, and be located in Minnesota or contiguous counties to receive payment for stem cell transplants. Transplant facilities requesting authorization must have, on file with DHS, a report of the facilities' standards and experience indicating that these criteria are being met.
All stem cell transplants require authorization.

**Allogeneic stem cell transplants** are covered for the treatment of leukemia or aplastic anemia when it is reasonable and necessary for the individual patient to receive this therapy; [ICD-9 list](PDF)

**Autologous stem cell transplants** are covered for: ([ICD-9 list](PDF)

**Organ Transplant List** [Organ Transplant List](PDF)

**Autologous Pancreatic Islet Cell Transplant (after pancreatectomy) Coverage**

Autologous pancreatic islet cell transplant (after pancreatectomy) coverage is not to be confused with pancreatic islet cell allograft transplant (non-covered) for a recipient with a diagnosis of Type I diabetes.

Pancreatectomy is covered for a recipient with a diagnosis of chronic pancreatitis with intractable pain. With pancreatectomy, the pain is relieved, but without the autologous pancreas islet cell transplant, the result is insulin dependent diabetes mellitus. The autologous pancreatic islet cell transplant has the potential to prevent diabetes or make the diabetes mild. This procedure is covered when performed in a Minnesota facility that meets UNOS criteria. All autologous pancreatic islet cell transplants (after pancreatectomy) require authorization.

**Billing Transplants**

The cost of organ, tissue, and stem cell procurement should be included on the inpatient hospital claim. The hospital stay for the donor is included in the DRG payment for the donee (MHCP recipient). All charges for the donor should be billed using the donee's MHCP ID number.

**Other Payers**

Liable third-party coverage, monies must be used to the fullest extent before MHCP payment will be made for a transplant. If a third-party payer denies payment, the denial and documentation of efforts to secure payment must be submitted with the claim. If appeals are available through the insurer, DHS will ask the recipient to pursue these appeals. Providers must obtain authorization, for transplants that require authorization even though private insurance may pay a portion of the charges.

**Medical Nutritional Therapy (MNT)**

**Medical Nutritional Therapy:** Counseling to assess and minimize the problems hindering normal nutrition, and to improve the patient's nutritional status.

**Licensed Dietician:** One who has been granted licensure by the Board of Dietetics and Nutrition Practice pursuant to MS 148.
Eligible Providers

Nutritional counseling may be provided in a physician's office, clinic, or outpatient hospital setting. This service may be provided by a physician or by a licensed dietician with a referral from the physician. Licensed dieticians cannot enroll in MHCP independently.

Covered Services

Medical nutritional therapy includes evaluation, follow-up, and/or group counseling prescribed by a physician. The medical necessity for these services must be documented in the medical record.

Weight Loss Services

MHCP covers physician visits, medical nutritional therapy, mental health services*, and laboratory work provided for weight management. Enrolled providers on a component basis with current CPT/HCPCS codes must bill services.

If an MHCP recipient elects to participate in a weight loss program, the recipient may be billed for components of the program that are not covered, as long as the recipient is informed of charges in advance.

Coverage standards for gastric restrictive surgery: See the Gastric Restrictive Surgery section of this chapter.

*Authorization may be required for mental health services. Refer to Mental Health Service (Ch. 16) for requirements.

Non-covered Weight Loss Services

- Weight loss services on a program basis;
- Nutritional supplements or foods for the purpose of weight reduction;
- Exercise classes;
- Instructional materials and books;
- Motivational classes;
- Counseling or weight loss services provided by persons who are not MHCP providers;
- Counseling that is part of the physician's covered services and for which payment has already been made; and
- Nutritional counseling for diabetic education when it is part of a diabetic education program (see Diabetic Education section of this chapter).
Billing

Payment for medical nutritional therapy provided by a licensed dietician (under the supervision of a physician) is limited to the following codes:

- **97802** Initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. This code is to be used only once per year, for initial assessment of a new patient.
- **97803** Reassessment and intervention, individual, face-to-face with the patient, each 15 minutes. Use this code for all individual reassessments and all interventions after the initial visit when there is a change in the patient’s medical condition that affects the patient’s nutritional status.
- **97804** Group (2 or more), each 30 minutes.
- **G0270** Reassessment and subsequent intervention following second referral in the same year due to change in diagnosis, medical condition or treatment regimen, individual, face-to-face with patient, each 15 minutes.
- **G0271** Reassessment and subsequent intervention following second referral in the same year for change in diagnosis, medical conditions or treatment regimen group (2 or more), each 15 minutes.

Diabetic Outpatient Self-Management Training Services (DSMT)

**Diabetic Outpatient Self-Management Training Service:** A preventative health service for persons diagnosed with diabetes. An outpatient diabetes self-management and training program includes education about self-monitoring of blood glucose, diet and exercise, an insulin treatment plan developed specifically for the patient who is insulin-dependent, and motivates patients to use the skills for successful self-management of diabetes. Diabetic outpatient self-management training services minimize the occurrence of disease and disability through instructions on maintaining health and well being of the patient.

**Eligible Providers**

- Diabetic care instructions may be provided by a physician or RN;
- Nutritional counseling may be provided by a physician or licensed dietician. Referrals should be made to licensed dieticians for in-depth nutritional counseling; and
- Licensed registered nurses may only provide nutritional counseling to the extent that their scope of practice and education experience allow.

A provider of dually eligible MHCP recipients must be a "certified provider" according to Medicare's definition. Certified providers for Medicare's purposes must meet the National Diabetes Advisory Board Standards.
Covered Services

A physician must order all diabetic DSMT services. DSMT services include:

- Diabetes overview;
- Stress and psychosocial adjustment;
- Family involvement and social support;
- Nutritional counseling;
- Exercise and activity;
- Medications;
- Monitoring and use of results;
- Relationships among nutrition, exercise, medication, and blood glucose levels;
- Prevention, detection, and treatment of chronic complications;
- Foot, skin, and dental care;
- Behavior change strategies, goal setting, risk factor reduction, and problem solving;
- Benefits, risks, and management options for improving glucose control;
- Preconception care, pregnancy, and gestational diabetes; and
- Use of health care systems and community resources.

Billing

Use the appropriate DSMT codes below when billing. Do not bill nutritional counseling, office visit (E/M) codes, facility codes, or other procedure codes with DSMT codes.

- **G0108** Diabetic outpatient self-management training services; individual session; 1 unit equals 30 minutes of training.
- **G0109** Diabetic outpatient self-management training services; group session; 1 unit equals 30 minutes of training.

Bill one unit per each half hour of DSMT services, with a maximum of not more than 10 hours within a continuous 12-month period for each recipient. After the initial 10-hour training, additional DSMT services are limited to one hour (group or individual) per year.

Nutritional Products

**Nutritional Product:** A commercially formulated substance that provides nourishment, and affects the nutritive and metabolic processes of the body. Nutritional products are covered by MHCP.
Providers

A parenteral nutritional product must be dispensed as a pharmacy service as prescribed by a physician. Refer to Pharmacy Services (Ch. 22).

An enteral nutritional product may be supplied by a pharmacy, home health agency, or medical supply provider with a written physician's order.

Covered Nutritional Services

MHCP covers enteral nutritional products when the patient's diagnosis can be linked to the need for a nutritional product. Refer to Equipment and Supplies chapter (Ch. 23), for additional information.

Podiatry

Providers

Podiatrists who practice as defined in MS 153 and physicians are eligible for payment for podiatry services.

Covered Services

- Debridement or reduction of pathological toenails, and of infected or eczematized corns and calluses;
- Avulsion of nail plate;
- Evacuation of subungual hematoma;
- Excision of nail and nail bed;
- Reconstruction of nail bed; and
- Other non-routine foot care.

Payment Limitations for Debridement or Reduction of Nails, Corns and Calluses

Payment for debridement or reduction of non-pathological toenails, and of non-infected or non-eczematized corns or calluses is limited. These services are considered routine foot care, unless the patient has a systemic condition which may require the expertise of a professional.

Although not intended as a comprehensive list, the following metabolic, neurologic, and peripheral vascular disease (with synonyms in parenthesis) most commonly represent the underlying conditions that may justify coverage for routine foot care:

- Diabetes mellitus;
• Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, or occlusive peripheral arteriosclerosis);
• Buerger's Disease (thromboangiitis obliterans);
• Chronic thrombophlebitis; or
• Peripheral neuropathies involving the feet associated with:
  ▪ Malnutrition and vitamin deficiency;
    – Malnutrition (general, pellagra);
    – Alcoholism;
    – Malabsorption (celiac disease, tropical sprue); or
    – Pernicious anemia;
  ▪ Carcinoma;
  ▪ Diabetes mellitus;
  ▪ Drugs and toxins;
  ▪ Multiple sclerosis;
  ▪ Uremia (chronic renal disease);
  ▪ Traumatic injury;
  ▪ Leprosy or neurosyphilis; or
  ▪ Hereditary disorders;
    – Hereditary sensory radicular neuropathy;
    – Angiokeratoma corporis diffusum (Fabry's); or
    – Amyloid neuropathy.

Non-covered Services

The following list includes, but is not limited to, podiatry services which are not covered by MHCP:

• Surgical assistant services (differing from assisting surgeons);
• Local anesthetics that are billed as a separate procedure;
• Operating room facility charges;
• Routine foot care:
  ▪ Foot hygiene (cleaning and soaking the feet to maintain a clean condition);
  ▪ Cutting or removal of corns and calluses (except as noted above);
  ▪ Trimming, cutting, clipping or debriding of nails (except as noted above);
  ▪ Use of skin creams to maintain skin tone; or
  ▪ Any other service performed in the absence of localized illness, injury or symptoms involving the foot;
• Services not covered by Medicare, or services denied by Medicare:
  ▪ Subluxation of the foot;
- Treatment of flat feet; or
- Routine foot care;
- Stock orthopedic shoes, except when attached to a leg brace; and
- Routine supplies provided in the office. Refer to List of Routine Supplies section in this chapter.

**Coverage Limitations**

The following coverage limitations apply to podiatry services:

- When a physician or podiatrist provides services to long term care (LTC) facility residents:
  - The referral must result from the resident, an RN, or LPN employed by the facility, the resident's family, guardian, or attending physician;
  - The LTC facility must document the referral in the medical record; and
  - LTC facilities are responsible for routine foot care.
- Coverage for the debridement and reduction of nails, corns, and calluses are limited to once every 60 days.
- For established patients, a podiatry visit charge must not be billed on the same day as the date for services described for debridement or reduction of nails, corns, and calluses.
- Provider may bill the avulsion and excision codes only once per nail.

**Billing**

- Podiatry services are billed on the CMS-1500. Refer to Billing Policy (Ch. 4) for billing instructions.
- National foot care modifiers are required on all routine foot care services, regardless of specialty.
- Refer to Laboratory/Pathology, Radiology and Diagnostic Services (Ch. 11) for billing instructions.

**Legal References**

MS [256B.0625](#), subd. 3; subd. 4 (general information)
Minnesota Rules [9505.0345](#); [9505.0355](#) (general information)
Minnesota Rules [9505.0330](#) (outpatient hospital)
MS [256B.0625](#), subd. 25 (physician assistant standards)
Minnesota Rules [9505.5010](#) (prior authorization)
MS [256B.0625](#), subd. 28a
MS [147A.01](#) (physician assistant)
MS [256B.0625](#), subd. 28a
MS [256B.0625](#), subd. 27; 256.0629 (organ transplants)
MS 256D.03, subd. 7 (second medical opinion)
Minnesota Rules 9505.5035 (second medical opinion)
MS 256B.0625, subd. 32 (nutritional products)
Minnesota Rules 9505.0325 (nutritional products)
MS 153 (podiatry licensing)
Minnesota Rules 9505.0350 (podiatry)
42 CFR 440.20
42 CFR 440.166
42 CFR 440.50
42 CFR 440.130(c)
Chapter 7

Anesthesia Services

Anesthesia services are provided to patients undergoing surgical or nonsurgical procedures in an outpatient or inpatient setting that requires the administration of an anesthetic. The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include, but are not limited to, general, regional, supplementation of local anesthesia, or other support services in order to provide the recipient the anesthesia care deemed appropriate. These services include preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (ECK, temperature, blood pressure, oximetry, capnography and mass spectrometry).

Definitions

**Anesthesiology:** The practice of medicine dedicated to the relief of pain and total care of the surgical patient before, during and after surgery.

**Anesthesiologist:** A physician who specializes in anesthesiology and is board certified as an anesthesiologist.

**Certified Registered Nurse Anesthetist (CRNA):** An advance practice registered nurse. CRNAs are registered nurses with a baccalaureate degree who have completed an additional 24 to 36 months of training in anesthesiology in an accredited program and are certified by the Council on Certification of Nurse Anesthetists, or the Council on the Certification of Nurse Anesthetists of the American Association of Nurse Anesthetists (AANA).

**Personally Performed:** To be considered personally performed, the anesthesiologist may not be involved in any other procedure or duties that take him/her out of the operating room. It should be assumed that if the anesthesiologist leaves the operating room, he/she is performing other duties. If the anesthesiologist leaves the operating room to perform any other duties, the anesthesia procedure may not be billed as personally performed.

Eligible Providers

- Anesthesiologists (MDA)
- Certified Registered Nurse Anesthetist (CRNAs)
- Hospitals may enroll CRNAs they employ
Criteria for Medical Direction

Anesthesiologists can be reimbursed for the personal medical direction (as distinguished from supervision) that they furnish to CRNAs.

Medical direction services personally furnished by an anesthesiologist will be reimbursed only if the anesthesiologist:

- Performs a pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence (if applicable);
- Ensures that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified individual;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present in the surgical suite and available for immediate diagnosis and treatment of emergencies; and
- Provides indicated post-anesthesia care.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation, and another may fulfill the other criteria. Similarly, one physician member of the group may provide post anesthesia care, while another member of the group furnishes the other component parts of anesthesia services. However, the medical record must indicate that physicians furnished the services and identify the physicians who rendered them.

DHS will reimburse anesthesiologists for supervision of residents per Medicare's formula and restrictions. The teaching physician must be present during induction, emergence, and during all critical portions of the procedure, and immediately available to furnish services during the entire service or procedure. The documentation in the medical records must indicate the teaching anesthesiologist's presence or participation in the administration of the anesthesia. The teaching physician’s presence is not required during the pre-operative or post-operative visits with the recipient. DHS follows Medicare guidelines for reimbursement to anesthesiologists for the supervision of residents. DHS does not reimburse for anesthesia assistants or interns.

Concurrent Medical Direction of CRNAs

In all cases in which the anesthesiologist furnishes medical direction, he/she must be physically present in the operating suite.

If the anesthesiologist concurrently medically directs two physician-employed or hospital-employed CRNAs, DHS will reduce the number of base units for the procedure by 10%.
If the anesthesiologist concurrently medically directs three physician-employed or hospital-employed CRNAs, DHS will reduce the number of base units for the procedure by 25%.

If the anesthesiologist concurrently medically directs four physician-employed or hospital-employed CRNAs, DHS will reduce the number of base units for the procedure by 40%.

If the anesthesiologist supervises anesthetists during five or more concurrent procedures, payment can be made only for patient services personally rendered by the anesthesiologist, not to exceed three base units plus 15 minutes for induction.

The billing or scheduling records that describe the anesthesia services provided must indicate the number of CRNA procedures concurrently medically directed by the anesthesiologist.

Calculation of Concurrent Medically Directed Anesthesia Procedures:
Concurrency is defined with regard to the maximum number of procedures that the anesthesiologist is medically directing within the context of a single procedure and whether or not these other procedures overlap each other. The following example illustrates the concept of concurrency:

Example: Procedures A through E are medically directed procedures involving CRNAs. The starting and ending times for each procedure represent the periods during which "anesthesia time" is counted. Procedure:
A begins at 8:00 a.m. and lasts until 8:20 a.m.
B begins at 8:10 a.m. and lasts until 8:45 a.m.
C begins at 8:30 a.m. and lasts until 9:15 a.m.
D begins at 9:00 a.m. and lasts until 12:00 noon
E begins at 9:10 a.m. and lasts until 9:55 a.m.

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Time of Total Surgery</th>
<th>The Physician Directed These Cases Concurrently</th>
<th>Time Frame That the Cases were Directed Concurrently</th>
<th>Number of Surgeries Directed</th>
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<tr>
<td>A</td>
<td>8:00-8:20 a.m.</td>
<td>A &amp; B</td>
<td>8:10-8:20 a.m.</td>
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<tr>
<td>B</td>
<td>8:10-8:45 a.m.</td>
<td>B &amp; C</td>
<td>8:20-8:45 a.m.</td>
<td>2</td>
</tr>
<tr>
<td>C</td>
<td>8:30-9:15 a.m.</td>
<td>C, D, &amp; E</td>
<td>9:00-9:15 a.m.</td>
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<tr>
<td>D</td>
<td>9:00-12 noon</td>
<td>C, D, &amp; E</td>
<td>9:00-9:15 a.m.</td>
<td>3</td>
</tr>
<tr>
<td>E</td>
<td>9:10-9:55 a.m.</td>
<td>C, D, &amp; E</td>
<td>9:00-9:15 a.m.</td>
<td>3</td>
</tr>
</tbody>
</table>
Criteria for Supervision

When the anesthesiologist does not fulfill the above criteria or is involved in supervising more than four procedures concurrently, his/her supervisory services are considered services to the hospital and are reimbursable only to the hospital. However, payment will be considered for pre-anesthesia services up to and including induction, when personally furnished by the anesthesiologist.

Supervision of Anesthesia Service by Surgeon

MHCP will not reimburse a surgeon for supervision of anesthesia services provided by a CRNA, anesthesia assistant, intern, or resident.

Payment for Qualifying Circumstances

MHCP reimburses anesthesia "for a patient of extreme age" only if the patient is less than one year of age or over 70 years of age. Bill the anesthesia for a patient of extreme age code on a separate line and bill for one unit. Do not use anesthesia modifiers. Independent CRNAs may bill if not under medical direction. If under medical direction, the decision has to be made whether the procedure is to be billed by the anesthesiologist or the CRNA.

Certified Registered Nurse Anesthetist Services

Enrollment

CRNAs must enroll and sign a provider agreement in order to be eligible for reimbursement. Hospitals may enroll the CRNAs that they employ.

Billing for Anesthesia Services

Claims Documentation Requirements

The provider must submit claims for anesthesia services on the CMS-1500 claim form or the electronic equivalent. Use specific CPT American Society of Anesthesiology (ASA) anesthesia codes or surgical codes with the appropriate anesthesia modifier. For authorized surgical services, MHCP prefers that anesthesia services are billed using surgical procedure codes with the appropriate anesthesia modifier.
**Exact Minutes**

Submit the exact number of minutes from the preparation of the patient for induction to the time when the anesthesiologist or the CRNA was no longer in personal attendance or continues to be required. Enter only the number of minutes in the units box. DHS will calculate the base units for each procedure.

**Modifiers**

To properly identify the exact nature of the service being rendered, the following HCPCS code modifiers should be used:

**Anesthesia Modifiers**

- **AA** Anesthesia services performed personally by anesthesiologist
- **AD** Medical supervision by a physician: more than four concurrent anesthesia procedures
- **QK** Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
- **QS** Monitored anesthesia care services
- **QX** CRNA service with medical direction by an anesthesiologist
- **QY** Anesthesiologist medically directs one CRNA
- **QZ** CRNA service without medical direction by an anesthesiologist

Anesthesiologists and CRNAs must comply with DHS requirements for billing sterilization procedures. A Sterilization Consent Form, signed and dated by the patient and the physician, must be submitted with anesthesia claims for sterilization procedures. (Refer to Reproductive Services (ch.10) for additional information.

**Anesthesiologist and CRNA**

When both an anesthesiologist and a CRNA are involved in a single anesthesia service, the service is considered personally performed by the anesthesiologist. No separate payment is ordinarily recognized for the CRNA service. Therefore, if DHS has a claim on file where the anesthesiologist billed for a procedure using an "AA" modifier (anesthesia services performed personally by an anesthesiologist), the CRNA service will normally not be reimbursable. However, DHS follows pre-1998 Medicare policy, which assumes medical necessity for certain major surgical procedures. Both services will be allowed for these procedures. For other procedures, DHS will cover a separate CRNA charge only if DHS receives specific claim documentation explaining why it was medically necessary for both the anesthesiologist and the CRNA to be involved.
Billing by Hospitals

The services of the hospital-employed CRNA as part of the DRG must be billed by the hospital on the UB-92. Refer to Hospital Services (ch.14) for additional billing information. Inpatient CRNA services are not separately biallable for hospitals that choose to retain CRNA costs in the rates.

Billing by CRNA

Inpatient CRNA services provided by an employee of a hospital that has chosen to remove CRNA costs from their rate, must be billed as inpatient CRNA services on the CMS-1500, or electronic equivalent, and must contain:

- The 7-digit base hospital MHCP provider ID number, where the CRNA services were performed, with the CRNA suffix "67" added in box 33; the Physician GRP# field on ITS; or log into MN-ITS using the 7-digit hospital provider ID number with the CRNA suffix “67”, which will allow the Billing Provider section on the Providers Tab screen to auto populate with the correct pay-to information,;
- The MHCP provider ID number of the CRNA, who performed the service, in box 24K; the Treating Provider Number field on ITS; or as the rendering provider, completing other required fields in that entry, in the Other Provider Types section on the Providers Tab screen in MN-ITS; and
- The 7-digit base hospital provider ID number (where the CRNA services were performed) with the suffix "00" added in box 17a; the ID Number of the Referring Physician field on ITS; or as the referring provider, completing other required fields in that entry, in the Other Provider Types section on the Providers Tab screen in MN-ITS.

Inpatient CRNA services provided by a CRNA who is independent or employed by a physician must be billed as inpatient CRNA services on the CMS-1500, or electronic equivalent, and must contain:

- The CRNA or physician’s MHCP provider ID number in box 33, the Physician GRP# field on ITS, log into MN-ITS using the 7-digit CRNA or physician’s ID number, which will allow the Billing Provider section on the Providers Tab screen to auto populate with the correct pay-to information, or ;
- The MHCP provider ID number of the CRNA (who performed the service) in box 24K, the Treating Provider Number field on ITS, or as the rendering provider, completing other required fields in that entry, in the Other Provider Types section on the Providers Tab screen in MN-ITS; and
- The 7-digit base hospital provider ID number (where the CRNA services were performed) with the suffix "00" added in box 17a, the ID Number of the Referring Physician field on ITS, or as the referring provider, completing other required fields in that entry, in the Other Provider Types section on the Providers Tab screen in MN-ITS.
Monitored Anesthesia Care (MAC)

Monitored anesthesia care is a specific anesthesia service in which an anesthesiologist or CRNA has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure.

Monitored anesthesia care includes all aspects of anesthesia care -- a preprocedure visit, intraprocedure care and postprocedure anesthesia management.

During monitored anesthesia care, the anesthesiologist or CRNA provides a number of specific services, including but not limited to:

- Monitoring of vital signs, maintenance of the patient's airway and continual evaluation of vital functions.
- Diagnosis and treatment of clinical problems that occur during the procedure.
- Administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary to ensure patient safety and comfort.
- Provision of other medical services as needed to accomplish the safe completion of the procedure.
- Anesthesia care often includes the administration of doses of medications for which the loss of normal protective reflexes or loss of consciousness is likely. Monitored anesthesia care refers to those clinical situations in which the patient remains able to protect the airway for the majority of the procedure. If, for an extended period, the patient is rendered unconscious and/or loses normal protective reflexes, then anesthesia care shall be considered a general anesthetic.

There must be continuous physical presence of the anesthesiologist or, in the case of medical direction, of the CRNA being medically directed.

Services by a CRNA: Monitored anesthesia care is a covered service if the CRNA performs the above-described services. The time the CRNA is physically present with the patient is covered. Use the appropriate anesthesia or surgical procedure code to bill this service and indicate the exact number of minutes in direct recipient contact. Modify the procedure code indicating the service was done under medical direction or performed independently. Indicate QS as the secondary modifier.

Services by an Anesthesiologist: Monitored anesthesia care is a covered service if the anesthesiologist performs the above-described services. The time the anesthesiologist is physically present with the recipient is covered.

An anesthesiologist may not bill for monitoring time not spent in direct contact with the recipient. Use the appropriate anesthesia or surgical procedure code to bill this service and indicate the exact number of minutes in direct contact. If the anesthesiologist is billing for medical direction, the anesthesiologist must meet the standards for medical direction. Modify the procedure code indicating medical direction or personally performed. Indicate QS as the secondary modifier.
Conscious Sedation

Conscious sedation, CPT codes 99141 and 99142, requires that:

1) The sedation be administered by the physician performing the procedure, and
2) An independent trained observer is present to assist the physician in monitoring the patient’s level of consciousness and physiological status.

The intent of conscious sedation is for the patient to remain conscious and able to communicate during the entire procedure. The patient retains the ability to independently and continuously maintain a patent airway and respond appropriately to physical stimulation and/or verbal command. Conscious sedation includes performance and documentation of pre-and post sedation evaluations of the patient, administration of the sedation and/or analgesic agents, and monitoring of cardiorespiratory functions (pulse oximetry, cardio respiratory monitor, and blood pressure).

*Conscious sedation codes cannot be billed when anesthesia services are provided at the same time.

Pre-anesthetic Evaluations and Post-operative Visits

DHS uses the CMS list of base values which were adopted from the relative base values established by the ASA. The base value for anesthesia services includes usual pre-operative and post-operative visits. No separate payment is allowed for the preanesthetic evaluation regardless of when it occurs unless the recipient is not induced with anesthesia because of a cancellation of the surgery.

In cases where an anesthetic is not administered due to a cancellation of the surgery, the anesthesiologist or the independent CRNA may bill an evaluation and management CPT code that demonstrates the level of service performed.

Patient Controlled Analgesia (During Hospitalization)

MHCP covers patient controlled analgesia for pain with the continuous infusion of pain medication facilitated by an infusion pump in a hospital setting. MHCP will separately reimburse the placement of an intrathecal or epidural catheter. The correct unmodified HCPCS Level I CPT surgical code should be used to bill the catheter placement. Do not bill the placement of the catheters with time units or with anesthesia modifiers.

MHCP covers the daily pain management service that is medically necessary. The service must be conducted face-to-face. The appropriate CPT code should be used to bill this service. This service is not billed in units of time, and is limited to one service per day.
Epidural Analgesia for Vaginal or Cesarean Section

The CPT code that describes the service of continuous epidural analgesia for labor and vaginal or cesarean delivery includes the placement of the epidural catheter. Do not bill the placement of the epidural catheter separately. Indicate in the units box the number of minutes that the provider is physically present with the recipient.

Anesthesia For Ocular Procedures and Pacemakers

Anesthesia policy for ocular and pacemaker surgery follows Medicare guidelines.

Special Services Provided by Anesthesiologists or Independent CRNAs

MHCP covers specialized services performed by an anesthesiologist or independent CRNA, such as insertion of Swan-Ganz catheters, placement of central venous lines, arterial lines, etc. These services should be billed with the appropriate unmodified CPT codes that describe the service. The service should be billed as a surgical procedure and no time units should be used.

Legal References

MS 256B.0625, subd. 3; subd. 11
Chapter 8

Clinic Services

The following clinic services are included in this chapter: Physician and Dental Clinics, Community Health Clinic, Public Health Clinic, Public Health Nursing Clinic, Federally Qualified Health Center, and Rural Health Clinics.

**Clinic Services:** Preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided by a facility that is not part of a hospital, but provides medical or dental care to outpatients. To enroll in MHCP, the clinic must have a federal employer's identification number and must report the number to the DHS Provider Enrollment Unit.

**Provider Requirements**

- A clinic that provides physician services must have at least two physicians on the staff. The physician service must be provided by an advanced practice registered nurse (APRN) or physician assistant (PA), or under the supervision of, a physician who is an MHCP provider.

- A clinic that provides dental services must have at least two dentists on the staff. The dental service must be provided by, or under the supervision of a dentist who is an MHCP provider.

**Covered /Non-Covered Services**

See [Physician and Professional Services chapter](#) (Ch. 6) and dental services outlined in the [Dental Services chapter](#) (Ch. 19) for a list of covered and non-covered services.

**Community Health Clinic Services**

**Community Health Clinic:** Health services provided by an APRN, PA, physician or under the supervision of a physician in a clinic that meets the following criteria:

- Has non-profit status as specified in applicable Minnesota Statutes;
- Has tax exempt status as provided for in the Internal Revenue Code;
- Is established to provide health services to low income population groups; and
- Has written clinic policies as required by the applicable provisions of Minnesota Rules.

**Eligible Providers**

To enroll as a Community Health Clinic, the following must be documented:

- A description of health services provided;
• Policies concerning medical management of health problems including health conditions which require referral to physicians or other health professionals and provision of emergency health services; and
• Policies concerning maintenance and review of health records by the physician.

**Covered Services**

• Physician and health professional services: A health service provided by a person who meets one or both of the requirements below as noted in Minnesota State Statute:
  - PA; or
  - APRN who contracts with, is a volunteer of, or is an employee of a community health clinic.

  See specific supervision requirements in the [Physician and Professional Services chapter](Ch. 6), Physician Extender section.

• Preventive health services;
• Family planning services;
• Early periodic screening, diagnosis, and treatment services, also known as Child and Teen Checkups or C&TC;
• Dental services; and
• Prenatal care services.

**Public Health Clinic Services**

**Public Health Clinic:** A health service provided by an APRN, PA or under the supervision of a physician in a clinic that is a department of, or operates under the direct authority of a unit of government.

**Covered Services**

• Physician services;
• Preventive health services;
• Family planning services;
• Prenatal care services;
• Dental services;
• Child and Teen Checkups; and
• Tuberculosis case management and directly observed therapy.
Tuberculosis Case Management and Directly Observed Therapy

Effective July 1, 1995, the Minnesota legislature passed the DHS Omnibus Bill which provides for coverage of case management and directly observed therapy services for MHCP recipients infected with tuberculosis. These services must be provided by certain persons employed by a Community Health Board.

Community Health Board: A board of health established, operating and eligible for a subsidy (from the Commissioner of Health). The board has general responsibility to develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards.

Case Management Services: Face-to-face services furnished to assist persons infected with TB in gaining access to needed medical services.

Persons Infected with TB: Individuals infected with latent or active tuberculosis who have a positive TB skin test, or have a negative tuberculin skin test, but a positive sputum culture for the TB organism; an individual whose TB test is negative, but whose physician's certification indicates the individual requires TB-related drug and/or surgical therapy can be considered TB infected.

Directly Observed Therapy: Physically watching the person take the drugs prescribed for TB.

Covered Services

- Case management services include, at a minimum:
  - Assessing the need for medical services to treat tuberculosis;
  - Developing a plan of care addressing those needs;
  - Assisting in accessing medical services identified in the care plan; and
  - Monitoring compliance with the care plan to ensure completion of tuberculosis therapy.

- Directly observed therapy.

Coverage Limitations

Case management services are covered if provided by a certified public health nurse, employed by a community health board. Directly observed therapy must be provided by a community outreach worker, licensed practical nurse, registered nurse trained and supervised by a certified public health nurse employed by a community health board, or by a certified public health nurse employed by a community health board.
Drugs for Tuberculosis

MHCP covers drugs for tuberculosis and other communicable diseases if prescribed by a licensed practitioner and dispensed by a physician or certified nurse practitioner employed by, or under contract with, a community health board for purposes of communicable disease control.

Billing Requirements

Use code X5698 for case management and code X5699 for directly observed therapy. These two codes should not be billed on the same day, nor should office or home visits be billed on the same day as case management. Bill on the CMS-1500.

Public Health Nursing Clinic Services

Public Health Nursing Clinic (PHNC): Provides certified public health nursing services and is a department of, or operates under the direct authority of a unit of government. Examples of a unit of government include county, city, or school district. PHNC services may be performed at a main clinic site, satellite clinics, mobile clinic sites that are open to the public, or the recipient’s home.

Certified Public Health Nurse (CPHN): Licensed registered nurse providing services within the scope of practice as defined in Minnesota Statutes and certified in public health nursing by the Minnesota Board of Nursing, or received certification from the Minnesota Department of Health prior to January 1990.

Registered Nurse (RN): A nurse licensed under and within the scope of Minnesota statutes.

Covered Services

MHCP will cover the following services of a Certified Public Health Nurse (CPHN) or licensed registered nurse supervised by a CPHN practicing in a Public Health Nursing Clinic (PHNC):

Health Promotion and Counseling:

- To alleviate or prevent health problems identified in a nursing assessment;
- To promote, maintain, or restore health; and
- To accept responsibility for the prevention of illness.

This service does not include in-depth nutritional counseling normally performed by a licensed dietician, nor does it include structured diabetic education programs. Refer to the Physician's Services chapter (Ch. 6): Nutritional Counseling; and Diabetic Education sections for coverage information and requirements.
**Medication Management:** A review of a recipient's current medications and adherence to the prescribed medication regime includes:

- A nursing evaluation for adverse reactions to medications;
- Education to understand proper medication administration; and
- Any contacts with the physician about prescription, tolerance or adherence to the medication regimen.

**Nursing Assessment and Diagnostic Testing:** A health history or examination that includes, but is not limited to the following:

- A review of the recipient's health status;
- Identification of health hazards;
- Identification of actual and potential health needs;
- Evaluation of health behavior;
- Evaluation of physical, emotional, and psychological health as it relates to personality, lifestyle, and culture factors;
- Standardized diagnostic tests performed by reagent strips (e.g., glucose testing); and
- Vital signs.

**Nursing Treatment:** A treatment performed within the scope of practice of a licensed registered nurse.

**Non-covered Services**

- Services that are part of the WIC (Women, Infants & Children Food Program) clinic package, such as height, weight, B/P, and client history;
- Traditional home health agency acute care services provided in the home, such as the type of home care reimbursable by Medicare; and
- Services provided by a school-based PHNC, which are available at no cost to a non-recipient student.

**Services Provided in the Home**

PHNC services may be performed in the recipient's home on an intermittent basis, when necessary to ensure that the recipient receives the necessary care. PHNC visits may not be used as a substitute for traditional home care, such as the type of home care that is reimbursable by Medicare. If a recipient needs traditional home care, the recipient should be referred to a Medicare Certified Home Care Agency.

**Billing For Services Provided in a Clinic Setting**

- Services provided in a clinic setting must be billed individually on the CMS-1500.
  - Nursing Assessment and Diagnostic Testing (X5546):
− This service may be billed if the CPHN conducts and documents a nursing assessment and diagnostic test (if appropriate) as defined in this chapter.
− Only one service code is billed regardless of whether the CPHN assesses multiple needs, performs multiple diagnostic tests, or performs one of each type of service.

### Health Promotion and Counseling (X5547):

− This service may be conducted with one recipient or multiple recipients. The service is billed in 15-minute increments. Any service, single or multiple, not conducted for at least 15 minutes is not billable to DHS.
− Health promotion and counseling services conducted with one recipient are to be modified with the SP modifier.
− Health promotion and counseling conducted with multiple persons, regardless of whether they are all MHCP recipients, must be modified with the MP modifier.
− The maximum number of units that DHS will reimburse is 8 units or 2 hours.

### Nursing Treatment (X5548):

− This service may be billed as the administrative component of immunization and medication administration.
− In addition, the code may be used for other nursing treatments, such as application of topical medications, dressing changes, foot care, etc.

### Medication Management (X5549):

− This service may be billed with the other service codes.
− Only one service code of medication management is billed regardless of whether multiple medications are reviewed.
− This service is limited to one per day.

- **Immunizations:** The administrative costs (such as nursing interview of parent, checking history of previous reactions) of immunizations are included in the "Nursing Treatment" service code. The nursing treatment code may be billed in addition to the immunization(s) code.

- **Child and Teen Checkups (C&TC):** If a health assessment, health counseling, immunization, nutritional assessment, hearing, etc. is performed as a C&TC service and billed as a C&TC service, the PHNC may not bill in addition to the C&TC services for the same recipient on the same day.

- **Injectible Medication:** Use the appropriate HCPCS code for the injectible drug and CPT code for administration.
Payment Limitations

Covered services are limited to one of each type of service (e.g., nursing treatment, medication management, etc.) per recipient per day. Any of the PHNC service codes may be billed on the same day as another PHNC service code, but the services may not be performed concurrently. Documentation must reflect that the services were performed during separate time periods. If two services were performed concurrently, only one of those services is billable.

If a recipient is seen at a facility that is enrolled in MHCP as a PHNC and another facility, such as a public health clinic, physician clinic, community clinic, MHCP will only pay for one scheduled clinic visit for the same recipient on the same day. MHCP will pay a PHNC visit and another visit only if it is documented to be medically necessary for the PHNC to refer the patient for more extensive physician services.

Billing For PHNC Service Provided in a Home Setting

Bill PHNC services provided in the home on a CMS-1500 claim form.

Bill using the DHS-only code X4010. This code is all-inclusive for all services provided to one person per day.

Immunizations: The administration costs of immunizations are included in the X4010 service code.

Injectable medication: Use the HCPCS code for the specific drug given.

Child and Teen Checkup services may not be billed on the same day as a PHNC service.

Federally Qualified Health Center and Rural Health Clinic Services

Federally qualified health center (FQHC) and rural health clinic (RHC) services provide covered services to MHCP recipients in a manner similar to other physician clinics. However, federal mandates and guidelines apply specifically to FQHCs/RHCs. Services provided to MA recipients are billed differently than services provided to GAMC recipients and MinnesotaCare recipients. See billing section.

Federally Qualified Health Center: A facility that:

- Is receiving a grant under section 329, 330, or 340 of the Public Health Service (PHS) Act, or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under section 329, 330, or 340 of the PHS Act;
- Is based on the recommendation of the PHS, determined by CMS to meet the requirements for receiving such a grant;
- Was treated by CMS, for purposes of Medicare Part B, as a comprehensive federally funded health center (FFHC) as of January 1, 1990; or
Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

Rural Health Clinic: A freestanding or provider based facility certified under Code of Federal Regulations, title 42, part 491.

Provider-Based Facility: A clinic that is an integral part of a hospital, skilled nursing facility, or home health agency that is participating in Medicare and is used, governed and supervised with other departments of the facility.

Dental Encounter (FQHC or Provider-Based RHS): Services provided during a dental visit.

Medical Encounter (FQHC or RHC): Services provided during a medical visit, including but not limited to:

- Professional services;
- Supplies and pharmaceuticals incidental to professional services;
- Pharmaceuticals provided by an FQHC or a provider-based RHC in compliance with pharmacy guidelines;
- Obstetrical and perinatal care;
- Clinic visits;
- FQHC or RHC professional services provided to FQHC or RHC patients if covering inpatient hospital visits;
- FQHC or RHC professional services provided to FQHC or RHC patients if surgical services are directly provided by the center or clinic; and
- Mental health visits provided in compliance with mental health guidelines.

Provider Enrollment

To continue enrollment as an FQHC/RHC and receive cost-based payment, existing FQHCs/RHCs must have submitted an application to the Minnesota Department of Health (MDH) for essential community provider (ECP) status by January 9, 1997. After July 9, 1998, newly declared FQHCs/RHCs were not eligible to enroll as FQHC/RHC providers with DHS.

FQHC/RHC providers may now enroll with DHS, effective July 1, 1999 without making ECP application, due to a 1999 legislative change.

Eligible Providers

A facility that meets the requirements of an FQHC or RHC (FQHC/RHC) and is enrolled as such with DHS.
Covered Services for MA Recipients

MA coverage for FQHCs/RHCs has been mandated for the following:

- Physician's services and supplies furnished as incident to a physician's professional service;
- Vaccines (e.g., pneumococcal, influenza, and hepatitis B);
- Services provided by a physician assistant, nurse practitioner, clinical psychologist, or clinical social worker, and services and supplies furnished as incident to their services;
- In an area in which a shortage of home health agencies exists, part-time or intermittent nursing care by a registered nurse or licensed practical nurse to a homebound individual under a written plan of treatment, either established and reviewed by a physician every 60 days or established by a nurse practitioner or physician assistant and reviewed at least every 60 days by a supervising physician; and
- Services and supplies incident to a physician's professional services are covered if they are:
  - Of a type commonly furnished in physicians' offices;
  - Of a type commonly rendered either without charge or included in the bill;
  - Furnished as an incidental, although integral, part of a physician's professional services;
  - Furnished under the direct, personal supervision of a physician;
  - Provided by a member of the clinic's health care staff who is an employee of the clinic; and
  - Drugs and biologicals, furnished as "incidental to" a physician's professional service, only if they cannot be self-administered.

Cost Reporting and Payment for MA Recipients

An FQHC/RHC participating in the Medicare program is required to submit a cost report to the intermediary, identifying actual costs and visits, costs and charges, for the specified reporting period. The reporting period must coincide with Medicare's reporting requirements.

An FQHC or provider-based RHC is paid an all-inclusive interim rate for MHCP covered services for each visit per medical or dental service provided to an MA recipient or MinnesotaCare recipient with MA benefits.

A freestanding RHC is paid an all-inclusive interim rate for mandated covered services for each medical visit provided to an MA recipient or MinnesotaCare recipient with MA benefits. Other health services provided by a freestanding RHC are paid according to the MHCP guidelines (e.g., dental, pharmacy).

The all-inclusive medical payment rate is the same whether the professional service is performed by a physician, nurse midwife, nurse practitioner, or physician assistant. New or expensive services and supplies are considered covered by the interim rate and no separate payment is made. Should the facility's current cost per visit differ significantly from the established interim
rate, DHS will consider adjusting the interim rate. To establish a new interim rate, cost estimate and updated statistical information for the non-historical items that affect the cost per visit calculation must be presented to the Payment Policy Section of DHS.

Legislative increases provided for fee-for-services obstetric, pediatric, physician, and dental services are not directly paid to the FQHC/RHC for MA services, because the FQHC/RHC payment rate is based on cost and there is a "settle-up to cost" procedure.

After the end of its fiscal year, an FQHC/RHC must provide a copy of the finalized Medicare cost report and Medicare's rate determination letter to the Payment Policy Section. An FQHC should also include the facility's audited financial statements.

If an FQHC does not have Medicare FQHC status, or if Medicare does not desk audit the RHC facility, the clinic should provide the following to the Payment Policy Section:

- A cost report utilizing Medicare cost reporting principles;
- Additional documentation showing specific MA covered service costs, including pharmacy and dental services; and
- Audited financial statements.

The Payment Policy Section of DHS will desk audit the financial information submitted and establish the finalized encounter rates for the cost reporting period. Desk audit rates may be subject to adjustments for Medicare appeal settlements, amendments, and on-site audit adjustments by Medicare or DHS.

New interim rates are established using the updated historical cost information from the most recent finalized reporting period. The new interim rate is paid for future FQHC/RHC claims submitted to DHS.

A 1999 legislative change adopted the Balanced Budget Act of 1997 (BBA) phase-out schedule for cost based reimbursement. The BBA phase-out schedule was modified by the Balance Budget Refinement Act of 1999. Cost based payments will be reduced to 95% of cost effective January 1, 2000 with additional adjustments to the cost based payment rates according to the phase-out schedule outlined below. The adoption of the BBA schedule replaces the complete phase-out of cost based reimbursement, which was to take effect January 9, 2000.

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1, 2000 - September 30, 2002</td>
<td>95%</td>
</tr>
<tr>
<td>October 1, 2002 - September 30, 2003</td>
<td>90%</td>
</tr>
<tr>
<td>October 1, 2003 - September 30, 2004</td>
<td>85%</td>
</tr>
</tbody>
</table>

Payment rates will reflect the cost reduction.
FQHC/RHC Billing Requirements

Provider Number

Use the 9-digit FQHC/RHC provider number to bill all MHCP services.

Billing for MA Recipients

Bill services provided to MA recipients and MinnesotaCare recipients with MA benefits using an all-inclusive encounter revenue code on a UB-92. Combine each usual and customary charge for the services provided, and bill the combined charges with the appropriate revenue code for each encounter.

Follow any frequency guidelines or request for authorization requirements.

See the C&TC billing section of Children Services chapter (Ch. 9) for instructions on billing for C&TC encounters.

Revenue codes 510 (FQHC) and 521 (RHC) are paid at the clinic's medical encounter rate. Revenue codes 512 (FQHC) and 522 (RHC) as well as C&CT services are paid at the dental encounter rate.

One visit per day, per recipient is covered unless another separate and distinct visit is medically necessary to treat the patient.

Billing and Coverage for GAMC and MinnesotaCare Recipients

Bill services provided to GAMC recipients and MinnesotaCare recipients as any other physician, dental clinic, medical supplier, or pharmacy. Refer to the specific chapter for coverage policy. Bill professional, physician/clinical services on the CMS-1500.

Services provided to a GAMC recipient or MinnesotaCare recipient without MA benefits are not paid at the all-inclusive FQHC/RHC rate.

Billing with Copays

Medical Services: FQHCs and RHCs must report the applicable amount of copays related to the encounter as a cumulative amount. To report the amount of the copays, FQHCs and RHCs must indicate the total amount of the copay(s) for the encounters billed in the prior payment form locator (FL 54) on the UB-92 claim form, or the electronic equivalent. The claim must indicate payer identification code 'I' (Other) in form locator 50. DHS will deduct the prior copay amount from the claim's payment.

Dental Services: FQHC and RHC dental services are subject to the $500 cap.
For services to be excluded from the cap:
- an FQHC must bill the 512 revenue code
- an RHC must bill the 529 revenue code

Revenue codes 512 and 529 must be billed with the emergency service code D9110, or the applicable exempt denture or extraction code. Only one exempt code is needed for the claim to be considered exempt.

If the extraction involves only tooth numbers: 1, 16, 17, and/or 32 and the individual is not preparing to obtain dentures, the 512 or 529 revenue code should be billed without a procedure code.

When billing encounter claims in the UB-92 claim format, FQHC and RHC providers should report the applicable amount of copays related to the encounter as a cumulative prior payment amount in form locator 54. The claim must indicate payer identification code "I" (Other) in form locator 50.

When billing for non-encounter services, bill usual and customary charges in the appropriate claim format. DHS will automatically calculate the copay and notify you on the RA of the amount of copay, if any, to collect.

You may collect copays at the time of the visit or bill the recipient, according to office policy.

**Health Plan Contracts**

FQHC/RHC services are included in the managed care capitated rates.

FQHCs/RHCs are required to maintain the total number of encounters provided during a reporting period. In addition, these providers must maintain encounter information on MA recipients and MinnesotaCare recipients with MA benefits who are participants of a managed care plan from which the FQHC/RHC has received payment for services. For each managed care plan, the FQHC/RHC must provide the Payment Policy Section the total number of MA and MinnesotaCare with MA benefits encounters for the reporting period.

An FQHC/RHC must report the total dollars received from each health plan for MA recipients and MinnesotaCare recipients with MA benefits.

**Advances on Health Plan Encounters**

DHS processes requests for advances on health plan payments. Advance requests can be submitted to the Payment Policy Section on an annual, semi-annual, or quarterly basis.
Settle-up

The settle-up on FQHC/RHC claims is made through an individual claim adjustment process by DHS. In addition, a settle-up amount is determined for health plan payments to adjust to the cost-based payment rate. These settle-up procedures occur after the cost reporting period has ended.

Legal References

Minnesota Rules [9505.0250](physician clinic)
MS [256B.0625](physician clinic)
MS [256B.0625], subd. 30 (community clinic)
Minnesota Rules [9505.0255](community clinic)
Minnesota Rules [9505.0380](PH clinic)
MS [256B.0625], subd. 40 (TB tx in PH clinic)
42 CFR 491 (RHC)
42 USC 1396d (RHC)
MS [256B.0625], subd. 29 (FQHC)
42 CFR 491 (FQHC)
Title XIX, Section 1905(l) of the Social Security Act
Chapter 9: Children's Services

This chapter provides policy and billing information for providers of Individualized Education Program (IEP) Services; Immunizations; and Child & Teen Checkups (EPSDT).

Individualized Education Program (IEP) Services

Individualized Education Program (IEP) Services refers to services included on an Individualized Education Program (IEP), an Individualized Family Service Plan (IFSP) or an Individual Interagency Intervention Plan (IIIP).

Definitions

**Audiologist:** A person who has a Certificate of Clinical Competence from the American Speech and Hearing Association.

**Augmentative Communication Device:** A device dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a recipient with severe expressive communication disorders. Examples of augmentative communication devices are: communication picture books, communication charts and boards, and mechanical/electronic devices.

**Certified Occupational Therapy Assistant (COTA):** A person who has successfully completed all academic and fieldwork requirements of an occupational therapy assistant program approved or accredited by the Accreditation Council for Occupational Therapy Education and is currently certified by the American Occupational Therapy Association as an occupational therapy assistant.

**Clinical supervision for mental health services:** Is the process of control and direction of mental health services by which a mental health professional accepts responsibility for the supervisee’s actions and decisions, instructs the supervisee in the supervisee’s work, and oversees or directs the work of the supervisee. The clinical supervisor accepts full professional responsibility. The clinical supervisor must be present on-site for at least one observation during the first 12 hours in which the practitioner provides services and on-site for observation as clinically appropriate thereafter. On-site observations must be documented in the recipient’s record and signed by the mental health professional.

**Direct Service:** Intervention services rendered by the provider in face-to-face contact with the recipient.
Direction of Mental Health Behavioral Aide Services: The mental health professional or mental health practitioner under the direction of the mental health professional assures that services are given in a manner determined necessary and appropriate by the mental health professional or practitioner. Direction should provide a balance of initial coaching (for those MHBAs who lack skills and experience) and a minimum amount of intrusion in the therapeutic process. Direction of mental health behavioral aides includes all of the following: one total hour of on-site observation by a mental health professional during the first twelve hours of service provided to a child; ongoing on-site observation by a mental health professional or mental health practitioner for at least one total hour every forty hours of service provided to a child; and immediate accessibility of the mental health professional or the mental health practitioner to the mental health behavioral aide during service provision.

Direction of Physical Therapy Assistant and Occupational Therapy Assistant Services: The actions of a physical or occupational therapist who instructs the physical or occupational therapy assistant, monitors the assistant’s provision of services, provides on-site observation of the treatment and documentation of its appropriateness at least every sixth treatment session for each recipient when treatment is provided by an assistant and meets other supervisory requirements in Minnesota Rule, parts 5601.1500 and 5601.1600, and Minnesota Statutes, section 148.6432.

Educational Speech-Language Pathologist (ESLP): A person who has a masters degree in speech/language pathology, is licensed by the Minnesota Board of Teaching as an education speech/language pathologist and either has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent education requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

Fellowship Year of Speech-language Pathology and Audiology: A person completing the clinical fellowship year required for certification may provide speech-language services under the supervision of a speech and language pathologist who has a Certificate of Clinical Competence from the American Speech and Hearing Association. A person completing the clinical fellowship year required for certification as an audiologist may provide services under the supervision of an audiologist who has a Certificate of Clinical Competence from the American Speech and Hearing Association.

IEP Evaluations: Evaluations that are health related and result in an IEP/IFSP/IIIP or determine the need for continued services. This includes pre-IEP evaluations that result in an IEP/IFSP/IIIP, ongoing assessments to determine progress/need for changes in services and re-evaluations. Activities included are: administering tests, interpreting test results and writing reports (meetings to discuss evaluations and make recommendations are not included).

Indirect Service: Non-direct (not face-to-face) intervention with the recipient. Examples of indirect include: attendance at staff meetings, staff supervision, development of instructional and treatment plans or materials, consultation between the service provider and parent, teacher, and other staff, documentation, team meetings and billing. MHCP does not pay for indirect service.
Individual Interagency Intervention Plan (IIIP): A single, written, multi-agency plan designed to be used in the place of multiple plans that describes services and payment arrangements for eligible children.

Individualized Education Program (IEP): A written individualized educational program developed annually for a student based on an evaluation of the student’s performance, presenting problems and the effect on learning in appropriate settings.

Individualized Family Service Plan (IFSP): A written plan for providing services to a child and the child’s family through interagency agreements. Procedural and program requirements for the IEP also apply to the educational components of the IFSP.

Licensed School Nurse (LSN): A person who has a current Minnesota Board of Nursing and Board of Teaching license.

Licensed Practical Nurse (LPN): A person who has a current Minnesota Board of Nursing license.

Mental Health Behavioral Aide (MHBA): A paraprofessional working under the direction of a mental health professional or mental health practitioner who is under the clinical supervision of a mental health professional to implement mental health services identified in a child/student’s IEP/IFSP/IIIP and individual behavior plan. Level I MHBA must: be at least 18 years of age; have a high school diploma or general equivalency diploma (GED) or two years of experience as a primary caregiver to a child with serious emotional disturbance within the previous ten years; and meet orientation and training requirements. Level II MHBA must: be at least 18 years of age; have an associate or bachelor’s degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents; and meet orientation and training requirements.

Mental Health Professional: A Licensed Psychologist (LP), Licensed Psychological Practitioner (LPP), Licensed Independent Clinical Social Worker (LICSW), Clinical Nurse Specialist Mental Health, Licensed Marriage and Family Therapist (LMFT), or Psychiatrist.

- Licensed Psychologist (LP): Licensed under Minnesota Statutes, sections 148.88 to 148.98, stated competencies in the diagnosis and treatment of mental illness to the Board of Psychology.

- Licensed Psychological Practitioner (LPP): Licensed under Minnesota Statutes, sections 148.908 and granted a variance from supervision requirements by the Board of Psychology in accordance with Minnesota Statutes, section 148.925, subdivision 7.


- Clinical Nurse Specialist Mental Health: An advanced practice registered nurse in accordance with Minnesota Statutes, sections 148.171-148.285 and certified as a clinical nurse specialist in psychiatric or mental health nursing in accordance with Minnesota
Statutes, sections 148.285, subdivision 4 or mental health nursing by the American Nurse Association with at least 4,000 hours of post-master supervised experience in the delivery of clinical services in the treatment of mental illness.

- Psychiatrist: Physician licensed under Minnesota Statutes, chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry.


**Mental Health Practitioner:** Provides services in the treatment of mental illness, under the supervision of a mental health professional and qualified in at least one of the following:

- School Psychologist: Licensed by the Board of Teaching.

- Licensed Graduate Social Worker (LGSW): Licensed by the Board of Social Work.

- Licensed Independent Social Worker (LISW): Licensed by the Board of Social Work.

- Bachelor degree in one of the behavioral sciences or related fields from an accredited college or university and have 2,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness.

- Completed 6,000 hours of supervised experience in the delivery of clinical services in the treatment of mental health services to children.

- Enrolled as a graduate student in one of the behavioral sciences or related fields formally assigned to the center for clinical training by an accredited college or university.

- Obtained a masters or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university and have less than 4,000 hours post-master’s experience in the treatment of emotional disturbance.

**Occupational Therapist (OT):** A person who is currently registered by the American Occupational Therapy Association as an occupational therapist and meets state licensure requirements under Minnesota Statutes 148.6401-148.6450.

**Personal Care Assistant and Para-Professional:** An individual who is trained in the skills needed to perform covered services and whose services are supervised by an RN, PHN, LSN, mental health professional, PT, OT, or SLP.

**Physical Therapist (PT):** A graduate of a physical therapy program approved by both the Committee on Allied Health Education of the American Medical Association and the Accreditation of the American Physical Therapy Association or its equivalent and licensed by the state.
**Physical Therapy Assistant (PTA):** A person who is a graduate of a physical therapy assistant education program accredited by the American Physical Therapy Association or a comparable accrediting agency. A physical therapy assistant performs selected physical therapy treatments and related duties as delegated by the physical therapist.

**Public Health Nurse (PHN):** A person who has a current Minnesota Board of Nursing license and is certified in public health nursing by Minnesota Department of Health.

**Registered Nurse (RN):** A person who has a current Minnesota Board of Nursing license.

**Serious and Persistent Mental Illness (SPMI):** The condition of a child (at least 18, but under age 21), must have a mental illness diagnosis, and meet at least one of the following criteria: the recipient has undergone two or more episodes of inpatient care for mental illness within the preceding 24 months; the recipient has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months duration within the preceding 12 months; the recipient has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder, evidences a significant impairment in functioning, and has a written opinion from a mental health professional stating he/she is likely to have future episodes requiring inpatient or residential treatment, unless community support program services are provided; or the recipient has, in the last three years, been committed by a court as a mentally ill person under Minnesota statutes, or the adult's commitment as a mentally ill person has been stayed or continued; or the recipient was eligible under one of the above criteria, but the specified time period has expired or the recipient was eligible as a child with severe emotional disturbance; and the recipient has a written opinion from a mental health professional, in the last three years, stating that he/she is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in the above criteria, unless ongoing case management or community support services are provided.

**Severe Emotional Disturbance (SED):** A child who has an emotional disturbance and who meets one of the following criteria: the child has been admitted to inpatient treatment/residential treatment or is at risk of being admitted, within the last three years; the child is a MN resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; a mental health professional has determined the child has one of the following: psychosis or clinical depression; risk of harming self or others as a result of emotional disturbance; or, psychopathological symptoms as a result of being a victim of physical/sexual abuse or psychic trauma within the past year. A mental health professional has determined the child has a significantly impaired home, school or community functioning lasting at least one year or presents a risk of lasting at least one year, as a result of emotional disturbance.

**Speech-Language Pathologist (SLP):** A person who has a certificate of clinical competence in speech-language pathology from the American Speech and Hearing Association and meets the state registration requirements. Speech language providers are required by MHCP to hold current registration with the Minnesota Department of Health.
Specialized Maintenance Therapy: A health service that requires the skill of a physical therapist, physical therapy assistant, occupational therapist, occupational therapy assistant, or speech/language pathologist that is specified in the recipient’s IEP/IFSP/IIIP and is necessary for maintaining a recipient’s functional status at a level consistent with the recipient’s physical or mental limitations.

Supervision of Fellowship Year of Speech-language Pathology and Audiology: A person completing the clinical fellowship year required for certification may provide speech-language services under the supervision of a certified SLP who has a certificate of clinical competence as specified in Minnesota Statute, section 148.515, subd. 4. A person completing the clinical fellowship year required for certification as an audiologist may provide services under the supervision of an audiologist as specified in Minnesota Statutes, section 148.515, Subd. 4.

Supervision of personal care assistants/para-professionals services: The qualified professional obtains the required physician’s orders; provides ongoing monitoring and supervision, appropriately delegates tasks; orients and trains the PCA to provide the services; ensures through direct observation or consultation that the person providing the service: is capable of providing the service; is knowledgeable about the plan of services to be provided before the assistant/para-professional performs the services; is knowledgeable the essential observations of the recipient’s health and observed conditions that should be brought to the supervisor’s attention; is knowledgeable about changes in the plan, and, keeps records of services provided and time spent providing the services. The supervising professional evaluates the services provided to the recipient through direct observation or consultation within 14 days after placement of the assistant/para-professional with the recipient, once every 30 days for the first 90 days, and once every 120 days after the first 90 days.

Eligible Providers

The following public schools and school districts that provide some or all covered IEP services to an eligible recipient:

- Charter schools
- Education districts
- Intermediate districts
- Public school districts
- Schools that receive Bureau of Indian Affairs funding
- Service cooperatives
- Special education cooperatives
- State academies

MHCP does not directly reimburse private schools for covered IEP services. IEP services provided to children who attend private schools are billed by and payments are made to the public school providing the IEP services.
Eligible Recipients

- MA recipients and MinnesotaCare recipients
- Under the age of 21
- Have covered IEP services included in a current IEP/IFSP/IIIP

Covered Services

Schools are responsible for assuring that the covered IEP services billed to MHCP are provided by qualified staff within the scope of practice, licensure and/or certification of service providers.

Services eligible for payment must meet all of the following criteria:

- Medically necessary;
- Provided to an eligible MA recipient or MinnesotaCare recipient under the age of 21;
- Included in the recipient’s individualized service plan (IEP, IFSP, IIIP);
- Health related services necessary for the recipient to benefit from his/her education;
- Provided by qualified service providers within the service provider’s scope of practice and/or licensure/certification;
- Documented in the recipient’s record - see Documentation Requirements section of this chapter;
- Authorized by the recipient’s individual school service plan/program team; and,
- Provided by the school during the school day.

Physical therapy: Individual, group and specialized maintenance therapy that requires the skill of a physical therapist or physical therapy assistant under the direction of a physical therapist. IEP evaluations provided by a physical therapist that are health related and result in an IEP/IFSP/IIIP or determine the need for continued services.

Occupational therapy: Individual, group and specialized maintenance therapy that requires the skill of an occupational therapist or certified occupational therapy assistant under the direction of an occupational therapist. IEP evaluations provided by an occupational therapist that are health related and result in an IEP/IFSP/IIIP or determine the need for continued services.

Speech-language hearing therapy: Individual and group therapy provided by an SLP, ESLP, an audiologist or a person completing the clinical fellowship year required for certification as an SLP or audiologist who is supervised by an audiologist or SLP. IEP evaluations provided by a SLP, ESLP or audiologist that are health related and result in an IEP/IFSP/IIIP or determine the need for continued services. Specialized maintenance therapy provided by an SLP.

Mental health services:

Skills training provided by a mental health professional or mental health practitioner who is supervised by a mental health professional. Skills training is individual or group services designed to improve the basic functioning of the recipient in the activities of daily and community living, and to
improve the social function of the recipient in areas important to the recipient= maintaining or reestablishing residency in the community (residence, work, school, or peer group).

Crisis assistance provided by a mental health professional or mental health practitioner who is supervised by a mental health professional. Crisis assistance services include a crisis risk assessment, screening for hospitalization, referral and follow-up to suitable community resources, and planning for crisis intervention and counseling services with other service providers, the child and the child=s family. Note: Crisis assistance does not take the place of necessary emergency services or a service designed to secure the safety of a child who is at risk of abuse or neglect.

Psychological testing provided by a licensed psychologist with competence in psychological testing as reported to the Board of Psychology. DHS does not publish or maintain a list of covered tests. Typically these are tests received in Buros=“Mental Assessments Handbook,” most recent edition.

IEP evaluations provided by a mental health professional or school psychologist that are health related and result in an IEP/IFSP/IIIP or determine the need for continued services. Concerns regarding mental illness or emotional disturbance should be referred to a mental health professional for mental health diagnostic assessment and treatment.

**Mental Health Behavioral Aide (MHBA) Services** - provided by a mental health behavioral aide who is under the direction of a mental health professional or mental health practitioner who is supervised by a mental health professional are designed to improve the functioning of the child and support the family in activities of daily and community living. Activities may include: assisting the child as needed with skill development in dressing, eating, and toileting; assisting, monitoring and guiding the child to complete tasks, including facilitating the child’s participation in medical appointments; observing and intervening to redirect inappropriate behavior; assisting the child in using age appropriate self-management skills as related to the child's emotional disorder or mental illness, including problem solving, decision making, communication, conflict resolution, anger management, social skills, and recreational skills; implementing any other mental health service that the mental health professional has approved as being within the scope of the behavioral aide's duties. assisting the parents to develop and use parenting skills that help the child achieve the goals outlined in the child’s IEP/IFSP/IIIP and individual behavioral plan (IBP);

**MBHA Responsibilities**: implement mental health services identified in the IEP/IFSP/IIIP and IBP; write progress notes; demonstrate family friendly behaviors that support healthy collaboration among child, child’s family and providers as services are planned and implemented; communicate effectively with the child, child’s family, mental health practitioner and mental health professional; and complete pre-services and continuing education requirements.

**Individual Behavior Plan (IBP) for MHBA Services**: An IBP is required and is to provide specific instructions to the MHBA in delivery of service. It outlines the MHBA’s responsibilities in assisting the child to achieve treatment outcomes. Mental health professionals must approve the services in the IBP before the services are provided by the MHBA. The IBP must include: detailed instructions on the service provided; time allocated for each service; methods of documenting the child’s behavior; methods of monitoring the child’s progress in reaching objectives; and goals to increase or decrease targeted behaviors. An IBP is in addition to an IEP/IFSP/IIIP.
Direction of MHBA services: When providing direction mental health professionals or mental health practitioners must: review progress notes prepared by mental health behavioral aides for accuracy and consistency with diagnostic assessment, treatment plan and behavior goals. Progress notes must be approved and signed by mental health professionals or mental health practitioners; identify changes in treatment strategies, revise the individual behavior plan and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly; demonstrate family friendly behaviors that support healthy collaboration among child, child's family and providers as treatment is planned and implemented; ensure that mental health behavioral aides are able to effectively communicate with the child, child's family and the provider; and record the results of any evaluation and corrective actions taken to modify the work of mental health behavioral aides.

Background study for candidates: A provider that offers services provided by a MHBA must: conduct a background study of each potential candidate for a mental health behavioral aide position that includes a search of information from the criminal justice data communications network in any state where the subject of the study has resided; and not hire the mental health behavioral aide candidate if the candidate's background information meets the disqualification conditions under Minnesota Statutes, section 245A.04, subdivision 3d.

Orientation and training requirements for an MHBA: Orientation and training requirements for an MHBA must be documented in the personnel record and include: 30 hours of pre-service training (15 hours of face-to-face training in mental health services delivery and 8 hours of parent teaming training) which includes these topics: provisions of the Minnesota Comprehensive Children’s Mental Health Act (MN Statutes sections 245.487-245.4887); core values and principles of the Child Adolescent Service System Program; how to coordinate services between the public education system and the mental health system; procedures for providing crisis assistance services according to Minnesota Statutes, section 245.4871, subd. 9a; information about eligibility for the programs specified in part 9535.4053; skills need to be supportive of a parent of a child with severe emotional disturbance; how to provide services effectively to a child of a minority race or minority ethnic heritage; how to provide services for children with developmental disabilities or other special needs and parent teaming.

Parent teaming components include: partnering with parents; fundamentals of family support; fundamentals of policy and decision-making; defining equal partnership; complexities of parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses; sibling impacts; support networks; and community resources.

A mental health behavioral aide must receive 20 hours of continuing education every two calendar years. Topics covered include those specified in part 9535.4068, subp. 2. The continuing education must be related to serving the needs of children with severe emotional disturbance and the child’s family in the child’s home environment.

Mental health services must be coordinated with a Children’s Mental Health (CMH) or Family Service Collaborative if one exists. Coordinated means that if a child is already in a CMH or Family Service Collaborative, is involved with more than one agency or could benefit from multi-agency coordination, the mental health services eligible for payment must be provided as part of a multi-
agency plan of care that includes the IEP/IFSP (the IIIP is a multi-agency plan) unless the child’s parents do not consent. The person with lead responsibility for overseeing implementation of the multi-agency plan of care must be involved in the development of the IEP/IFSP to ensure service coordination.

A mental health professional must develop the treatment plan/program or review and approve the treatment plan/program developed by a mental health practitioner.

A recipient who is eligible for mental health services must meet the criteria for severe emotional disturbance (SED) or serious and persistent mental illness (SPMI), one component of which is a diagnosis of mental illness or emotional disturbance.

**Nursing services:** Face-to-face nursing care provided by an LPN, RN, PHN, or LSN within nurse’s scope of practice. Examples of nursing care include: catheterization, tube feeding, suctioning, ventilator care, nursing assessment and diagnostic testing such as glucose testing, vital signs, health counseling (except in-depth nutritional counseling normally performed by a licensed dietician and structured diabetic education programs), and complex medication administration. Complex medication administration is a service that requires the skill of a nurse and is administered rectally or through an IV, injection, nebulizer, or gastrostomy tube.

Simple medication administration is the administration of prescription medications by a licensed nurse who is employed by or under contract with a school district. To be a covered service, simple medication administration must be related to a child’s disability and identified in the child’s individualized education plan (IEP), individualized family service plan (IFSP) or individual interagency intervention plan (IIIP) for treatment of the identified disability.

IEP evaluations provided by an RN, PHN, or LSN that are health related and result in an IEP/IFSP/IIIP or determine the need for continued services.

Medication management provided by an RN, LSN, PHN, or LSN that includes a review of a recipient’s current medications and adherence to the prescribed medication (including a review/knowledge of all medications taken; frequency and dosage) and the following as appropriate:

- nursing evaluation for adverse reactions to medications (could include: nursing assessment/review health status, identification of health hazards and actual/potential health needs, evaluation of health behavior, physical, emotional, and psychological health and standardized diagnostic tests performed by reagent strips and vital signs),
- educating the recipient about his/her medication, and proper medication administration (could include: teaching the recipient about his/her medication, possible side affects and reactions, and need for compliance), and
- any contacts with the physician about prescriptions, tolerance or adherence to the medication regimen.

**Personal care assistant/para-professional services:** Provided by a personal care assistant or para-professional under the supervision of a qualified professional as designated in the IEP. Qualified professionals include: RN, PHN, LSN, mental health professional, physical therapist, occupational
therapist, speech therapist, audiologist or physician. One or more qualified professional may provide supervision of pca/para-professional services as appropriate in consultation with the child/student’s teacher.

Covered services are:

Activities of daily living (ADL’s): Services and supports furnished to an individual, as needed to assist in accomplishing activities of daily living - eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning. Instrumental activities of daily living (IADL’s) - Meal planning and preparation, managing finances, shopping for food, communication by telephone and other media, getting around and participating in the community. Health related functions through hands-on assistance, supervision, and cuing.

Health related functions are services that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

Redirection and intervention for behavior including observation and monitoring.

**Assistive technology devices:** MHCP covers rental, purchase and repairs. Covered devices are:

- Augmentative communication devices
- Hearing amplification devices
- Mobility devices
- Positioning devices
- Hardware and software essential to use a covered device

Assistive technology devices:

- Belong to the recipient for whom the device is purchased or rented;
- Must be included in the IEP/IFSP/IIIP;
  (It is not necessary to identify a specific device by model name and number. Use of general terms such as, “stander”, “wheelchair”, is acceptable.)
- Can be used at school only by the recipient for whom purchased or rented;
- Can not be primarily for education, such as Math Blaster software or a device to assist with homework;
- Must be purchased or rented and delivered to the recipient before billed; and,
- Can be used for home and school as needed.

**Special transportation:** Special transportation is covered when provided by the school or the school transportation contractor and when:

The recipient has a physical or mental impairment that keeps him/her from safely accessing and using common carrier transportation such as a bus, taxi-cab, private automobile, or other common carrier.

- The need for special transportation is included on the IEP/IFSP/IIIP.
• The recipient is transported to and from home and school and receives another covered IEP service on the same day.

• The recipient requires a special adaptation to the bus such as a wheelchair lift, special harness, safety vest or special car seat (not a regular car seat or seat belt) or a one-on-one (one-on-two, three) aide.

School buses are exempt from the Department of Transportation certification requirement. Department of Public Safety inspection is required for school buses.

**Oral Language Interpreter Services:** Oral language interpreter services are covered when provided by a person who speaks the language and who is employed by or has a contract with the school district to provide language interpreter services and who is not a relative. Oral language interpreter services must be provided in conjunction with another covered IEP service to a child/student with limited English proficiency. Oral language interpreter services are not covered when provided in conjunction with special transportation.

**Service Limitations and Authorization Requirements**

Orders from a physician, nurse practitioner or physician assistant are required for services provided by personal care assistants and para-professionals. Orders are required for those nursing services that would require such orders if performed in another setting such as a hospital, home, clinic, etc. Orders must be obtained annually by the school, can cover a period of time of up to one year and must be in place at the time the service is billed. Signatures must be dated.

The recipient’s IEP/IFSP/IIIP team authorizes the services included in the plan.

IEP services do not count against limits or thresholds for recipients on home and community-based waivers, CAC, CADI, MR/RC and TBI.

IEP services are not calculated in parental fees.

IEP services do not count against authorization caps for home-care services.

**Non-covered Services**

Services such as: developing the IEP/IFP/IIIP; attendance at staff meetings, staff supervision; development of instructional and treatment plans or materials; consultation between the service provider and parent, teacher and other staff; service documentation, in-service training, team meetings and billing.

Services that are not medically necessary.

Services that are not included on the recipient’s IEP/IFSP/IIIP.
Services provided by service providers who do not meet MHCP qualifications.

Services provided at times other than the normal school day.

Services provided by parents, foster parents, and adult siblings.

Services provided without the required supervision or direction as defined in this chapter.

Supervision and direction.

Services provided under 504 plans.

Observation and consultation except as covered under mental health services, pca/para-professional services and nursing services in this chapter.

Classroom instruction and education services.

Case management or service coordination.

Assessments or evaluations except as covered under mental health services in this chapter.

Day treatment and other non-covered mental health services outlined in chapter 16.

Medical care, such as, illness and injury care, health education (examples: first aid classes, chemical abuse classes), and nursing services provided to all students (examples: vision/hearing screening).

Simple medication administration, dispensing oral medication, when it does not require the skill of a nurse and does not qualify as complex medication administration.

Art, music, recreation therapy and adaptive physical education.

Parent or staff training, homemaker services or vocational services.

Personal care assistant and paraprofessional services provided by drivers while transporting recipients.

Communications between the service provider and the recipient that are not face-to-face.

Transportation of recipients who do not require a special adaptation to the vehicle or an aide.

Transportation of recipients when the services are not included in the IEP/IFSP/IIIP.

Transportation provided by parents, foster parents, family members, and neighbors.
Equipment including, personal computers and laptops that are not dedicated communication devices, printers, tape recorders, video recorders, telephone answering machines, telephones, alert systems, motorized lifts for a vehicle, medical response systems, exercise equipment, stair lifts, toys, and instructional materials.

Facilitated communication or modifications, construction, programming or adaptations of communication systems.

Equipment and assistive technology used primarily for education purposes.

Services provided by a therapy aide or assistive technology specialist.

Services provided by students except as covered under mental health services in this chapter.

Oral language interpreter services such as scheduling appointments and translating printed materials.

Evaluations and assessments that are educational.

Medication administration for the treatment of acute episodic illnesses, such as ear infections.

Simple medication administration alone is not a covered service when administered by a provider other than a school district.

**Documentation Requirements**

The recipient's records must include:

- A current and complete copy of recipient's IEP/IFSP/IIIP that includes: type, frequency, duration and scope of services provided, measurable outcomes and all amendments to the plan;

- Medical diagnosis and/or condition;

- Results of tests and evaluations;

- Documentation of each occurrence of a covered IEP service billed to MHCP, including: recipient's name, date of birth, and school, date, type of service, service code, length of service, number of children in group, description of service provided, results/progress notes, and name, title and signature of the service provider;

- Documentation of supervision provided including notes and evaluations as required under supervision and direction in the scope of practice, the date, name, title and signature of the supervisor;
Orders from a physician, physician’s assistant, or nurse practitioner as required for personal care assistant/paraprofessional services and nursing services;

For assistive technology devices: copies of purchase, rental and/or repair information including manufacturer, rental agency, repair service, model name and number, and description of the device or repair service.

For special transportation: recipient’s name, date of birth, school, dates of service, mileage to and from school and home, and name, title and signature of the person responsible for documenting mileage.

A copy of a current, signed informed consent as required by state law for children who are eligible for private health care.

A copy of the annual notice of the school district’s intent to bill MHCP for IEP services that is sent to the parent or legal representative and a copy of a release of information for billing purposes signed by the parent or legal representative.

Billing

Schools may contract for billing functions with a billing agent and for services with a qualified provider. Information regarding billing agents is in the Billing Policy chapter (Ch. 4). The school seeking payment for IEP/IFSP/IIIP services is accountable for all services provided, documentation of services and claims submitted to DHS.

IEP services are billed by the school or school’s billing agent. Use only these codes to bill for covered IEP services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
<th>Units</th>
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<tr>
<td>Physical Therapy</td>
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<td>1 unit per day per child</td>
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<td>Occupational Therapy</td>
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<td>Speech/Language/Hearing Therapy</td>
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</tr>
<tr>
<td>Assistive Technology Devices</td>
<td>X5386</td>
<td>1 unit per item</td>
</tr>
<tr>
<td>Special Transportation</td>
<td>X5387</td>
<td>1 unit = 1 mile</td>
</tr>
<tr>
<td>Oral Language Interpreter Services</td>
<td>T1013</td>
<td>1 unit = 15 minutes</td>
</tr>
</tbody>
</table>

Bill 1 unit per day per child per service for PT, OT, SLP, mental health services, nursing services and pca/para-professional services.
The number of days in the dates of service span must equal the number of units except for special transportation and oral language interpreter services.

Bill assistive technology devices using one of these modifiers:

- RP for repairs; NU for purchased equipment; and RR for rented equipment.
- Attach copies of purchase, rental and/or repair information including manufacturer, rental agency, repair service, model name and number, and description of the device or repair service to the claim.

Bill oral language interpreter services using 1 unit for each 15 minutes of oral language interpreter service provided during another covered IEP service, except special transportation.

**Rates and Payments**

Schools are paid the federal share of the rate minus an administration fee of up to 5%.

Schools are responsible for the non-federal share of rates.

Rates for assistive technology devices are based on the purchase price, rental cost, or repair cost.

The rate for special transportation is $2.21 per mile.

The rate for oral language interpreter services is $12.50 per 15 minutes.

Rates for physical therapy, occupational therapy, speech/language hearing therapy, mental health services, nursing services and personal care assistant/para-professional services are based on each school’s costs.

During the school year in which services are provided, schools are paid interim rates based on a previous year’s cost information provided by the schools.

Settle-up rates are calculated after the end of the school year in which the services were provided and after schools report actual cost information. Paid claims are reprocessed and paid at the settle-up rate.

**Immunizations**

**Covered Services**

Administration of vaccines and toxoids to MHCP enrolled infants, children, and adults is covered. Clinic, physician, C&TC, outpatient hospital, certified nurse-midwife, certified family and certified pediatric nurse practitioner, home health agency, public health clinic, and public health nursing
clinic providers may bill for immunizations. Pharmacies may also provide vaccines to long-term care facilities. See the Pharmacy Services chapter (Ch. 22).

Refer to the Child and Teen Checkups section of this chapter for immunization requirements.

**Billing Requirements for Vaccines for Children**

Providers must bill according to the following instructions:

All providers, except pharmacy, submitting charges on the HCFA-1500 must bill for immunizations using CPT codes. Providers must modify the CPT vaccine codes for vaccines supplied by the Minnesota Vaccines for Children (MNVFC) program with the HIPAA-compliant SL modifier, which replaces the XV modifier (effective for dates of service October 1, 2003). Continue to enter the price of the vaccine at $0 and use the appropriate administration code:
- 90471: administration of the first vaccine.
- 90472: more than one vaccine administered on a single date of service. This code will deny if you have not billed 90471 for the initial vaccination.

Each single or combination vaccine administered will be reimbursed at $8.50.

**New Influenza Vaccine**

A new influenza vaccine inhaler, Flumist, was approved by the FDA for use in healthy people, ages 5-49. Medical Assistance (MA) will not reimburse providers for the Flumist vaccine treatment, but will continue to reimburse for influenza vaccines administered by injection.

*Special notice regarding Flumist aerosol flu vaccine:* Due to the shortage of injected flu vaccine, DHS has made a change to the coverage policy for the Flumist aerosol flu vaccine. MHCP will reimburse providers for this vaccine beginning Dec. 1, 2003. This coverage will be available only for the 2003-2004 flu season. Flumist is intended for use only with healthy people ages 5-49 years.

All providers must obtain the available vaccines from MnVFC. Most routine childhood vaccines are available through MnVFC. MHCP will pay for administration of MnVFC vaccines. MHCP does not pay for purchase of vaccines available through MnVFC. For a current list of vaccines available through MnVFC, providers should contact the Minnesota Department of Health at 1-800-657-3970.

For vaccines not available through MnVFC, payment to providers for immunization procedure codes is based on the average wholesale price plus a standard administration fee. When billing for a non-MnVFC supplied vaccine, an administration code must also be billed. Immunization reimbursement rates are updated regularly as wholesale prices change.

In addition to the CPT vaccine codes, usual and customary charges for an office visit associated with the immunization may also be billed.
Coverage Limitations

Home health agency providers may not bill for immunizations provided to GAMC recipients.

School districts may not bill for immunizations as an IEP or IFSP service.

Child and Teen Checkups (C&TC)/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

Definition

Child and Teen Checkups (C&TC) is the name for Minnesota’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. EPSDT is a required service under Title XIX of the Social Security Act. C&TC/EPSDT is a comprehensive child health program provided to MHCP recipients under the age of 21. The purpose of the program is to reduce the impact of childhood health problems by identifying, diagnosing, and treating health problems early.

Coordination of Preventive Health Care

The C&TC/EPSDT Program emphasizes the need to avoid fragmentation of care and the importance of continuity of care in comprehensive health supervision. Providers can assist in reducing duplication of services by substituting a C&TC/EPSDT screening service (when appropriate) for other preventive health care visits, such as:

- Newborn or well-baby;
- School, camp or athletic;
- Well-child;
- Family planning visits; and
- WIC or Head Start.

Eligible Providers

Screening, diagnosis, and treatment can occur during one or more office visits with one or more providers. An example of all services completed at one office visit is: a hemoglobin test indicates a low blood count (screening); the physician decides the child is anemic (diagnosis); and prescribes iron supplements (treatment).
To be reimbursed for C&TC/EPSDT screening services, fee-for-service C&TC/EPSDT screening service providers must be enrolled as an MHCP provider and sign a C&TC agreement. For more information about enrolling as an MHCP provider, see the Requirements for Providers chapter (Ch. 1).

To be reimbursed for diagnosis and treatment services, providers must follow the requirements for those services (see appropriate chapters).

**Covered Services**

A C&TC/EPSDT screening service is reimbursable under MHCP and consists of the following components as outlined in the current “C&TC/EPSDT Periodicity Schedule of Age-Related Screening Standards” (below).

http://edocs.dhs.state.mn.us/live/DHS-3379-ENG.pdf

- Anticipatory guidance and health education;
- Assessment of physical growth and measurements;
- Health history;
- Developmental/behavioral assessment;
- Physical examination;
- Immunizations and review;
- Laboratory tests;
- Vision screening;
- Hearing screening; and
- Dental referral.

Diagnosis and treatment of health conditions listed in the MHCP manual, and others determined to be medically necessary, are also covered services. Referral for diagnosis and treatment should be made as appropriate.

**Screening Standards for C&TC/(EPSDT) Components**

The current component standards below should be followed for a C&TC/EPSDT screening service. Refer to the “C&TC/EPSDT Criteria Guidelines”.
Fee-for-Service C&TC/EPSDT Screening Service Billing/Coding

States are required by federal law to maintain an 80% participation rate in the C&TC/EPSDT screenings. This participation rate is based on eligible children receiving a C&TC/EPSDT screening service during the reporting year. Accurate billing/coding is critical for Minnesota to be able to reach the 80% participation goal.

States are also required to follow-up on referrals made as a result of a C&TC/EPSDT screening to assure that children/families receive the necessary services to correct or improve health problems.

HCFA-1500 C&TC/EPSDT Screening Billing Format

A separate (CPT/HCPCS) procedure code must be entered in box 24D for each completed C&TC/EPSDT screening component. In order to be reimbursed for a “complete” C&TC/EPSDT screening service, a C&TC alpha code must be entered in box 24H, or the EPSDT/Family Planning field on ITS, for each CPT/HCPCS procedure code entered in box 24D, or the Procedure/Service field on ITS.

(See “C&TC Alpha Code” list and also see “Alpha Code Simplification” information below.)

C&TC Alpha Codes

<table>
<thead>
<tr>
<th>Child and Teen Checkups (C&amp;TC) Alpha Codes</th>
<th>Child and Teen Checkups (C&amp;TC) Alpha Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listed in alphabetical order by alpha code</td>
<td>Listed in alphabetical order by provider type</td>
</tr>
<tr>
<td>A  Inpatient Hospital</td>
<td>S  Audiologist</td>
</tr>
<tr>
<td>B  Outpatient Hospital</td>
<td>E  C&amp;TC Screening Procedure - No Referral</td>
</tr>
<tr>
<td>C  Schools</td>
<td>O  Chiropractor</td>
</tr>
<tr>
<td>D  Mental Health Center</td>
<td>V  County Nursing Service/Indian Health</td>
</tr>
<tr>
<td>E  C&amp;TC Screening Procedure – No Referral</td>
<td>Nursing Service</td>
</tr>
<tr>
<td>G  Rehabilitation Agency</td>
<td>L  Dentist</td>
</tr>
<tr>
<td>H  Services for Handicapped Children Clinic</td>
<td>T  Family Planning Agency</td>
</tr>
<tr>
<td>I  Physician</td>
<td>A  Inpatient Hospital</td>
</tr>
<tr>
<td>J  Primary Care Clinic</td>
<td>D  Mental Health Center</td>
</tr>
<tr>
<td>K  Occupational Therapist</td>
<td>Z  Multiple Providers</td>
</tr>
<tr>
<td>L  Dentist</td>
<td>W  Nurse Practitioner/Physician Assistant</td>
</tr>
<tr>
<td>M  Optometrist</td>
<td>K  Occupational Therapist</td>
</tr>
<tr>
<td>O  Chiropractor</td>
<td>M  Optometrist</td>
</tr>
</tbody>
</table>
Chapter 9: Children’s Services

Child and Teen Checkups (C&TC)

Alpha Codes
For Box 24H on HCFA-1500
Listed in alphabetical order
by provider type

P Physical Therapist
Q Speech Language Pathologist
R Psychologist
S Audiologist
T Family Planning Agency
U Public Health Clinic
V County Nursing Service/Indian Health Nursing Service
W Nurse Practitioner/Physician Assistant
X Yourself
Y Other
Z Multiple Providers
Y Other
B Outpatient Hospital
P Physical Therapist
I Physician
Podiatrist (no longer a valid code, use Y- "Other" for podiatry services)
J Primary Care Clinic
R Psychologist

Child and Teen Checkups (C&TC)

Alpha Codes
For Box 24H on HCFA-1500
Listed in alphabetical order
by provider type

V County Nursing Service/Indian Health Nursing Service
W Nurse Practitioner/Physician Assistant
X Yourself
Y Other
Z Multiple Providers
U Public Health Clinic
G Rehabilitation Agency
C Schools
H Services for Handicapped Children Clinic
Q Speech Language Pathologist
X Yourself

“Alpha Code Simplification Information”

- When billing for a complete C&TC/EPSDT, whether electronically or on the HCFA-1500, it is no longer required to use the full range of 24 alpha codes in Box 24H. Only the "E" and "R" alpha codes need to be used. However, all alpha codes will remain valid and will be accepted. Each procedure code will still require an alpha code in Box 24H.
- To simplify alpha coding, providers may choose to use the "R" code to indicate one or more "referrals". The "R" or "Referral" code will indicate that a problem or concern was identified during the complete C&TC/EPSDT screening which requires the child to be seen for follow-up.
- The use of only "E" codes on a claim will continue to indicate that a complete C&TC/EPSDT screening was done and no problems or concerns were identified which required follow-up or referral.
- C&TC alpha code definitions:

  E = EPSDT/C&TC both complete and normal, no problems or concerns identified which require the child to be seen for follow-up or referral for further assessment, diagnosis and/or treatment.

  R = Referral as a result of a problem or concern identified during the complete C&TC /EPSDT screening which requires the child to be seen for follow-up assessment, diagnosis or treatment. The "referral(s)" can be back to the screening provider, to another provider within the clinic or to a provider at another location.

The "R" code:

* Indicates that there were one or more referrals as a result of the screening;
* May be listed just once on the claim even if there are multiple referrals;
* Does not have to correspond to the procedure code which represents the reason for the referral; and
* Can correspond to the first procedure code or any procedure code on the claim.

**Reminder:** Each procedure code on a claim needs a corresponding alpha code. Claims with only "E" codes are counted as normal, no referral. Claims with "E" codes and at least one "R" (or other non-"E" codes) are counted as a screening with one or more referrals.

The HCPCS code X5622 used by some health plans, cannot be used by DHS to report C&TC/EPSDT fee-for-service screening services. Claims submitted to DHS with this code will be denied.

Any HCFA-1500 claim submitted with C&TC/EPSDT screening services cannot have additional non-C&TC/EPSDT procedures billed on the same claim. When procedures in addition to the completed C&TC/EPSDT screening components are performed at the same visit (e.g., tympanometry), bill the additional procedures on a separate HCFA-1500 and do not include the C&TC alpha code in box 24H.

Providers who use paper HCFA-1500 claims can use more than one claim form to bill a complete C&TC/EPSDT screening service. When there are too many procedures to fit on one claim, list each completed procedure only once and paper clip the forms together. On the top of the first page of the claim, in red ink, write “1 of 2” and on the second page write “2 of 2” and so on. This will alert the Claims staff that these claims go together. If they do not know the claims go together, the claims would be denied for not being a “complete” C&TC/EPSDT screening.

Lab services performed at an outside lab must be included on the C&TC/EPSDT claim to be complete. To indicate lab services were sent to an independent laboratory, indicate the place of service of 81 in box 24B, or the Place of Service field on ITS. Use the appropriate CPT/HCPCS procedure code for the lab service and use modifier 90. Enter the independent laboratory’s MHCP provider ID number in box 24K, or the Treating Provider Number field on ITS.

More information about billing and reimbursement is found in the Billing Policy chapter (Ch. 4).

**C&TC/EPSDT Information**

To obtain information on the C&TC/EPSDT Program write to:

Minnesota Department of Human Services
C&TC Coordinator
Performance Measurement and Quality Improvement Division
444 Lafayette Road North
St. Paul, MN 55155-3865
(651) 296-1723
The following C&TC forms, brochures and information may be found on the Minnesota Department of Human Services C&TC website at http://www.dhs.state.mn.us/healthcare/ctc/default.htm:

- Child and Teen Checkups (C&TC) Coordinators List
- Child and Teen Checkups (C&TC) Health Care For Kids Brochure
- Child and Teen Checkups (C&TC) Your Growing Child (YGC) – A Family Brochure
- Child and Teen Checkups (C&TC) Being a Teenager…
- Child and Teen Checkups (C&TC) Periodic Screening Schedule
- Child and Teen Checkups (C&TC) Materials List and Ordering Information
- Nutrition Education for New Americans Project
- DHS Bulletins
- Child and Teen Checkups (C&TC) Documentation Forms for Providers and Clinics
- Criteria Guidelines for C&TC Documentation Forms
- Child and Teen Checkups (C&TC) Screening Checklists for Parents

Other related websites:

- [Child & Teen Checkups (C&TC) Screening Training](http://www.dhs.state.mn.us/healthcare/ctc/default.htm) (Minnesota Department of Health)
- [Child & Teen Checkups (C&TC) Fact Sheets](http://www.dhs.state.mn.us/healthcare/ctc/default.htm) (Minnesota Department of Health)
- [Child & Teen Checkups (C&TC) Denver II training](http://www.dhs.state.mn.us/healthcare/ctc/default.htm) (Minnesota Department of Health)
- [Early Childhood & Family Initiatives](http://www.dhs.state.mn.us/healthcare/ctc/default.htm) (Minnesota Department of Children, Families and Learning)

**Recommended Childhood Immunization Schedule Minnesota, 2002**

[Recommended Childhood Immunization Schedule Minnesota, 2002 (PDF)](http://www.dhs.state.mn.us/healthcare/ctc/default.htm)

**Routine Blood Lead Screening Risk Questionnaire for:**
children under three years of age--OR
children under six years of age who have never been tested for blood lead poisoning.

Name of patient: ____________________________  Date: _____________

Age of child: _______ (years)  Physician or Nurse Practitioner: ____________________________

Please circle the correct answer to the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have reason to believe that your child may have blood lead poisoning?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason for concern: ____________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child moved to Minnesota from a foreign country or from a major metropolitan area within the last 12 months?</td>
<td>Yes</td>
<td>Don't Know</td>
</tr>
<tr>
<td>Does your child live within the city limits of Minneapolis or St. Paul?</td>
<td>Yes</td>
<td>Don't Know</td>
</tr>
</tbody>
</table>
Do you receive:
- Medical Assistance (MA) which includes the Prepaid Medical Assistance Program (PMAP);
- The Supplemental Food Program for Women, Infants, and Children (WIC); or
- MinnesotaCare (MnCare)?

| Yes | Don't Know | No |

During the past six months has your child lived in or regularly visited a home, childcare, or other building built before 1950?

| Yes | Don't Know | No |

During the past six months has your child:
- Lived in, or
- Regularly visited a home, childcare, or other building built before 1978 with recent or ongoing repair, remodeling, or damage (such as water damage or chipped paint)?

| Yes | Don't Know | No |

Has your child’s brother, sister, housemate, or playmate been diagnosed with blood lead poisoning?

| Yes | Don't Know | No |

---

**Periodic Blood Lead Screening Risk Questionnaire for:**

children three to six years of age who **have been tested** for blood lead poisoning in the past.

Name of patient: __________________________ Date: ______________

Age of child: ________ (years) Physician or Nurse Practitioner: __________________________

Please circle the correct answer to the following questions:

| Do you have reason to believe that your child may have blood lead poisoning? | Yes | No |
| Has your child moved to Minnesota from a foreign country or from a major metropolitan area within the last 12 months? | Yes | Don't Know | No |
| Since your child's last blood lead test has your child's brother, sister, housemate, or playmate been diagnosed with blood lead poisoning? | Yes | Don't Know | No |
| Since your child's last blood lead test has your child moved to or started regularly visiting a home, childcare, or other building built before 1950? | Yes | Don't Know | No |
| Since your child's last blood lead test has there been:  
  - Repair;  
  - Remodeling; or  
  - Damage (such as water damage or chipped paint) to a home, childcare, or other building built before 1978 that your child lives in or regularly visits? | Yes | Don't Know | No |
Blood Lead Screening Guidelines for Minnesota

A physician should test a child at any age:
- If the parent expresses a concern about, or asks for their child to be tested for blood lead poisoning
- If the child moved from a major metropolitan area or another country within the last twelve months

Routine Screen:
Child health-care providers should use a blood lead test* to screen children at one and two years of age, and children up to six years of age who have not previously been screened if:

The child lives within the city limits of Minneapolis or St. Paul;

or

The child receives services from Minnesota Care (MnCare), the Supplemental Food Program for Women, Infants, and Children (WIC), or Medical Assistance (MA) - which includes the Prepaid Medical Assistance Program (PMAP);

or

The child does not fit the criteria above, and the answer to any of the following questions is "Yes" or "Don't Know":

- During the past six months has the child lived in or regularly visited a home, childcare, or other building built before 1950?

- During the past six months has the child lived in or regularly visited a home, childcare, or other building built before 1978 with recent or ongoing repair, remodeling or damage (such as water damage or chipped paint)?

- Has the child or his/her sibling, playmate, or housemate had an elevated blood lead level?
Periodic Evaluation:
In order to monitor a change in the child's status, administer the following questions annually to all children three to six years of age whose previous test results were less than 10 ug/dL. Screen the child with a blood lead test* if the answer to any of the following questions is "Yes" or "Don't Know"

Since the child's last blood lead test:

- Does the child have a playmate, housemate, or sibling who has recently been diagnosed with an elevated blood lead?
- Has the child moved to or started regularly visiting a home, childcare, or other building built before 1950?
- Has there been any repair, remodeling, or damage (such as water damage or chipped paint) to a home childcare, or other building built before 1978 that the child lives in or regularly visits?

* A blood lead test for lead poisoning is a laboratory analysis for lead in the blood of a child or adult. An elevated blood lead test is a result greater than or equal to 10 micrograms lead per deciliter of blood. Laboratories performing blood lead analysis are required to report all results to the Minnesota Department of Health.

For more information about lead screening, call the Environmental Impacts Analysis Unit at (651) 215-0700; or 1-(800) 657-3908; or TTY (651) 215-0707
Environmental Impacts Analysis Unit - P.O. Box 64975 - St. Paul, MN - 55164-0975

Follow-up Care

<table>
<thead>
<tr>
<th>If result of capillary screening test (ug/dL) is:</th>
<th>Perform diagnostic test on venous blood within:</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-19</td>
<td>3 months</td>
</tr>
<tr>
<td>20-44</td>
<td>1 month - 1 week&gt;</td>
</tr>
<tr>
<td>45-59</td>
<td>48 hours</td>
</tr>
<tr>
<td>60-69</td>
<td>24 hours</td>
</tr>
<tr>
<td>&gt;70</td>
<td>Immediately as an emergency lab test</td>
</tr>
</tbody>
</table>

Follow-up testing for children with elevated diagnostic BLLs

- Children with diagnostic BLLs of 10-14 ug/dL should have at least one follow-up test within 3 months.
- Children with diagnostic BLLs of 15-19 ug/dL should have a follow-up test within 2 months.
- If the result of the follow-up testing is ≥ 20 ug/dL, or if the child has had two or more venous BLLs of 15-19 ug/dL at least 3 months apart, the child should receive clinical management.
- Children with diagnostic BLLs ≥ 20 ug/dL should receive clinical management which includes follow-up testing.
Clinical management includes
- Clinical evaluation for complications of lead poisoning.
- Family lead education and referrals.
- Chelation therapy, if appropriate.
- Follow-up testing at appropriate intervals.

Provide appropriate chelation therapy
- A child with a BLL > 45 ug/dL should be treated promptly with appropriate chelating agents and be removed from sources of lead exposure.

Environmental Management
- Contact the Minnesota Department of Health/Local Public Health Agency.

Sources of Lead
The most common sources of lead are paint, dust, soil, and water.

Other sources include:

<table>
<thead>
<tr>
<th>Traditional Remedies/Cosmetics</th>
<th>Occupations/Industries</th>
<th>Hobbies</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Latino communities for abdominal pain called empacho (yellow/orange powders): alarcon, azarcon, cora, greta, liga, rueda</td>
<td>Ammunition/explosives maker</td>
<td>(may include above occupations)</td>
</tr>
<tr>
<td>In Asian communities for intestinal disorders: ghasard (brown powder), bali goli (flat black bean), kandu (red powder)</td>
<td>Auto repair/auto body work</td>
<td>Remodeling, repairing, renovating home</td>
</tr>
<tr>
<td>In Hmong communities for fever or rash: pay-loo-ah (red powder)</td>
<td>Battery maker</td>
<td>Painting/striping cars, boats, bicycles</td>
</tr>
<tr>
<td>In Arab communities as a cosmetic, treatment for skin infections and umbilical stump: kohl or alkohl (powder)</td>
<td>Building or repairing ships</td>
<td>Soldering</td>
</tr>
<tr>
<td></td>
<td>Cable/wire stripping, splicing or production</td>
<td>Melting lead for fishing sinkers or bullets</td>
</tr>
<tr>
<td></td>
<td>Construction</td>
<td>Making stained glass</td>
</tr>
<tr>
<td></td>
<td>Ceramics worker (pottery, tiles)</td>
<td>Firing guns at a shooting range</td>
</tr>
<tr>
<td></td>
<td>Firing range worker</td>
<td>Plumbing</td>
</tr>
<tr>
<td></td>
<td>Leaded glass factory worker</td>
<td>Pouring molten metal (foundry work)</td>
</tr>
<tr>
<td></td>
<td>Industrial machinery/equipment</td>
<td>Radiator repair</td>
</tr>
<tr>
<td></td>
<td>Jewelry maker or repair</td>
<td>Remodeling/repainting/renovating houses or buildings</td>
</tr>
<tr>
<td></td>
<td>Junkyard employee</td>
<td>Removing paint (sandblasting, scraping, sanding, heat gun or torch)</td>
</tr>
<tr>
<td></td>
<td>Lead miner</td>
<td>Salvaging metal or batteries</td>
</tr>
<tr>
<td></td>
<td>Melting metal (smelting)</td>
<td>Welding, burning, cutting or torching</td>
</tr>
<tr>
<td></td>
<td>Painter</td>
<td>Steel metalwork</td>
</tr>
<tr>
<td></td>
<td>Paint/pigment manufacturing</td>
<td>Tearing down buildings/metal structures</td>
</tr>
<tr>
<td></td>
<td>Plumbing</td>
<td></td>
</tr>
</tbody>
</table>

For more information about lead, contact the Minnesota Department of Health at (651) 215-0880
Legal References

Minnesota Statutes, sections 256B.04; 256B.0625 (C&TC)
Minnesota Statutes, section 256B.0625, subd. 26 (IEP)
Minnesota Statutes, section 256B.0625, subd. 39 (immunizations)
Minnesota Rules, parts 9505.0275, 9505.1693 to 9505.1748 (C&TC)
42 CFR 440.40(b); 42 CFR 441.50-441.62 (C&TC)
Title XIX, Sections 1902(a)(43), 1905(a)(4)(B), 1905(r) of the Social Security Act (C&TC)
Chapter 10

Reproductive Health - Obstetrics and Gynecology

The following health services are included in this chapter:

- Family Planning;
- Sterilization;
- Hysterectomy;
- Obstetric and Gynecology Services;
- Minnesota Pregnancy Assessment Form and "At Risk" Pregnancy Services;
- HIV Counseling & Testing for Pregnant Women;
- Certified Nurse Midwife Services; and
- Abortion Services

Family Planning

- MHCP covers family planning services and supplies for individuals of childbearing age, including minors.
- Recipients must be free of coercion and free to choose the method of family planning they want to use.
- The provider cannot require that an unmarried minor's parent or guardian consent to family planning services for the minor.

Definitions

**Family Planning Service:** A family planning health service, includes screening, testing, and counseling for sexually transmitted diseases, such as HIV, when provided in conjunction with the voluntary planning of conception and childbearing, and related to a recipient's condition of fertility.

**Family Planning Supply:** A prescribed drug or contraceptive device ordered by a physician or other eligible provider with prescribing authority for treatment of a condition related to a family planning service.

**Family Planning Agency:** A family planning agency means an entity having a medical director that provides family planning services under the direction of an MHCP enrolled physician. The medical director must ensure that the counseling and information on family planning are performed by trained personnel and according to accepted community standards.
Providers

Physicians, certified nurse midwives, certified nurse practitioners, physician assistants, clinical nurse specialists, clinics, outpatient hospital departments, pharmacies, and family planning agencies may provide some or all of the available family planning services and family planning supplies. (Refer to applicable chapters for information and requirements relevant to the various providers.)

Free Choice of Provider

- All MHCP recipients have free choice of family planning providers and may obtain family planning services (including sterilization procedures) from any qualified provider, including those outside of their provider network.
  - If a provider furnishes a family planning service to a managed care recipient and the provider is not part of the recipient's health plan provider network, the provider must contact the health plan for payment.
- MHCP recipients have free choice of providers for diagnosis of infertility. Infertility treatment is **not** included in free choice of providers.
  - Recipients in managed care health plans must seek infertility treatment through their managed care network. If the provider is not part of the managed care network, the provider must contact the recipient's health plan for payment.
  - Fee-for-service recipients (those not enrolled in a health plan) may see any enrolled MHCP provider for infertility treatment.

Covered Services

The following family planning services are covered (although all providers listed above may not directly provide all of these services):

- Contraceptive devices (e.g., diaphragm, interuterine device [IUD]);
- Family planning supplies (e.g. condoms, thermometers);
- Contraceptive implants (e.g., Norplant);
- Contraceptive injections (e.g., Depo-Provera);
- Prescriptions for the purpose of family planning;
- Emergency contraception (e.g., Previn); Note: Plan B is not covered by MHCP
- Consultation, examination, and medical treatment;
- Genetic counseling [see Physician Extender section (Ch. 6) for billing];
- Family planning counseling;
- Distribution of family planning information;
- Laboratory examination and tests;
- Diagnosis and treatment of infertility (except fertility drugs and all associated services, in vitro fertilization and artificial insemination);
- Voluntary sterilization (see Sterilization section of this chapter);
STD testing;
HIV blood screening and counseling performed before and after HIV blood screening test.

For all family planning services, the recipient must have full knowledge of and consent freely to all family planning services.

Non-covered Services

- Reversal of voluntary sterilization;
- Fertility drugs and all associated services; and
- Artificial insemination including in vitro fertilization.

Billing

- Bill on the CMS-1500.
- Indian Health Services, family planning agencies and community health clinics dispensing oral contraceptives should use HCPCS code S4993. Up to a one year supply (13 units) may be billed for each recipient per year.
- Emergency contraceptives should be billed using HCPCS code J3490. The drug name and dosage information must be provided on the claim.

Sterilization

Definitions

**Informed Consent/Sterilization Consent Form**: A Sterilization Consent Form must be completed for each MHCP recipient who requests a sterilization procedure (see **Obtaining Sterilization Consent** at the end of this section). The Sterilization Consent Form provides an opportunity for providers to obtain *informed* consent by giving the recipient:
- An opportunity to ask questions about the sterilization process;
- An oral explanation about the procedure and any procedural risks in accordance with consent form requirements;
- A copy of the consent form; and
- Advice that the decision to be sterilized will not affect future care or benefits, and that the sterilization will not be performed for at least 30 days, except in the case of premature delivery.

The Sterilization Consent Form must be completed in order for MHCP to reimburse providers for performing sterilization procedures. This requirement is applicable to all MHCP recipients (MA, GAMC and MinnesotaCare). **Under no circumstances will the requirement be waived.**
**Institutionalized Individual:** An individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental health or other facility for the care and treatment of mental illness, or confined under a voluntary commitment in a mental health or other facility for the care and treatment of mental illness.

**Mentally Incompetent Individual:** An individual who is declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.  
**Note:** A recipient who has a legal guardian is considered a mentally incompetent individual.

**Sterilization:** Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

For information about **hysterectomies** refer to the [Hysterectomy section](#) of this chapter; different guidelines apply.

**Free Choice of Provider**

- Sterilization is a family planning service. All MHCP recipients have free choice of family planning providers and may obtain family planning services from any qualified provider, including those outside of their provider network.
- If a provider furnishes a family planning service to a managed care recipient and the provider is not part of the recipient's health plan provider network, the provider must contact the health plan for payment.

**Covered Services**

The Code of Federal Regulations (42 CRF 441.250 – 441.259) outlines requirements, including use of the Sterilization Consent Form for obtaining informed consent, which must be met for MHCP to reimburse providers for performing sterilization procedures. The requirements apply to all MHCP recipients (MA, GAMC and MinnesotaCare). Under no circumstances will these requirements be waived.

**The following criteria must be met in order for a sterilization to be covered by MHCP:**

- The individual is at least 21 years of age at the time the consent form is signed.
- The individual is not mentally incompetent.
- The individual is not institutionalized.
- The individual has voluntarily signed the Sterilization Consent Form (a consent form signed by a guardian, conservator, or anyone other than the individual to be sterilized, will not be accepted).
- Consent form signature timelines:
The individual to be sterilized must sign and date the consent form. At least 30 days, but not more than 180 days, must pass between the date the individual signed the consent form and the date of surgery.

The interpreter, if one was provided, must sign and date the consent form after the patient signs but before the day of surgery.

The person obtaining the consent must sign and date the consent form after the patient signs but before the day of surgery. The person obtaining the consent certifies, by signing the consent form, that he/she explained the requirements for informed consent orally and, to the best of his/her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

The physician who performs the sterilization procedure must sign and date the consent shortly before (no more than 15 days prior to surgery) the day of surgery, or after the surgery. The physician certifies by signing the consent form, that he/she advised the individual to be sterilized that no federal benefits will be withdrawn if the recipient chooses not to be sterilized, explained the requirements for informed consent, and, to the best of his/her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

Exceptions to timelines:

Emergency abdominal surgery – when an individual is sterilized at the time of emergency abdominal surgery payment will be made if at least 72 hours have passed since he or she signed the consent form.

Note: An emergency cesarean section is not considered emergency abdominal surgery.

Premature delivery – when an individual is sterilized at the time of premature delivery, payment will be made if at least 72 hours have passed since she signed the consent form and the consent form was signed by the individual at least 30 days before the expected date of delivery.

Consent cannot be obtained nor may the recipient consent to sterilization when the recipient is:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the recipient's state of awareness.

There may be situations, other than those listed above, in which the provider believes that the recipient is unable to give informed consent. It is incumbent upon the physician to obtain informed consent. If the physician does not believe the recipient can give informed consent, he/she should not perform the sterilization or may request additional information to determine whether the recipient is capable of giving informed consent (such as a psychiatric evaluation).

Non-covered Services

- Reversal of voluntary sterilizations.
• Sterilization of a mentally incompetent individual.
• Sterilization of an institutionalized individual; individuals living in the following institutions, whether voluntarily, civilly committed, or court ordered are considered institutionalized:
  ▪ Intermediate care facilities for the mentally retarded (ICF-MR);
  ▪ Regional treatment centers that are not institutions for mental disease (RTC, not IMD);
  ▪ Regional treatment centers that are institutions for mental disease (RTC-IMD);
  ▪ Institutions for mental disease (IMD);
  ▪ Correctional facilities (county or non-county);
  ▪ Chemical dependency rehabilitation programs; and
  ▪ Residential facilities for mentally ill persons.

• Sterilization of anyone under 21 years old at the time consent was obtained.
• **MHCP does not cover sterilization procedures without the informed consent of the individual being sterilized. Under no circumstances will MHCP pay for a sterilization in which a person has given consent for another person; this includes court-ordered sterilization of a mentally incompetent or institutionalized individual.**

**Required Counseling**

The person obtaining the consent for the sterilization must answer the recipient's questions regarding the procedure, provide a copy of the Sterilization Consent Form, and explain the requirements for informed consent that are listed on the consent form. Additionally, shortly before the sterilization, the physician who will perform the procedure must explain the requirements for informed consent that are listed on the Sterilization Consent Form.

**Interpreter Services**

The provider must supply a language interpreter to ensure that the information regarding the sterilization is communicated effectively for recipients who do not understand English. A sign language interpreter must be provided to ensure that information is communicated effectively to hearing impaired. Refer to Requirements for Providers (Ch.1).

**Transfer of Consent**

If a recipient moves or changes providers, the consent form may be transferred to the new provider. However, the physician who performs the surgery must complete the physician section and sign within the appropriate time limits.
Billing

- A copy of the Sterilization Consent Form must accompany claims from the physician, anesthesiologist, CRNA, and hospital or surgical center. The consent form must be attached to a paper copy of the claim; do not bill electronically.

  - Every space on the form must be completed except: Race and Ethnicity of recipient (optional), and Interpreters Statement (if an interpreter was unnecessary).
  - Dates corresponding to signatures must be filled in by the person whose signature is on the preceding line (patient, interpreter, person obtaining consent, or physician). Under no circumstances should the consent form dates be typed onto the form or filled in by someone other than the signatory.
  - Dates can be changed only to correct a clerical error. If, for example, a person writes 1/8/01 instead of 1/8/02, the error should be struck through, but not obliterated, and the correct date entered. The reason for the change should be evident.
  - The alternate final paragraphs section (lower right hand section of the consent form) requires a choice between paragraph one or paragraph two. If paragraph two is selected information about the premature delivery or emergency abdominal surgery must also be provided.

- Retroactive eligibility:

  - Sterilization Consent Form requirements cannot be met retroactively. When an individual without financial resources or insurance coverage requests sterilization and indicates that he/she is considering application or has applied for MA/GAMC, it is advisable for the provider to obtain informed consent, complete a consent form, and allow for the 30-day waiting period.
  - If a recipient becomes retroactively eligible for MA/GAMC and has paid for the sterilization procedure, the provider must reimburse the recipient the full amount paid and bill DHS if there is a valid consent form and the 30-day waiting period was observed.

Obtaining Sterilization Consent Forms

The Sterilization Consent Form is contained in U.S. Department of Health and Human Services booklets that explain the sterilization procedure.

- [Information for Women - Your Sterilization Operation](DHS-2510); and
- [Information for Men - Your Sterilization Operation](DHS-2511).
Hysterectomy

Definition

Hysterectomy: A medically necessary procedure or operation for the purpose of removing the uterus. MHCP does not cover hysterectomy for sterilization purposes.

Covered Services

The Code of Federal Regulations (42 CFR 441.250 – 441.259) outlines requirements, including recipient acknowledgment of information, that must be complied with for MHCP to reimburse providers for performing hysterectomy procedures. See the sample Hysterectomy Acknowledgment Statement at the end of this section.

Coverage Restrictions

A hysterectomy is not covered under the following circumstances:

- When it is performed solely for the purpose of making a recipient sterile; or
- If there is more than one purpose for the procedure, but it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

A written Hysterectomy Acknowledgment Statement (HAS) is required in order for the procedure to be covered.

Written Acknowledgment

- MHCP requires the provider to secure authorization to perform a hysterectomy by informing the individual (and her representative, if applicable), that the hysterectomy will make her permanently incapable of reproducing. The recipient and her representative, if any, must sign a HAS verifying that they received this information, both orally and in written form. The HAS must accompany any claim(s) submitted by the physician, anesthesiologist, CRNA, and hospital.

- A sample HAS is included at the end of this section. It is not mandatory for the provider to use this sample acknowledgment statement. Any document that the recipient (or her representative) has signed that shows the provider informed the recipient that she would be incapable of reproducing due to the hysterectomy is permissible.

- Do not use the Sterilization Consent Form: MHCP does not cover a hysterectomy as a means for sterilization.

- The recipient or guardian may sign the HAS before or after the hysterectomy. However, if the statement is signed after the hysterectomy, it must indicate that before the surgery
took place, the recipient was informed that the hysterectomy would make her sterile.

- Guardians must sign the HAS for mentally incompetent recipients.

- A recipient residing in an institution, such as a regional treatment center, may sign the HAS for herself unless she has been found incompetent by a court or unless the head of the institution determines that the recipient is incompetent and requires a representative.

**Sample Hysterectomy Acknowledgment Statement**

My doctor informed me, both orally and with written materials, that the performance of a hysterectomy would make me sterile (not able to have children).

Signed ___________________________ Date _____________________________

If the recipient signs the acknowledgment after the hysterectomy, the acknowledgment must show that the recipient was informed of the consequences of the hysterectomy before the procedure was performed.

**Exceptions**

The written HAS requirement is waived in the following situations:

- **Recipient Already Sterile:** A hysterectomy performed on a recipient who was sterile before the surgery, is not subject to the written acknowledgment requirement. The claims submitted by the physician who performed the hysterectomy, the anesthesiologist, CRNA, and the hospital must be accompanied by a written physician certification (including physician signature and date) of the recipient's sterility and the cause of the sterility.

**Sample Statement – Recipient Already Sterile**

(Patient’s name) had a tubal ligation procedure on (date) making her sterile prior to the hysterectomy performed on (date).

Signature of physician: ___________________________ Date: __________________

**Life-threatening Emergency:** When a recipient needs a hysterectomy because of a life-threatening emergency situation in which a physician determines that prior acknowledgment is not possible. The physician must provide a written certification (including physician signature and date) that prior acknowledgment was not possible and describe the nature of the emergency. This certification must accompany all claims for services associated with the hysterectomy.
Obstetric Services

MHCP covers prenatal, delivery, postpartum, and newborn care services.

All pregnant recipients must be screened to determine risk status using the Minnesota Pregnancy Assessment Form (MPAF), DHS-3294. Enhanced services are available for women determined to be "at risk." (Refer to the “At Risk” Pregnancy Services Section in this Chapter.)

Maternal Health Classes

- Prenatal education is provided to pregnant women for health promotion or risk reduction intervention. Do not bill for classes that are provided free to non-MHCP recipients.
- Use HCPCS codes S9436 – S9443 to bill for birthing and lactation classes. Use HCPCS code S9447 to bill for infant health and safety classes (including infant CPR).
- Bill one unit for each class session (a session is an encounter). For weekend classes use the appropriate code with a 22 modifier and an explanation for the number of hours billed.
- The following providers may provide and bill for prenatal education classes: enrolled physicians, physician clinics, community clinics, public health clinics, outpatient hospitals, nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwives.
- Clinics and outpatient hospitals, whose prenatal education program is directed by an enrolled provider, may bill for RNs, or health educators with at least a baccalaureate level degree in health education or national certification for prenatal education.

Breast Pumps

Breast pumps are covered when ordered by a physician, certified nurse midwife or nurse practitioner for any nursing mother experiencing separation from her infant because of work, school, illness or for medically necessary reasons (see Equipment and Supplies [Ch. 23]).

Subcutaneous Terbutaline Pump (SQTP)

Use of the SQTP is a covered service for MHCP recipients. The following criteria must be met and documented in the medical record:

- Gestation of 20 weeks or greater but less than 37 weeks;
- Experiencing symptoms suggestive of preterm labor;
- Intact amniotic membranes;
- Cervical dilation <4 cm; and
- Modified or complete bedrest.
Ambulatory Uterine Monitoring Device

Ambulatory Uterine Monitoring Device: Medical equipment designed to be used by the lay person to monitor uterine activity.

Equipment and Systems Standards

Authorization requests for the ambulatory uterine device will be considered when the following equipment standards are met:

- The equipment is ambulatory, which means monitoring may occur while the patient is conducting daily activities. A unit that must be plugged into an electrical outlet to function is not ambulatory.
- The equipment records data specifically labeled with the time on the printout.
- The equipment is designed for use by a lay person.
- The system monitors uterine activity for a minimum of two one-hour sessions daily.
- The equipment transmits uterine contraction data on a daily basis.
- The prescribing physician or certified nurse midwife is notified immediately by a nurse when abnormal contraction data or contraction data that fall outside of the prescribing physician's or certified nurse midwife's parameters is transmitted.
- The physician or certified nurse midwife receives a report and graph describing each week's uterine activity on a weekly basis.
- The belt fits properly for the monitor to work effectively. The device may not accommodate extremely obese patients.

Authorization for the rental of this device must be obtained from the medical review agent under contract with DHS (CDMI). It is the responsibility of the medical supply provider to submit the Pharmacy/Medical Supply Authorization Form (DHS-3065) with:

- Sufficient information from the medical supply provider establishing that criteria listed in the "Equipment Standards" have been met; and
- Sufficient information from the prescribing physician or certified nurse midwife to establish that criteria listed in the “Medical Necessity Standards” has been met.

Medical Necessity Standards/Documentation

Authorization requests for this device will be approved only when the following requirements are met:

The patient is "at risk" for preterm labor and delivery based on the MPAF and a combination of the following medical necessity factors exist:

- Occurrence of preterm labor with current pregnancy (describe);
- Preterm labor or delivery with a previous pregnancy;
- Multiple gestation;
- An anomalous uterus;
- Cervical problems including: an incompetent cervix; cervical changes (describe); and placenta previa.

The patient is, or has recently been, under treatment to prevent preterm labor with a combination of the following methods:
- Bed rest or restricted activity (describe restricted activity);
- Tocolysis drug therapy (describe), including dosage/frequency;
- Increased office visits or phone contact for patient counseling and monitoring; and
- Hospitalization for preterm labor (admission and discharge dates);
- Less expensive appropriate alternative treatment was undertaken but was not successful or was contraindicated (describe);
- The device is prescribed for a period that begins no earlier than the 24th week and continues no longer than the 34th week;
- In the opinion of the physician or certified nurse midwife, the patient is capable of complying with a home monitoring program (explain);
- The information required above is in letter format, individualized to the patient, and includes the following:
  - Documentation of each item listed under medical necessity standards; and
  - The duration of pregnancy (EDC).

Billing

- The home uterine monitoring device must be billed by the medical supplier.
- MHCP will not pay for days in which data is not transmitted from the patient to the nurse.
- MHCP will not pay for "add-on" programs such as blood pressure, pulse, weight gain, or glucose monitoring.

Physician Standby Attendance for Newborn

MHCP will cover a pediatric standby during fetal distress. The following are examples of fetal distress that may warrant a pediatric standby:

- Fetal bradycardia;
- Diabetes in the mother;
- Meconium;
- Premature labor;
- Foul-smelling amniotic fluid; and
- Mother taking certain medications.

If the pediatrician bills for standby services, the reason for the pediatrician giving unusual services to the infant must be thoroughly documented.

Problems such as prolonged labor, failure to progress, and cephalopelvic disproportions are generally not reasons for billing physician standby services unless fetal distress is also a factor.
Billing Obstetric Services

Obstetric care can be billed either globally or by components. The billing method used is the provider’s choice, but only one method can be used for each obstetric case. Follow CPT guidelines for global and component billing.

The following services are paid independent of the component and global methods:

- Completion of the MPAF, using code H1000 after the form is on file at DHS (fee-for-service recipients). Providers can bill for up to four MPAFs for each pregnant woman, when applicable, in a 12-month period. For health plan recipients, follow the instructions of the applicable health plan. (For federally qualified health centers, rural health clinics, and Indian health services, performing the pregnancy assessment and completing the form is included in the encounter.)
- Obstetric laboratory panel, regardless of the billing method used. However, do not bill the CPT obstetric panel code unless all components of the laboratory panel are performed. If all components of the panel are not performed, bill the individual laboratory procedure codes using the appropriate CPT code. Refer to the Laboratory/Pathology, Radiology and Diagnostic Services chapter (Ch. 11) for further billing instructions.
- Miscellaneous services (e.g., amniocentesis, ultrasound, fetal non-stress test, fetal Fibronectin, oxytocin challenge, estriol, etc.) with the appropriate codes.
- MHCP pays a higher rate for vaginal deliveries for women who previously delivered by cesarean section (VBAC). Use the appropriate CPT procedure code.
- To bill for vaginal delivery of multiple gestation births, use modifier 22 with the appropriate CPT procedure code.
- For consideration of additional payment for other complicated vaginal or cesarean deliveries, attach a delivery report and other relevant information to the paper claim.
- Pregnancy and non-pregnancy related services must be billed on separate invoices using appropriate ICD-9-CM diagnoses.
- All services provided to a newborn should be billed using the newborn's MHCP ID number and date of birth. This includes normal newborn care and any inpatient services to the newborn, whether before or after the mother's discharge. Services provided to the mother should be billed using the mother's MHCP ID number.
- Please see the Inpatient Hospital Authorization chapter (Ch. 13) for billing instructions when a newborn is transferred to another facility for specialty services.

The Minnesota Pregnancy Assessment Form and “At Risk” Pregnancy Services

Definitions

Minnesota Pregnancy Assessment Form (MPAF): The MPAF (DHS-3294) is a uniform tool used to determine a pregnant woman’s risk for preterm delivery, a low birth weight infant, or a poor birth outcome. Enhanced services are available for women determined to be “at risk.”
**Risk Assessment**: Identification of the medical, genetic, life-style, and psychosocial factors which put a recipient "at risk" for preterm delivery, a low birth weight infant, or a poor birth outcome.

"At Risk": A pregnant woman who requires additional prenatal care services because of factors that increase the probability of a preterm delivery, a low birth weight infant, or a poor birth outcome.

**Low Birth Weight**: Birth weight less than 2,500 grams (5.5 pounds).

**Preterm Birth**: Birth before the gestational age of 38 weeks.

**Enhanced Services**: Services available to recipients identified on the MPAF as "at risk" for a poor pregnancy outcome. These services are reimbursed in addition to routine obstetric services. Enhanced services include “at risk” antepartum management, care coordination, prenatal health education I & II, prenatal nutrition education, and postpartum follow-up home visit.

**Minnesota Pregnancy Assessment Form (MPAF)**

A physician, certified nurse midwife, or certified nurse practitioner is authorized to complete and sign the MPAF. The risk assessment must be done at the first visit, and a second screening should be done between 24th and 28th weeks of gestation.

The MPAF, DHS-3294, and the MPAF Technical Assistance Guide, MS-1878, are available online at: [http://edocs.dhs.state.mn.us](http://edocs.dhs.state.mn.us). A copy of the MPAF needs to be:

- Kept on file in the recipient’s medical record;
- Sent to DHS, PO Box 64893, St. Paul, MN 55164, for fee-for-service recipients; and
- Sent to the prepaid health plan (PPHP) if the recipient is enrolled in a PPHP.

Payment will not be made for routine prenatal care services for fee-for-service recipients if an MPAF is not completed and on file at DHS.

A provider can update the MPAF at any time during the pregnancy if a risk factor becomes apparent. This will qualify the woman for enhanced services. If a woman is determined to be "at risk," the provider is required to order enhanced services applicable to the woman's "at risk" status.

**Enhanced Services For "At Risk" Pregnancies**

When a physician, certified nurse midwife, or certified nurse practitioner determines that a recipient is "at risk" for a poor birth outcome, the recipient is eligible for enhanced services. **Enhanced services are only available for women identified as "at risk" on the MPAF.** The primary care provider is responsible for referring these services; this is not done by DHS. The physician, certified nurse midwife, or certified nurse practitioner is required to specify the enhanced services ordered and the name of the provider furnishing those services on the MPAF in the box entitled "Enhanced Services" (on the lower left side of the form).
Six enhanced services are covered for "at risk" pregnancies:

- "At Risk” Antepartum Management
- Care Coordination
- Prenatal Health Education I
- Prenatal Health Education II: Lifestyle and Parenting Support
- Prenatal Nutrition Education
- Postpartum Follow-up Home Visit

Enhanced services and documentation requirements are outlined in the MPAF Technical Assistance Guide (MS-1878).

**Billing Codes for Enhanced Services**

<table>
<thead>
<tr>
<th>Enhanced Services</th>
<th>HCPCS Code</th>
<th>Providers Authorized to Provide Service and Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced Service Package (all enhanced services)</td>
<td>H1005</td>
<td>Medical Doctor (MD), Doctor of Osteopathy (DO), Certified Nurse Midwife (CNM),</td>
</tr>
<tr>
<td>Minnesota Pregnancy Assessment Form (MPAF)</td>
<td>H1000</td>
<td>MD, DO, CNM, Certified Nurse Practitioner (CNP)</td>
</tr>
<tr>
<td>&quot;At Risk” Antepartum Management</td>
<td>H1001</td>
<td>MD, DO, CNM</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>H1002</td>
<td>MD, DO, CNM, CNP, Physician Assistant (PA), Registered Nurse (RN)</td>
</tr>
<tr>
<td>Prenatal Health Education I</td>
<td>H1003</td>
<td>MD, DO, CNM, CNP, PA, RN, Health Education Professional</td>
</tr>
<tr>
<td>Prenatal Health Education II</td>
<td>H1003</td>
<td>MD, DO, CNM, CNP, PA, RN, Health Education Professional</td>
</tr>
<tr>
<td>Prenatal Nutrition Education</td>
<td>H1003</td>
<td>MD, DO, CNM, PA*, RN* Dietitian, Nutritionian</td>
</tr>
<tr>
<td>Postpartum Follow-up Home Visit</td>
<td>H1004</td>
<td>MD, DO, CNM, CNP, PA, RN</td>
</tr>
</tbody>
</table>

* Providers authorized to perform service with documented specialized nutritional education.

**Billing Enhanced Services**

- Enhanced services will be paid only for "at risk" pregnant women. The MPAF must indicate an "at risk" status and specify the enhanced services ordered and the provider furnishing those services.
- An MPAF must be on file at DHS before a provider can bill or be paid for routine prenatal care and enhanced services (for fee-for-service recipients).
- Do not attach claims to the MPAF. Submit claims after you have received the notification letter, to ensure that the MPAF is in the DHS system.
- A provider can update the MPAF to an "at risk” status at any time during a pregnancy. MHCP allows up to four Minnesota Pregnancy Assessment Forms (MPAF) per recipient within a 12-month period.
• Bill the usual and customary charge in box 24F on the CMS-1500 or the electronic equivalent.
• The primary provider may opt to contract or refer the enhanced services to other MHCP enrolled providers. In this case, the enrolled provider performing the service may bill MHCP directly using the CMS-1500 with the codes listed in this section.
• The primary provider may opt to contract or refer enhanced services to providers not enrolled in MHCP (i.e., RN or nutritional counselor). In this case, the primary provider is responsible for billing MHCP for all services provided and paying the provider(s) who performed the services.
• Physician extender modifiers are not required when billing for enhanced prenatal services.

Electronic Submission of the MPAF

The MPAF can be submitted electronically through the Information Transfer System (ITS) software. To find out more about submitting the MPAF electronically, contact the EDI Help Desk at (651) 282-5545 or 1-800-366-5411.

Note: The MPAF is no a HIPAA required form and has not been converted to MN-ITS. Please continue to submit the MPAF via ITS.

The MPAF can be mailed to DHS at PO Box 64893, St. Paul, MN 55164. The same instructions apply to both types of submission.

HIV Counseling and Testing for Pregnant Women

A consent form or passive consent notification for HIV testing must be kept in the medical record. If the recipient refuses HIV testing after counseling, this information must be documented in the medical record. Counseling, screening and education for HIV will be reimbursed if provided, whether or not the recipient consents to have HIV testing. Testing will be reimbursed when consent is given and the testing is complete.

HIV positive pregnant women should be informed of their treatment options and made aware of the related HIV services that are available. For more information, call the Program HH office at (651) 582-1980 or 1-800-657-3761.

Definitions

**Voluntary Testing:** A recipient consents to HIV testing after she receives pretest counseling, is informed of her right to refuse HIV testing, is informed that her refusal will not jeopardize her health benefits, and does not refuse the testing.

**Pretest Counseling:** Includes the following components:

• Explanation of what HIV is;
• Risk factors for HIV infection and how the virus is transmitted;
• Treatment available for HIV positive women during pregnancy and after delivery;
• Risk factors for the newborn;
• Treatment options for the newborn;
• Rights of the pregnant woman to choose testing;
• Who has access to test results and confidentiality; and
• HIV risk assessment.

**Post-test Counseling:** Includes the following components:

• Give and explain test results;
• Risk factors for HIV infection and how to reduce the risk of infection;
• If HIV test results are positive, referrals for additional services and information on treatment options;
• Information on how the virus is transmitted and how to reduce the risk of transmission;
• If HIV test results are positive, counseling and/or referrals related to health issues for partner(s) and children that may have been infected;
• Information on the need for repeat follow-up testing whether the results are positive or negative;
• Referral for case management services for HIV positive women and their newborns; and
• Referral to local community support services such as Minnesota AIDS Line (612) 373-AIDS (2437), 1-800-248-AIDS; TTY (612) 373-2465, statewide TTY 1-888-820-2437.

**Informed Consent:** The recipient received the following information:

• That HIV testing is voluntary;
• The entities who have access to HIV test results (such as third party payers or public health agencies); and
• When, and under what circumstances, this information can be released (such as a legal subpoena).

**Confidentiality:** Documentation indicating that HIV test results are private. Confidential HIV information can be released only to individuals or entities with the written permission of the recipient. The recipient must be informed about the law that allows the release of the HIV test results (without permission) under limited circumstances.

**Positive Test:** A test result that is positive for the HIV antibody.

**Negative Test:** A test result that is negative for the HIV antibody. (Additional follow-up testing, especially for recipients with known recent HIV exposure or with continued risk behaviors, may be needed to determine recent infection.)

**Follow-up:** Follow-up health services provided to HIV positive women and their infants should include:
• Review of what it means to be HIV positive. (It does not mean that they have AIDS, but it does mean they can infect others);
• Ongoing lab tests to evaluate immune system function;
• Ongoing counseling regarding HIV status and treatment options;
• Emphasis on the need for good health practices;
• Information about current treatment practices to reduce the risk of transmission of the HIV virus and to promote the health of the woman;
• Information that a positive HIV test result can mean that children and partners could be infected with HIV and that those individuals should be referred for medical testing and follow-up;
• Information that a baby born to an HIV positive mother should receive regular medical care from a physician who is knowledgeable about HIV treatment to ensure appropriate care;
• Information that all babies are born with the mother's antibodies and many months of follow-up are required to determine the newborn's HIV status. If a baby is not infected, the HIV test will be negative by 18 - 24 months;
• Discussion with women who are breast feeding or considering breast feeding of the risk of transmission of the HIV virus through breast feeding (The CDC recommends that HIV positive women not breast feed.); and
• Emphasize that the HIV virus is not spread through casual contact.

Providers

A physician, certified nurse midwife, Doctor of Osteopathy, physician assistant, certified nurse practitioner, licensed registered nurse, and other physician extenders may provide HIV counseling to pregnant women within their scope of practice.

Billing

• MHCP pays for HIV screening, education, counseling, and testing in addition to routine prenatal care.
• Providers must bill on the CMS-1500 and use the appropriate CPT codes for services related to HIV screening, education, testing, and counseling.
• Physician extenders must use the appropriate modifier.

General Information

MHCP follows the recommendations of the Centers for Disease Control and Prevention, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Minnesota Department of Health that advocate HIV testing for all pregnant women.

MHCP recommends that all pregnant recipients receive screening, education, counseling, and voluntary testing for HIV at the first prenatal visit to ensure timely and therapeutic reproductive decision making. Advances in the treatment of HIV infection, and progress in reducing the transmission of HIV infection to newborns, makes early intervention crucial.
Certified Nurse Midwife (CNM) Services

Definitions

Certified Nurse Midwife: An individual licensed as a registered nurse by the Board of Nursing and certified by a national nurse certification organization acceptable to the Board of Nursing to practice as a nurse midwife.

Certified Nurse Midwife Practice: The management of women’s primary health care, focusing on pregnancy, childbirth, the postpartum period, care of the newborn, and the family planning and gynecological needs of women, including diagnosing and providing nonpharmacologic treatment within a system that provides for consultation, collaborative management, and referral as indicated by the health status of patients.

Prescribing: The act of generating a prescription for the preparation of, use of, or manner of using a drug or therapeutic device in accordance with Minnesota law. Prescribing does not include recommending the use of a drug or therapeutic device that is not required by the Food and Drug Administration to meet the labeling requirement for prescription drugs and devices.

Enrollment

A CNM may enroll as an independent MHCP provider and obtain a provider number.

Scope of Service

Payments for services provided by a CNM are limited to those within the CNM’s scope of practice, provided directly to the patient, and in accordance with Minnesota law.

CNMs must practice within a system that provides for consultation, collaborative management, and referral as indicated by the health status of patients.

A CNM may prescribe and administer drugs and therapeutic devices within the scope of practice of a CNM as defined in Minnesota law. In addition, a CNM who is authorized to prescribe drugs is authorized to dispense drugs subject to the same requirement established for the prescribing of drugs.

Billing

- Refer to billing sections in this chapter for detailed instructions on billing maternity and delivery care, enhanced services, and standby attendance for newborn care.
- To receive payment, the CNM’s provider ID number must be entered in box 24K on the CMS-1500 or electronic equivalent. Do not use a modifier when billing CNM services.
- If a CNM provides services as part of a clinic or physician practice (group clinic or physician office), the CMS-1500 should include the clinic or physician group provider number in box 33 in
the GRP# field or the electronic equivalent. The CNM provider number must be entered in box 24K on the CMS-1500 or the electronic equivalent.

- If a CNM provides services as part of a CNM practice, the CNM should submit his/her individual provider number in box 33 on the CMS-1500 or the electronic equivalent.

**Certified Neonatal Nurse Practitioner (CNP) Services**

**Definitions**

**Certified Nurse Practitioner:** Is certified for advanced registered nurse practice in a specific field or nurse practice.

**Certified Nurse Practitioner Practice:** Within the context of collaborative management, diagnosing, directly managing, and preventing acute and chronic illness and disease, and promoting wellness including providing nonpharmacologic treatment. The certified nurse practitioner is certified for advanced registered nurse practice in a specific field of nurse practitioner-practice.

**Collaborative Management:** A mutually agreed upon plan between a certified nurse practitioner and one or more physicians or surgeons that designates the scope of collaboration necessary to manage the care of patients. The nurse practitioner and the one or more physicians must have experience in providing care to patients with the same or similar medical problems.

**Prescribing:** Refer to definition in [Certified Nurse Midwife](#) section.

**Enrollment**

Neonatal nurse practitioners are eligible to enroll in MHCP and bill for services provided when the following criteria are met:

- The neonatal nurse practitioner is certified as a neonatal nurse practitioner by the Minnesota Board of Nursing and according to Minnesota law; and
- The neonatal nurse practitioner is in independent practice.

**Covered Services**

Services performed by a certified neonatal nurse practitioner are covered under the following circumstances:

- The service provided is a physician service.
- The service is within the scope of practice of the certified neonatal nurse practitioner.
- The service is a covered service.
- The service is medically necessary.
- The service, if provided on an inpatient basis, is not included as part of the cost for inpatient services included in the hospital’s operating payment rate. If services have been billed historically by a hospital as inpatient services, the costs for these services are included in the
calculation of the hospital’s payment. Therefore, these services cannot be billed separately by another provider.

- The service is within the scope of practice of the CNP as described in MS, 148.171-148.285.

Billing

Refer to the Nurse Practitioner section of the Physician Services chapter (Ch. 6) for information on billing procedures.

Abortion Services

This section includes MHCP coverage and billing policy for induced abortions and abortion related services.

Covered Services

MA and GAMC

Payment for induced abortions and abortion related services provided to MA and GAMC recipients is available under the following conditions:

- The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by, or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless the abortion is performed;
- Pregnancy resulted from rape;
- Pregnancy resulted from incest; or
- Abortion is being done for other health/therapeutic reasons.

MinnesotaCare

Payment for induced abortions and abortion related services provided to MinnesotaCare recipients is available under the following conditions:

- Pregnancy resulted from rape;
- Pregnancy resulted from incest;
- Abortion is being done to prevent substantial and irreversible impairment of a major bodily function; or
- Continuation of the pregnancy would endanger the woman’s life.

Women enrolled in MinnesotaCare who seek an abortion for health/therapeutic reasons must apply for Medical Assistance (MA). The recipient must be covered under MA for the month that the abortion for health/therapeutic reasons is performed. The coverage can be retroactively applied for up to three months. DHS form DHS-3239 is used to apply for MA coverage. MA for
pregnant women requires that a woman complete the application and meet income/resource
guidelines.

**Abortion Related Services**

Abortion related services are services directly related to performing an induced abortion. Examples of abortion related services include:

- Hospitalization when the abortion is performed in an inpatient setting;
- The use of a facility when the abortion is performed in an outpatient setting;
- Counseling related to the abortion;
- General or local anesthesia provided in conjunction with the abortion;
- Drugs provided during or directly after the abortion (treatment of infection or other complications as a result of the abortion is a covered service);
- Uterine ultrasound, performed immediately following abortion;
- Abortion service codes (surgical induced abortion and medical abortion service codes);
- Supplies (trays, Laminaria, etc.);
- Drugs (anti-anxiety, narcotics, anaesthetics, antibiotics, etc.); and
- Cervical block and/or related services.

**Non-Abortion Related Services**

Services that are **not** abortion related include (this list is not all-inclusive):

- A history and physical exam;
- Tests for pregnancy and venereal disease;
- Blood tests;
- Rubella titre;
- Gonadotropin levels (hCG);
- Hemoglobin and hematocrit;
- The GAM (TM);
- A pap smear;
- Laboratory examinations for the purpose of detecting fetal abnormalities;
- Family planning services provided as a separate service;
- Uterine ultrasound to confirm pregnancy;
- RhD drugs; and
- Drugs used in conjunction with pregnancy, or post-pregnancy state.

**Billing**

- All induced abortion and abortion related services whether provided to women who are on fee-for-service programs or are enrolled in a health plan are paid on a fee-for-service basis and should be billed to DHS See **Abortion Related Services list** above.
• Non-abortion related services for women on fee-for-service programs must be billed on a separate claim and billed to DHS. Claims that include both abortion and non-abortion services will be denied. See Non-Abortion Related Services list above.
• Non-abortion related services provided to women enrolled in health plans must be billed to the health plan. See Non-Abortion Related Services list above.
• Services performed for pregnancy, but performed prior to, on the day of, or after an induced abortion are billable to the health plan (examples: diagnostic “V” codes – V22 [preg], V23 [preg], V25 [contraceptive management], and V26 [procreative management]).
• Other non-induced abortion diagnoses such as a pregnancy with fetal demise, missed abortion, spontaneous abortion, etc., are not subject to this process. They do not require induced abortion attachments and are billed to the health plan for women enrolled in a health plan and to DHS for women in fee-for-service programs.
• Abortion services performed out of state or the contiguous Minnesota counties require prior authorization.
• Health Plans must pay for non-abortion related services regardless of whether or not they have a contract with the provider of abortion services.
• Billing for abortion services requires that the first diagnosis code indicates ICD-9-CM codes: 635.0 through 635.9, 637.0 through 637.9, 69.01, 69.51 or 75.0. If a second code is used, this code must relate to the abortion procedure. Do not include family planning, contraceptive management, or pregnancy related ICD-9 codes. If non-abortion ICD-9 codes are used, the claim will be denied.
• Box 24H on the CMS-1500 or the electronic equivalent must remain blank when submitting a claim for an abortion. Do not enter a code in box 24H for an abortion claim.
• CPT procedure code 59200 (insertion of cervical dilator) can be billed separately only when the service is provided on a day other than the day the abortion was performed.
• CPT procedure code 88300 (surgical pathology, gross examination) may be billed only by a pathologist.
• Medical abortions: HCPCS codes S0190 and S0901 should be used. Induced abortion ICD-9 codes should be used. Do not bill any non-abortion related services with medical abortion services.

S0190 mifepristone and S0191 misoprosotol can be billed only when used together and not within 3 weeks of a surgical abortion. These codes cannot be billed with an induced abortion CPT procedure code. The FDA has approved mifepristone with administration guidelines. Information regarding FDA guidelines may be obtained at http://www.fda.gov/cder/drug/infopage/mifepristone/medguide.htm.

Legal References
MS 254A.17, subd. 1a (pregnant women with children)
MS 256B.0625, subd. 13
MS 256B.0625, subd. 14 (prenatal with HIV)
Minnesota Rules 9505.0235
Minnesota Rules 9505.0320 (certified nurse midwife)
Minnesota Rules 9505.0355 (prenatal birth classes)
42 CFR 440.165 & 441.21 (certified nurse midwife)
42 CFR 441.250-441.259 (hysterectomy)
42 CFR 441.200-441.208 (abortion)
Chapter 11

Laboratory/Pathology, Radiology & Diagnostic Services

Laboratory/pathology, radiological and diagnostic services enable physicians and other licensed practitioners to identify the existence, nature or extent of illness, injury, or health deviation in a patient.

**Contrast Material:** The phrase “with contrast” represents contrast material administered intravascularly, or intra-articularly injections for image enhancement.

**Laboratory:** A facility that performs laboratory testing on specimens derived from humans for the purpose of providing information on diagnosis, prevention care, health assessment or treatment of diseases or impairment.

**Panel Codes:** are groups of laboratory test (components) that are frequently performed together. Tests included in each panel are listed by name with the CPT code identified in parenthesis. In order to report a panel code, all listed tests must be performed.

**Pathology:** A service requiring additional medical interpretive decision, consisting of a written report performed by a pathologist, at the request of a physician.

**Provider Performed Microscopy Procedures (PPMP):** It allows physician office laboratories to perform a limited number of microscopy procedures. Certified PPM approved procedures are subject to change at any time.

**Radiology:** Radioactive substance's radiant energy and with the diagnostic and treatment of diseases by means of both ionizing and non-ionizing radiation.

**Waived Complexity:** CMS has identified a number of simple laboratory procedures that can be performed in the physician offices after obtaining a Certificate of Waiver. Waived tests are subject to change at any time, so review all Medicare mailing for changes to waived test.

Laboratory/Pathology Services

**Eligible Providers**

To be eligible as a provider of laboratory services, a vendor must be certified under the CLIA program.

Providers of lab services must have their CLIA certificate number on file with MHCP. If you did not indicate your certificate number on your MHCP enrollment application, or your office has obtained a certificate since your original enrollment, please provide DHS Provider Enrollment with the certificate number. The edit code 320 will suspend claims for undocumented CLIA certificates.
It is the responsibility of providers to keep their CLIA certification number current and up to date with their most recent level of certification on file with MHCP.

**Covered Services**

MHCP covers all laboratory tests paid under the Clinical Diagnostic Laboratory fee schedule from (CMS).

To be eligible for MHCP payment as a laboratory/pathology service, the service must be:

- Ordered and provided by or under the direction of a physician or other licensed practitioner of healing arts within the scope of practice as defined by state law;
- Provided in a hospital or independent laboratory;
- Directly related to the diagnosis and treatment of a recipient's health status; and
- Authorized under the laboratory's CLIA certification.

**Clinical Laboratory Improvement Amendment (CLIA)**

Congress passed the Clinical Laboratory Improvement Amendment (CLIA) in 1988, establishing a minimum quality of standards for all laboratory testing to ensure high quality of testing regardless of the laboratory location.

MHCP follows Medicare guidelines. All hospitals and physician owned and free-standing laboratories require CLIA certification. MHCP will not cover lab services provided by laboratories without CLIA certification. Claims will deny with EOB code 320, if the CLIA certification number is not on file with DHS.

**CMS CLIA Requirements**

The Centers for Medicare & Medicaid Services (CMS), formerly known as the Center for Medicare and Medicaid (CMS), requires all providers performing laboratory testing to register with the CLIA program. Inquiries about CLIA certification should be directed to CMS.

Registration is through the CMS’s Health Standards and Quality Bureau. If the provider performs clinical laboratory testing and has not received CLIA information, please write:

CMS CLIA PROGRAM  
P.O. Box 26689  
Baltimore, MD 21207-0489

**Medicaid Internet Site:** Use the Internet as a means to obtain updates about CLIA certification. This site is updated on a regular basis. CLIA waiver tests, provider performed microscopy procedures (PPMP), and tests required under CLIA edit are subject to change at anytime. Providers are advised to review this site on a regular basis, as MHCP will no longer publish updated CLIA requirements: [http://cms.hhs.gov/clia/default.asp](http://cms.hhs.gov/clia/default.asp)
How to Apply for a CLIA certificate: form CMS-116
http://cms.hhs.gov/clia/cliaapp.asp

Provider Enrollment Criteria

Providers of any level of laboratory services must have their CLIA certificate number on file with MHCP in order to be paid for laboratory services. DHS requires the certification number and the expiration dates.

If you did not indicate your certificate number on your MHCP enrollment application, or your office has obtained a certificate since your original enrollment, please provide MHCP with the following information: provider name, MHCP provider number, CLIA certificate number and expiration date. Send or fax to:

DHS Provider Enrollment Unit
444 Lafayette Road N.
St. Paul MN 55155-3856
Fax: (651) 297-1273

Billing CLIA Waiver Tests

Waived laboratories must meet only the following requirements under CLIA:

- Enroll in the CLIA program;
- Pay applicable certificate fees biennially; and
- Follow manufacturers' test instructions.

Laboratories with waiver certification (certification type 2) are approved to bill only for waiver tests.

To bill CLIA waiver tests, the procedure code must have the modifier QW. Do not use the CLIA number on the claim form. If the QW is missing, the claim will deny with EOB code 320. Do not use the QW modifier for services that do not require CLIA certification.

Provider Performed Microscopy Procedures (PPMP)

PPMP laboratories must meet only the following requirements under CLIA:

- Enroll in the CLIA program;
- Pay applicable certificate fees biennially; and
- Certain quality and administrative requirements

Laboratories with a provider performed microscopy procedure (PPMP) certification may perform PPMP tests as well as those granted CLIA waiver status. Certified PPM approved procedures are subject to change at any time.
Billing Technical Component of Surgical Pathology

The technical component of surgical pathology and supplies is not subject to CLIA requirements. When providing only these services, do not apply for CLIA certification. Billing for the technical component of a lab test includes:

- The slide preparation for interpretation by the physician; and
- Other usual pre-slide preparation.

Do not use modifiers 22 & 52 on pathology codes. Use the TC modifier when billing for CPT pathology codes (88300-88399).

Automated Multichannel Laboratory Organ or Disease Oriented Panels

The organ and disease panel codes represent chemistry tests that are frequently performed in combinations on automated multichannel equipment. When combinations of these tests are provided for a recipient on the same date, claims submitted to MHCP are subject to a payment cap specified by CMS for the Medicare program.

The organ and disease panel codes are defined in the Physician's Current Procedural Terminology (CPT) manual. If other tests are performed in addition to those indicated for a particular panel, report the tests on individual lines on the claim along with CPT panel codes 80048 through 80090 (codes are subject to change per CPT and American Medical Association yearly).

All multichannel laboratory tests performed on the same date/same recipient, must be submitted on one claim form. Billing the complete automated chemistry panel is advisable, if all tests are done. If the laboratory diagnostic tests do not fit on one claim form, follow the instructions for multiple claims (see below).

Submitting Multiple Claims for Automated Tests/Panels

If the number of claim lines is insufficient for the number of tests provided, use additional claim forms (paper clipped) with a cover letter stating, "The attached claim forms must be processed as one claim." Tests submitted with multiple claims other than described above will be denied as a duplicate test.

If subsequent tests are provided for the same patient on the same date, submit a replacement claim on a separate claim form, and include the additional tests on one claim form.

MHCP will process Medicare crossover claims as submitted per Medicare's billing instructions.

Handling/Specimen Collection

MHCP will cover the collection and handling (if applicable) for each type of specimen listed below, per recipient per day:
• Routine venipuncture for collection of specimens, use G0001.
• Collection of pap smears, use Y8900.
• Catheterization for collection of a specimen, single homebound, nursing facilities, use P9612.
• Catheterization for collection of a specimen, multiple patients, use P9615.
• Newborn screening for metabolic disorder, use X5328. (When the service is provided on an inpatient basis, payment is included in the DRG, and may not be billed separately).

A "handling fee" for laboratory specimens will be paid when the laboratory provider requests a lead collection kit from the Minnesota Department of Health (MDH). MDH's provider number must be in box 24K or Treating Provider Number field on ITS.

**Laboratory Services in a Physician's Office**

MHCP will require all physician office laboratories to be CLIA certified in order to receive payment. CLIA regulations include the conditions that all laboratories must meet to be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Claims will be denied for physician office laboratories that do not meet CLIA requirements - either because the laboratory’s CLIA certificate has expired, or the billed test is not covered by the laboratory’s CLIA certificate, or the services rendered are outside the effective dates of the CLIA certificate.

Payment for a laboratory service performed in a CLIA certified physician's laboratory will not exceed the amount paid for similar services performed in an independent laboratory. Physicians may also send laboratory specimens to independent or outpatient hospital laboratories.

**Reference (Outside) Lab**

Providers may choose to bill for laboratories services sent to a reference lab by indicating the reference lab’s MHCP provider number on the CMS-1500 in box 24k or the treating provider number field on ITS. The claim line must include the lab procedure code, place of service 81 (independent lab), and modifier 90 (reference lab). Reference laboratories must be CLIA certified for the level of services they are providing.

**Independent Pathologist Services**

Independent pathologists do not need CLIA certification. The laboratory requires CLIA certification. Pathology and Laboratory (80049-89399): If a pathologist must review a test result and render an opinion, the modifier 26 should be attached to indicate that only a professional component was provided.

- Independent pathologists who bill for the professional component of laboratory services must indicate the hospital's or independent laboratory's MHCP provider ID number in box 24K or the Treating Provider Number field on ITS.
- Use modifier 26 and modifier 90 in box 24D or the MOD field on ITS.
The DHS payment system has been set up to first look at the header or "pay-to-provider" for CLIA certification on file with DHS.

If modifier 90 is used, the system will look at the treating provider field for CLIA certification.

Do not use CLIA numbers on claims to MHCP.

Modifiers

Modifier 51 is distinct procedural services, multiple services submitted by a laboratory for the same patient on the same day. These situations usually involves microbiology where samples or cultures are taken from a patient from different anatomical sites or different wounds, use the same CPT code, and are tested on the same day.

Modifier 90 Reference (outside) laboratory identifies laboratory procedures performed by a CLIA certified lab other than the treating or reporting physician.

The 91 modifier replaces the QR modifier effective January 1, 2000.

Modifier 91 indicates repeat clinical diagnostic laboratory test (CPT code) on the same date of services, at different intervals to obtain subsequent, additional test results. Bill laboratory services in units that are run on the same day and NOT repeated. The 91 modifier may only be used for laboratory tests paid under the clinical laboratory fee schedule. Example: repeating an arterial blood sample or potassium at different intervals on the same day.

The 91 modifier can be used to bill repeat laboratory services, except for the following CPT codes: G0001, 82962, 84520, 87040, 87088, 87103, 87163, 87186, Q0111, and P9604 (non-inclusive list).

The 91 modifier may **not** be used when:

- There are standard CPT/HCPCS codes available that describe a series of results (e.g., glucose tolerance tests, evocation/suppression tests, etc.);
- Tests are run to confirm initial results due to testing problems with the specimen or equipment; and/or
- For any other reason when a normal, one-time, reportable result is required.

When billing pathology codes, modifiers 76, 77, and 91 are allowed. Modifiers 22 and 52 cannot be used when billing pathology codes.

Billing in Units

Laboratory tests that are not repeats are to be billed in units. Do not use the repeat modifier. Examples: Blood, urine etc. cultures should be billed in “units of.” Multiple organism ID is billed in “units of” units are set up to identify the most common type of organisms. One CPT code for a genetic/cyto test may cover up to 15 different components (results).
Pap Smear Billing

MHCP covers one professional and one technical component for pap smear testing, per specimen per day.

- For the professional component, bill either of these codes: 88141, P3001, G0124, or G0141;
- For the technical component, bill one CPT or HCPCS code; and
- For pap smear collection, use Y8900.

Cytogenetic Testing

MHCP covers cytogenetic testing performed on an MHCP recipient. Documentation in the medical record must reflect the medical necessity for the testing. All claims submitted for payment of cytogenetic testing must contain the specific diagnosis related to the tests being performed. Use the most specific ICD-9 code available. (Some cytogenetic tests require authorization.) Bill in units.

MHCP does not cover cytogenetic testing for:

- Legal, paternity, or informational purposes, unless it is medically necessary for the recipient to receive cytogenetic testing;
- Family members who are not MHCP recipients; and
- Fetus testing.

Lead Toxicity Testing

The lead toxicity screening test consists of a capillary or venous blood lead test, hemoglobin (Hgb), hematocrit (HCT), and other age-appropriate exams or tests (as noted in the schedule of age-related screening standards). Refer to the Child and Teen Checkup (EPSDT) section of the Children's Services chapter (Ch. 9) for more information pertaining to lead toxicity testing.

The following lead testing services are not covered:

- Paint chip, water and soil testing; and
- Assessments performed by a registered environmental health specialist/sanitarian.

Drug Testing

Drug screening for routine work related issues or testing related to chemical dependency treatment are not covered. This test reports qualitative screening to detect the presence of specific drugs or classes of drugs.
Billing

- Use 80100-80103 to report qualitative screening to detect the presence of specific drugs or class of drugs. Code 80100 is a drug screen for multiple drug classes chromatographic method. Code 80101 is a single drug class method. One specimen is used to screen for several different drug types. This test screens for common classes of drugs. Drug screening is used to identify drug toxicity and drug abuse. The screen reports what drugs are present in the specimen, and in which class (e.g., tricyclic antidepressants, phenothiazines, amphetamines, barbiturates, cannabinoids, methadone).
- When drugs or a single drug is detected, use 80102 to confirm the drug type present in the drug screen which is reported separately.
- Use the confirmatory drug test (80102) to report illegal substances or those required by law.
- Use the following CPT procedure codes when the specific drug being tested is known. Quantitative screening tests are coded by procedure. Refer to the "Chemistry Section" in CPT or the "Therapeutic Drug Assay" section of CPT.

Radiology/Diagnostic Services

Eligible Providers

To be eligible as a provider of independent x-ray services or portable x-ray services, a vendor must be certified by CMS for participation in the Medicare program.

Covered Services

To be eligible for MHCP payment for radiology, or diagnostic services, the service must:

- Be ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of practice as defined by state law;
- Provided in a facility other than a hospital outpatient department or clinic, if an independent service;
- Meet the requirements for certification by Medicare; and
- Be directly related to the diagnosis and treatment of a recipient's health status.

Professional Component

The professional component of a radiology procedure includes the professional services of the physician and the:

- Examination of patient when indicated;
- Performance or supervision of the procedure;
- Interpretation; and
- Written report of the examination.
The professional component is applicable in an encounter when the physician submits a charge for professional services only. It does not include the cost of personnel, materials, space, equipment, or other facilities.

**Technical Component**

The technical component of a radiology procedure code includes the personnel and materials, including:

- Contrast media and drugs;
- Film or xerography;
- Space;
- Equipment; and
- Other facilities.

Oral and/or rectal contrast administration alone does not qualify as a study “with contrast.”

**Total Components**

Total components include both technical and professional components and are covered by MHCP. Do not use modifiers when billing for the total components.

**Mammography**

MHCP covers medically necessary mammography services.

All facilities (hospital, outpatient department, clinic, radiology practice, mobile unit, physician's office, or other facility) providing diagnostic and screening mammography services are required to have FDA certification under the Mammography Quality Standards Act (MQSA). No facility may conduct an examination or procedure involving mammography unless the facility has obtained an MQSA certificate.

Use "V" diagnosis codes when billing mammography screening services:

- Principal diagnosis code for non-high risk, use V76.12;
- Principal diagnosis for high-risk, use V76.11; and
- Applicable secondary diagnosis codes, use V10.3, V16.3 or V15.89

**Computerized Tomography and Magnetic Resonance Imaging**

MHCP covers medically necessary MRI's, CT scans, bone density studies and MRI’s for angiography. Magnetic resonance spectroscopy (MRS), and positron emission tomography (PET), and brain mapping require authorization. Refer to the Authorization chapter (Ch. 5). (non-inclusive list, subject to change)
Billing

When more than one provider is involved in providing and billing a procedure, the providers must establish a written agreement as to which component each provider will bill.

For example, a physician bills for the professional component of the service he/she provided, (bill on the CMS-1500 claim) while the hospital bills for the technical component (on the UB-92). Or, the hospital bills on the UB-92 for the total component (professional and technical) and the physician would not bill, but rather be paid by the hospital. Both the physician and the hospital cannot be paid for both components.

When a physician or clinic is billing for services performed, and the equipment is owned by either the physician or clinic, the service cannot be separated into a technical and professional component.

HCPCS (level 1,2,3 codes and modifiers when required) must be used on all claims. Claims submitted for payment of CT and MRI scans must have a specific medical diagnosis. Use the most complete and highest level of specificity ICD-9 CM diagnosis code. PET scans are billed using CPT coding.

Professional Component

The professional component represents the professional services of the physician which includes:

- Examination of the patient;
- Performance or supervision of the procedure;
- Interpretation; and
- Written report.

Inpatient professional component services should be billed on the CMS-1500 using a 26 modifier.

When a physician provides the professional component of an outpatient service, he/she may only bill the professional component using a 26 modifier.

The professional component is applicable in any duration in which the physician submits a charge for professional services.

Injection of contrast material is part of the “with contrast” CT, MRI and MRA procedures.

Technical Component

The technical component includes the charges for personnel, materials, usual contrast media, drugs, film or xenograft, space, equipment and other facility charges, but excludes the cost of radioisotopes and low osmolar contrast materials.
The technical component of all inpatient services is included in the inpatient DRG and billed on the UB-92.

For a provider transporting their own equipment to another site, the technical components may be billed by the provider owning the equipment. To identify a charge for the technical component, enter the procedure code with a TC modifier.

**Total Components**

Total components include the technical and professional component. Use the appropriate procedure code without a modifier.

**Interventional Radiologic Procedures and Diagnostic Studies with Injection**

These types of procedures include professional, technical, and injection components.

Use of radiopharmaceuticals is regulated by the Nuclear Regulatory Commission (NRC) under strict procedures and guidelines. Persons administering radiopharmaceuticals should have either a license from the NRC or be credentialed by an institution having a board license from the NRC.

**Professional Component:** Bill the appropriate procedure code that states supervision and interpretation only, and use modifier 26.

**Technical Component:** Bill the appropriate procedure code that states supervision and interpretation only, and the TC modifier.

**Injection Component:** Bill radiology procedures using the appropriate CPT code that indicates "with contrast," if available. Contrast media provided in a hospital must be billed with the appropriate CPT or HCPCS code on the UB-92.

**Contrast Material:** Bill separately using most appropriate HCPCS code.

**Contrast Media Provided in an Inpatient Hospital:** Bill the appropriate CPT or HCPCS code on the UB-92.

**Legal References**

- Minnesota Rules [9505.0305](#)
- Minnesota Rules [9505.0445](#)
- State Medicaid Manual, Section 4385 B
- 42 CFR 440.30
- 42 CFR 441.17
- 42 CFR 441.56
- 42 CFR 493
Chapter 12

Ambulatory Surgical Services

Ambulatory surgical services include the non-professional or facility services provided in a freestanding Ambulatory Surgical Center (ASC).

**Ambulatory Surgical Center:** A facility licensed and certified as an outpatient surgical center to provide surgical procedures which do not require overnight inpatient hospital care.

**Facility Services:** Items and services provided by an ASC in connection with a covered surgical diagnostic procedure.

**Eligible Providers**

A freestanding ASC that has met the requirements of an ASC.

**Eligible Recipients**

All MHCP recipients are eligible.

**Covered Services**

Services rendered in an ASC are subject to all applicable MHCP coverage rules including medical necessity, request for authorization, consent, and second medical opinion.

The following services and supplies are covered as ASC services and included in the MHCP ambulatory surgery procedure payment. These services and supplies may not be billed separately:

- Use of facility: operating and recovery rooms, patient preparation areas, waiting rooms, all other areas used by the patient, or offered for use by persons accompanying the patient.
- Nursing and technician services rendered by employees of the ASC (e.g., nurses, technicians, orderlies).
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment. This category includes all supplies and equipment commonly furnished by the ASC in connection with surgical procedures. Secondary coverings (ace bandages, elastic stockings, spence boots, etc.) are included in the facility services.
- Urinary supplies, such as: collection devices, indwelling and external catheters, any type drainage bags, leg straps, external urethral clamps, irrigation supplies (bulbs, syringes, tubing, sterile saline or water), insertion trays, and perianal fecal collection pouches.
- Primary surgical dressings that are therapeutic and protective coverings applied directly to the skin or on openings to the skin and required as a result of a surgical procedure.
• Routine laboratory, x-ray, or other diagnostic tests routinely provided prior to surgery (e.g., urinalysis, hemoglobin, hematocrit), is required by ASC protocol.
• Administrative, record keeping, and housekeeping services necessary to operate the facility (e.g., scheduling, cleaning, utilities, rent).
• Blood, blood plasma, and platelets. Covered procedures are limited to those not expected to result in extensive loss of blood.
• Anesthetic and any supplies, whether disposable or reusable, necessary for its administration.
• Post-anesthesia observation and post-emergency observation.

Separately Billable Services

The following services and supplies are not covered as ASC services nor included in the MHCP ambulatory surgery procedure payment. These services and supplies may be billed separately:

• Professional services: physician, anesthesiologist (administration or supervision of administration of anesthesia), and CRNA services;
• Laboratory, x-rays, or diagnostic procedures other than those directly related to the performance of the surgical procedure;
• Prosthetic devices (except IOL’s) leg, arm, back and neck braces, and artificial limbs;
• Ambulance services;
• Durable medical equipment for use in the patient's home;
• Take home supplies and medications not furnished at the time of surgery with a written physicians order from a supplier;
• Pathology services;
• Secondary dressings applied over a primary dressing. Examples of secondary dressings are: ace bandages, elastic stockings, support hose, spence boots and other foot coverings, leotards, knee supports, surgical leggings, gauntlets, pressure garments for arms and hands, etc.

Terminated Procedures

• Surgical procedures that are terminated after a patient has been prepped and taken to the operating room, but before the induction of anesthesia, will receive partial ASC payment for the procedure(s).
• Surgical procedures that are terminated after the induction of anesthesia, due to medical complication(s), will receive total/full ASC payment for the procedure(s).
ASC Modifiers

- Use appropriate modifiers for ASC hospital outpatient use:
  - CPT Level I modifiers; and
  - Level II (HCPCS/National level) modifiers.

Billing

Bill ASC services:

- The UB-92 format;
- Type of bill 831, or 837 for a replacement claim;
- The appropriate CPT code; and
- Modifiers approved for ASC hospital outpatient:
  - Terminated procedures must be billed with the appropriate modifier.
  - If more than one procedure was performed, use the appropriate modifier(s) as described in CPT or the HCPCS manual for subsequent surgeries requiring modifiers.
  - Used CPT Level I and Level II (HCPCS/National) modifiers.

List primary procedures first, followed by any subsequent procedures with appropriate modifiers.

Legal References

Minnesota Rules 4675.0100 to 4675.2800 (facility licensure)
Minnesota Rules 9505.0240; 9505.0445
42 CFR 416
Chapter 13

Inpatient Hospital Authorization

Inpatient Hospital Authorization (IHA) is required for certain patients to ensure that all inpatient hospital services paid under MHCP are medically necessary and consistent with the recipient's diagnosis or condition and cannot be provided on an outpatient basis. Inpatient Hospital Authorization (IHA) does not determine recipient eligibility.

Definitions

Admission: The time of birth at a hospital or other act that allows the recipient to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Inpatient Hospital Authorization (IHA): The determination by the medical review agent that all or part of a recipient's inpatient hospital services are medically necessary and cannot be provided at a less intensive level of care.

Admitting Physician: The physician who orders the recipient's admission to the hospital and who is a party to a written provider agreement with DHS.

Concurrent Review: A medical record review completed to determine medical necessity of inpatient hospital services while the recipient is in the hospital. The review consists of admission review, continued stay review, and, when appropriate, procedure review.

Continued Stay Review: A review and determination of the medical necessity of continuing inpatient hospital service to the recipient after the IHA and during a patient's hospitalization.

Diagnostic Categories: The diagnostic classifications established under Minnesota Statutes, section 256.969, subdivision 2, containing one or more diagnosis related groups (DRGs) under Medicare.

Diagnostic Category Validation: The process of comparing documentation in the medical record to the information submitted on the inpatient hospital billing form to ascertain the accuracy of the information upon which the diagnostic category was assigned.

Inpatient Hospital Service: A service provided by or under the supervision of a physician after admission to a hospital, and furnished in the hospital and outpatient services provided by the same hospital that immediately precede the admission.

Medically Necessary: An inpatient hospital service that is consistent with the recipient's diagnosis or condition and under the admission guidelines cannot be provided on an outpatient basis. Copies of the Admission Guidelines can be found at the end of this chapter.
Medical Review Agent: The authorized representative of the Commissioner administering procedures for IHA, medical record reviews and reconsiderations, and other functions as stipulated in the terms of the contract.

Out-of-Area Hospital: A hospital located outside Minnesota that is not a local trade area hospital.

Physician Adviser: A physician who practices in the specialty area of the admitting or principal diagnosis or a specialty area related to the admitting or principal diagnosis.

Principal Diagnosis: The condition established, after study, to be responsible for causing the admission to the hospital for inpatient hospital services.

Principal Procedure: A procedure performed for definitive treatment of the principal diagnosis rather than one performed for diagnostic exploratory purposes or a procedure necessary to take care of a complication. When multiple procedures are performed for definitive treatment, the principal procedure is the procedure most closely related to the principal diagnosis.

Readmission: An admission that occurs within 15 days of a discharge not including the day of discharge or the day of readmission.

Reconsideration: A review of a denial or withdrawal of inpatient hospital authorization.

Retrospective Review: A review conducted after inpatient hospital services are provided to a recipient. The review is focused on validating the diagnostic category, verifying recertification, where applicable, and determining the medical necessity of the admission, the medical necessity of any inpatient hospital services provided, and if all medically necessary inpatient hospital services were provided.

Transfer: The movement of a patient after admission from one hospital directly to another hospital with a different provider number, or to or from a unit of a hospital to another unit recognized as a rehabilitation distinct part by Medicare.

Requirements for Inpatient Hospital Authorization (IHA)

The number of cases that require Inpatient Hospital Authorization (IHA), previously called Admission Certification, has decreased for fee-for-service claims processed after July 23, 2002. Even though certain admissions are exempt from IHA, the patient must require the level of care and/or the intensity of service provided to an inpatient. Since IHAs can be requested from the medical review agent, CDMI, any time prior to claim submission, hospitals are asked to request an IHA after discharge of the patient or once the hospital is able to predict the DRG or other inclusion or exclusion groups. These components are necessary in deciding if an admission requires an IHA.
The medical records of patients covered under a MHCP are subject to retrospective review. Current admission guidelines are available at the end of this chapter. Previous exclusions from “admission certification” found in Minnesota Rules, part 9505.0520, subpart 2 remain in effect.

Admissions Excluded From IHA

The following are admissions that may no longer require IHA. The only time that they would still require IHA is if the admission also meets the criteria listed in the section that follows entitled “Admissions That Continue To Require IHA.”

- Admission of a pregnant woman that results in the delivery of a newborn or a stillbirth, and the admission of a newborn resulting from birth. (A delivery that groups to any DRG other than 370-375 requires Inpatient Hospital Authorization. Payment for neonates is for admissions that group to DRGs 385-391.)

- Admission for Medicare Part A covered inpatient hospital services which are provided to a recipient who is also eligible for Medical Assistance (MA) and for which MA payment is requested for the coinsurance and deductible payments only.

- Admission to a hospital that is not located in Minnesota or the local trade area for which a prior authorization has been obtained according to Minnesota Rules, parts 9505.5000 to 9505.5030.

- Neonates transferred after birth from the hospital where the birth occurred to a neonatal intensive care unit at another hospital.

- Children and adolescents (age less than 18 years at the time of admission) admitted to a psychiatric unit and the DRG assigned is 424-432.

- Patients hospitalized for an organ transplant or bone marrow transplant.

- Patients hospitalized in an intensive care unit (must require the level of care provided in an ICU). This includes admissions to the ICU, transfers to an ICU at any time during the patient’s hospitalization, patients who require ICU following surgery, and patients who do not fall into another IHA exemption category. ICU revenue codes that are exempt from IHA are listed at the end of this chapter.

- Admissions that, upon discharge, group to a Diagnostic Related Group (DRG) found on the exclusion list at the end of this chapter.

- County approved inpatient hospital services for chemical dependency billed to the Consolidated Chemical Dependency Treatment Fund (CCDTF).

- Recipients enrolled in prepaid health plans under contract with MHCP and following guidelines established by the prepaid health plan.
• Mental health providers under contract with DHS to provide community based inpatient hospital services for patients under judicial commitment or voluntary patients in lieu of commitment (referred to as 45-Day Psych Contract Beds).

• Patients received in transfer from another acute care hospital unless the admission is included on the list “Admissions That Continue To Require IHA”.

**Admissions That Continue To Require IHA**

The following admissions continue to require IHA even though the patient falls into an exemption group identified in the section above.

• Admissions that group to DRG 434, 435, 521, 523 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders) even though the patient may be hospitalized in an ICU bed.

• Patients admitted to a Medicare rehabilitation distinct part or unit.

• Patients being readmitted to Medicare rehabilitation distinct part or unit after an acute care hospitalization that interrupted the rehabilitation program. (Refer to the Readmission section in this chapter.)

• Admissions to hospitals outside Minnesota and the Minnesota local trade area unless a prior medical authorization has been received.

• Admissions to long-term care hospitals.

• Patients hospitalized for more than 59 consecutive days require completion of form Inpatient Hospital Extension/Adverse Decision Notice & Physician Recertification (included as an attachment at the end of this chapter).

**Diagnostic Related Groups (DRG) Exclusions**

A list of DRGs (Diagnostic Related Groups) that are excluded from requiring Inpatient Hospital Authorization (IHA) is available at the end of this chapter. The DRGs are taken from *DRG, Diagnostic Related Groups, Definitions Manual Version 19* published by 3M, the DRG grouper used for MHCP effective January 2003. Most hospitals began using *Version 20* on October 1, 2002. Due to the time lag in Grouper versions, the anticipated DRG of a claim may be new or the definition may have changed. If that is the situation and the necessity of obtaining an IHA is unclear, the hospital can either obtain an IHA prior to claim submission, or wait until notification from the MHCP claims payment system that the claim will not be paid without an IHA.
Obtaining Inpatient Hospital Authorization

An admitting physician or hospital must obtain Inpatient Hospital Authorization (IHA) from the medical review agent when a recipient is:

- Admitted, readmitted or transferred and the admission does not fall into an exclusion group found in the list above “Admissions Excluded from IHA” or “DRG Listing of Exclusions”.
- Admitted, readmitted or transferred and the admission falls into a group that requires certification found on the list above “Admissions That Continue to Require IHA”.

IHA can be requested in writing, by telephone, or facsimile. Telephone and fax numbers are included at the end of this chapter under Medical Review Agent Information. Facsimile requests for IHA must follow the format and order specified in the list of required information found below.

The admitting physician or hospital must provide the following information to the medical review agent:

- Caller/requester name and telephone number;
- Recipient's name, MHCP identification number, date of birth, and sex;
- Date of admission, or expected date of admission;
- Admitting physician's name and provider number;
- Hospital's name and provider number, city (and state when appropriate);
- Admitting diagnosis and secondary diagnosis descriptor with codes, according to the most recent ICD-9-CM;
- Primary or principal procedure descriptor with code, when applicable, according to the most recent ICD-9-CM and anticipated date of surgery;
- Anticipated DRG or actual DRG if IHA requested after discharge;
- Whether it is a transfer from another hospital; and
- Specific inpatient acute care criteria and information from the plan of care to determine whether or not admission is necessary.

To assist in the IHA process, a copy of the "MA/GAMC Inpatient Hospital Authorization Form" is found at the end of this chapter. Complete this form prior to contacting CDMI for IHA. For admissions that require IHA, using the form will help ensure that the necessary information is available when contacting CDMI.

If the medical review agent determines that the admission is medically necessary, an IHA admission number will be issued. The IHA number can be used one time, only for the admission requested, and submitted on only one claim.

The admitting physician or hospital that obtains IHA must inform all other providers of inpatient hospital services of the IHA number. The IHA number must be entered on the inpatient UB-92 claims submitted for inpatient services.
If the nurse reviewer for the medical review agent is unable to determine medical necessity, the case is referred to a physician. If the physician determines that the admission is medically necessary, the medical review agent will issue an IHA number.

If the physician determines that the admission is not medically necessary, or is unable to determine if the admission is medically necessary, the medical review agent will notify the admitting physician or hospital by telephone. The provider may request, within 24 hours of notification, a second physician's opinion.

If the admitting physician or hospital requests a second physician opinion, the medical review agent will contact a second physician. If the second physician determines that the admission is medically necessary, the medical review agent will issue an IHA number. The second physician will make the determination within 24 hours exclusive of weekends and holidays.

If the second physician determines that the admission is not medically necessary or is unable to determine medical necessity, the medical review agent will deny inpatient hospital authorization.

If the inpatient admission is denied prior to services being provided, a written notice is sent to the admitting physician, the hospital, and the recipient of the denial with the reason for the denial clearly stated. The recipient is also informed of his/her appeal rights. The physician and hospital are notified of their right to request a reconsideration.

**Reconsiderations**

The admitting physician and hospital may request reconsideration of a decision to deny or withdraw an inpatient hospital authorization. Reconsideration requests must be submitted:

- In writing;
- To the medical review agent;
- With the recipient's medical records and any additional information required to justify the admission;
- With the reason for the dispute; and
- Within 30 days of the date of receipt of the certified letter denying or withdrawing IHA or approval for payment.

Reconsideration requests must:

- Be heard by at least three physician advisers not involved in the decision to deny or withdraw IHA;
- Include one psychiatrist who practices outside a metropolitan statistical area (MSA) for all non-MSA psychiatric reviews; and
- Be completed within 60 days of the medical review agent's receipt of the information necessary to complete reconsideration.
The outcome of the reconsideration is the majority opinion of the physician advisers. The admitting physician and hospital may appeal the reconsideration decision to the Commissioner.

Appeal requests must be submitted in writing within 30 days of the date of receipt of the certified letter upholding the denial or withdrawal of IHA and sent to:

Minnesota Department of Human Services
Provider Appeals Division
444 Lafayette Rd. N
St. Paul, MN 55155-3841

The admitting physician and hospital may appeal the Commissioner's decision to the district court of the county in which the physician or hospital is located and by submitting written notice to the Commissioner within 30 days of the Commissioner's decision.

Concurrent, Continued Stay, and Retrospective Reviews

The medical review agent performs concurrent, continued stay and retrospective reviews. A physician adviser is consulted if the medical record and other supporting information do not clearly demonstrate the medical necessity of the admission, continued stay, services provided, or the reasons for the patient's discharge and readmission.

- If the physician adviser determines medical necessity was not established, the medical review agent will, for cases issued IHA, withdraw the previously issued IHA number and notify the admitting physician and hospital of the withdrawal and reconsideration rights by certified letter mailed within five working days of the determination.
- If the recipient is still an inpatient, the hospital and physician will be informed by telephone within one working day in addition to the letter.
- If the admission was exempt from Inpatient Hospital Authorization but the physician adviser determines that medical necessity was not established, the medical review agent will notify the admitting physician and hospital of the decision of the denial and reconsideration rights by certified mail within five working days of the determination.

Denial or Withdrawal of IHA or Retrospective Denial of Coverage for Not Meeting Inpatient Criteria

If an IHA number is withdrawn or it is determined that an admission that did not require IHA did not meet inpatient hospital criteria, DHS may recover all or part of the MHCP payment made to the admitting physician, hospital, and other providers of inpatient hospital services.

If admission IHA is denied or withdrawn or if the medical review agent determines that the admission did not meet inpatient criteria, the services may be billed as outpatient observation hospital services only if all three of the following apply:
• Inpatient billing has not occurred; or
• An inpatient bill has not been submitted; and
• The recipient was in the hospital (total time) less than 24 hours (refer to Hospital Services chapter (Ch. 14).

Criteria to Determine Medical Necessity

The medical review agent (CDMI) uses criteria originally published, in its entirety, in the Appropriateness Evaluation Protocol (AEP) of the National Institute of Health to determine medical necessity of inpatient hospital medical services, or The Criteria For Inpatient Psychiatric Treatment, 1981 edition, revised 1991, published by Blue Cross and Blue Shield of Minnesota, for medical necessity of inpatient psychiatric services. Interpretive Guidelines for Use of the AEP (revised 2001) are available by contacting the Provider Call Center. Interpretive Guidelines for Inpatient Psychiatric Treatment (developed 2001) are included at the end of this chapter.

Readmission

The medical records of inpatients readmitted to the hospital within 15 days may be reviewed retrospectively by the medical review agent. The initial admission and the readmission are reviewed to monitor quality of care (e.g., under-utilization of services, fragmented care, premature discharge), to determine if payment should be made for one or both hospitalizations, or if payment should be made according to transfer payment established by Minnesota rule. In cases where an IHA number is withdrawn or denied because it is considered continuous with the previous admission, reconsideration may be requested.

The medical review agent will issue an IHA number for a readmission that meets the criteria for medical necessity, whether the admitting and readmitting hospitals are the same or different.

Medical records with clearly documented situations of patient preference, AMA (leaving hospital against medical advice), patient noncompliance, physician/hospital convenience or scheduling conflicts will not be sent through physician review. Situations of episodic illness (same or different episode) or prevailing medical standards, practice, and usage will be sent to physician review if the medical review agent cannot make a determination or the provider disagrees with the determination.

Medical records of an admission must clearly state:

• The reason a recipient was discharged from the hospital; and
• What the recipient's status was upon discharge.

Medical records of a readmission must clearly state:

• The reason a recipient was readmitted; and
• What the recipient's medical status was at readmission.

Inpatient Hospital Authorization for Readmissions

A readmission considered a **second admission**: The medical review agent determines that both the admitting and readmitting hospitals, whether they are the same or different, retain their IHA numbers or, if IHA was not issued, retain payment.

A readmission considered **continuous with the initial admission**: The medical review agent withdraws either the admission or readmission IHA number or, if no IHA was required, the medical review agent informs the hospital of the need to combine admissions.

A readmission considered **eligible for transfer payment**: The medical review agent determines that MHCP payment to each hospital will be made as a transfer payment, according to the transfer payment established in the Payment Rule for the inpatient hospital services necessary for the recipient’s diagnosis and treatment.

Criteria used to determine whether a readmission is considered as a second admission, as continuous with the first admission, or eligible for transfer payment are as follows:

**Criteria:** A readmission considered to be a **second admission** is a readmission that resulted from one of the following circumstances:

- The recipient left the hospital against medical advice;
- The recipient was noncompliant with medical advice (i.e., the recipient was informed of his/her medical condition and fully understood the need for treatment and follow-up yet refused to adhere to medical recommendations). The information provided to the recipient is documented in the medical record at the hospital of the first admission;
- A new episode of the same diagnosis of an episodic illness or condition; or
- The recipient was discharged and readmission was medically necessary according to prevailing medical standards, practice and usage.

**Criteria:** A readmission considered to be **continuous with the initial admission** is a readmission that resulted from one of the following circumstances:

- The recipient was discharged from the admitting hospital without receiving the procedure or treatment for the condition diagnosed during the admission because of the physician's or hospital's preference or because of a scheduling conflict. If the admitting and readmitting hospitals are the same, the medical review agent will determine that the admission is eligible to retain the IHA number and will withdraw the readmission IHA number. If the admitting and readmitting hospitals are not the same and the patient is transferred, the requirements regarding a readmission eligible...
for a transfer payment apply (see below).

- The recipient's discharge was not appropriate according to prevailing medical standards, practice, and usage. If the admitting and readmitting hospitals are the same, the initial admission is eligible to retain the IHA number and the medical review agent will withdraw the readmission IHA number. If the admitting and readmitting hospitals are different, the medical review agent will withdraw the initial admission IHA number and determine that the readmission is eligible to retain the IHA number.

- The preference of the recipient or his/her family that the treatment be delayed, and be discharged without receiving the necessary procedure or treatment, and then be readmitted to the same hospital for the necessary procedure or treatment. In this situation, "preference" differs from AMA discharge because the choice is compatible with prevailing medical standards. If the admitting and readmitting hospitals are the same, the initial admission is eligible to retain the IHA number and the medical review agent will withdraw the readmission IHA number. If the admitting and readmitting hospitals are not the same, the requirements regarding a readmission eligible for a transfer payment apply (see below).

- The readmission results from the same episode of the same diagnosis/disease of a condition or episodic illness.

Criteria: A readmission eligible for transfer payment is an inpatient discharge followed by a readmission that resulted from one of the following circumstances:

- The preference of the recipient or his/her family is to delay treatment, be discharged from inpatient care without receiving the necessary procedure or treatment, and then be readmitted to a different hospital for the necessary procedure or treatment. This situation involves inpatient discharge with admission to another facility occurring within hours. In this case, both hospitals will retain their IHA numbers, or if IHA was not needed, both hospitals retain transfer payment.

- The readmission results from a referral from one hospital to a different hospital because the recipient's medically necessary treatment is outside the scope of the admitting hospital's available services. In this case, both hospitals will retain their IHA numbers if:
  - The admitting hospital admitted the recipient as an emergency; or
  - At the time of admission, the admitting hospital was unaware and had no reason to believe that the recipient's treatment was outside the scope of the hospital's available services.
  - There is a physician or hospital scheduling conflict at the admitting hospital and the readmission is at a different hospital. In this case, both hospitals will retain their IHA numbers.
Recertification

The recertification requirement applies only to MA recipients as stipulated in the Code of Federal Regulations.

A physician, physician assistant, or nurse practitioner, acting within the scope of practice as defined by state law and under the supervision of a physician, must verify a recipient's need for continued placement at an inpatient hospital level of care by completing the Inpatient Hospital Extension/Adverse Decision Notice and Physician Recertification form (DHS-1931, 4/00). A copy of the form can be found at the end of this chapter.

The recertification must be provided at least every 60 days after the hospitalization and/or the initial IHA. The initial IHA begins on the date of admission and consists of the admitting physician's written order and plan of care in the hospital's medical record documenting that the recipient needs inpatient hospital services. The initial IHA loses its validity after 60 days. If the patient is not an MA recipient on the date of admission, but applies during the hospital stay and is approved, the 60-day recertification period begins on the day the county approves the MA eligibility.

To be valid, the recertification must be:

- In writing;
- In the recipient/enrollee's medical record;
- Signed by an MD or DO (physician assistant or nurse practitioner signatures are not accepted); and
- Dated at the time of signature.

Documentation that justifies the recertification must be in the medical record and include:

- A signed and dated physician's statement that continuation of inpatient hospital care is necessary;
- Signed and dated physician's orders that clearly indicate a need for continued inpatient hospital care;
- Signed and dated progress notes indicating the need for continuation of inpatient hospital care; and
- A signed and dated physician consultant report, if applicable, that clearly indicates the need for continuation of inpatient hospital care.

The hospital must maintain Utilization Review Committee minutes or forms indicating that the patient's care was reviewed by a physician and that continued inpatient hospital care is necessary. The physician's signature and date must appear on the minutes or form. The medical review agent will verify that recertification is in the medical record.
Billing

When billing for inpatient hospital services, enter the IHA number in the appropriate box:

- HFCA-1500: box 23 or the IHA field on ITS
- UB-92: FL-63 or the Treatment Authorization Codes field on ITS

An inpatient claim will deny for payment if the admission requires IHA but the authorization number is not included on the claim.

An inpatient claim that includes an authorization number but IHA is not required will be processed as if the number was not included on the claim.

If an IHA number and a medical authorization number are issued, the IHA number must be the first number entered in FL-63.

If admission IHA is denied or is withdrawn, patient billing is prohibited.

FORMS/RESOURCES:

MA/GAMC Inpatient Hospital Authorization Form

[PDF version](#)

Guidelines for Inpatient Acute Care Admission

Appropriateness Evaluation Protocol (AEP). The guidelines are available by contacting DHS Provider Relations.

Inpatient Psychiatric Admission Interpretive Guidelines

[Inpatient Psychiatric Admission Interpretive Guidelines](#) (Web page)

Inpatient Hospital Authorization for Detoxification

[Inpatient Hospital Authorization for Detoxification](#) (Web page)

Inpatient Hospital Extension/Adverse Decision Notice & Physician Recertification

[PDF version](#)
Resources


Medical Review Agent Information

CDMI 651-662-5275 (Mpls/St. Paul metro area phone)
3535 Blue Cross Road 888-878-0139 ext. 25275 (toll-free #)
P.O. Box 64265, W1-01 651-662-1109 (FAX # for IHA only)
St. Paul, MN 55164-0560

DRGs Excluded From Inpatient Hospital Authorization (IHA) Requirement

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<th>Medical (M)</th>
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<td>27</td>
<td>Traumatic Stupor and Coma, Coma &gt;1 Hour</td>
<td>M</td>
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<tr>
<td>28</td>
<td>Traumatic Stupor, Coma &lt;1 Hour, Age &gt;17 with CC</td>
<td>M</td>
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<tr>
<td>29</td>
<td>Traumatic Stupor, Coma &lt; 1 Hour, Age &gt;17, without CC</td>
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<tr>
<td>30</td>
<td>Traumatic Stupor, Coma &lt; 1 Hour, Age 0-17</td>
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<tr>
<td>MDC 3: DISEASES AND DISORDERS OF THE EAR, NOSE, MOUTH AND THROAT</td>
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<tr>
<td>53</td>
<td>Sinus and Mastoid Procedures, Age &gt;17</td>
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<tr>
<td>55</td>
<td>Miscellaneous Ear, Nose, Mouth and Throat Procedure</td>
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<tr>
<td>57</td>
<td>Tonsillectomy &amp; Adenoidectomy Procedures, except T&amp;A Only, Age &gt;17</td>
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<td>59</td>
<td>Tonsillectomy and/or Adenoidectomy Only, Age &gt;17</td>
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<tr>
<td>71</td>
<td>Laryngotraechitis</td>
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<td>MDC 4: DISEASES AND DISORDERS OF THE RESPIRATORY SYSTEM</td>
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<tr>
<td>75</td>
<td>Major Chest Procedures</td>
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<tr>
<td>76</td>
<td>Other Respiratory System O.R. Procedures with CC</td>
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</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Payment Method</td>
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<td>77</td>
<td>Other Respiratory System O.R. Procedures without CC</td>
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<tr>
<td>78</td>
<td>Pulmonary Embolism</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>83</td>
<td>Major Chest Trauma with CC</td>
<td>M</td>
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</tr>
<tr>
<td>84</td>
<td>Major Chest Trauma without CC</td>
<td>M</td>
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</tr>
<tr>
<td>87</td>
<td>Pulmonary Edema and Respiratory Failure</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Pneumothorax with CC</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Pneumothorax without CC</td>
<td>M</td>
<td></td>
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<tr>
<td>475*</td>
<td>Respiratory System Diagnosis with Ventilator Support</td>
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<td>482*</td>
<td>Tracheostomy for Face, Mouth and Neck Diagnoses</td>
<td>S (Pre-MDC)</td>
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<tr>
<td>483*</td>
<td>Tracheostomy except for Face, Mouth and Neck Diagnoses</td>
<td>S (Pre-MDC)</td>
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<tr>
<td>495*</td>
<td>Lung Transplant</td>
<td>S (Pre-MDC)</td>
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**MDC 5: DISEASES AND DISORDERS OF THE CIRCULATORY SYSTEM**

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<thead>
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<th>Code</th>
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<tr>
<td>103</td>
<td>Heart Transplant</td>
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<tr>
<td>104</td>
<td>Cardiac Valve Procedure with Cardiac Catheterization</td>
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<tr>
<td>105</td>
<td>Cardiac Valve Procedure without Cardiac Catheterization</td>
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<tr>
<td>106</td>
<td>Coronary Bypass with PTCA</td>
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</tr>
<tr>
<td>107</td>
<td>Coronary Bypass with Cardiac Catheterization</td>
<td>S</td>
</tr>
<tr>
<td>108</td>
<td>Other Cardiothoracic Procedures</td>
<td>S</td>
</tr>
<tr>
<td>109</td>
<td>Coronary Bypass without Cardiac Catheterization</td>
<td>S</td>
</tr>
<tr>
<td>110</td>
<td>Major Cardiovascular Procedure with CC</td>
<td>S</td>
</tr>
<tr>
<td>111</td>
<td>Major Cardiovascular Procedure without CC</td>
<td>S</td>
</tr>
<tr>
<td>112</td>
<td>Percutaneous Cardiovascular Procedures</td>
<td>S</td>
</tr>
<tr>
<td>113</td>
<td>Amputation for Circulatory Disorders except Upper Limb, Toe</td>
<td>S</td>
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<tr>
<td>114</td>
<td>Upper Limb, Toe Amputation for Circulatory Disorders</td>
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<tr>
<td>115</td>
<td>Permanent Cardiac Pacemaker Implantation with AMI, Heart Failure or Shock, or AICD Lead or Generator Procedure</td>
<td>S</td>
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<td>116</td>
<td>Other Permanent Cardiac Pacemaker Implant</td>
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<tr>
<td>117</td>
<td>Cardiac Pacemaker Revision except Device Replacement</td>
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<td>118</td>
<td>Cardiac Pacemaker Device Replacement</td>
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<tr>
<td>121</td>
<td>Circulatory Disorders with AMI and Major Complications, Discharged Alive</td>
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<td>122</td>
<td>Circulatory Disorders with AMI without Major Complications, Discharged Alive</td>
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<tr>
<td>123</td>
<td>Circulatory Disorders with AMI, Expired</td>
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<td>126</td>
<td>Acute and Subacute Endocarditis</td>
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<td>127</td>
<td>Heart Failure and Shock</td>
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<td>128</td>
<td>Deep Vein Thrombophlebitis</td>
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<tr>
<td>129</td>
<td>Cardiac Arrest, Unexplained</td>
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<tr>
<td>138</td>
<td>Cardiac Arrhythmia and Conduction Disorder with CC</td>
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<tr>
<td>139</td>
<td>Cardiac Arrhythmia and Conduction Disorder without CC</td>
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<td>514*</td>
<td>Cardiac Defibrillator Implant with Cardiac Cath</td>
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<tr>
<td>515*</td>
<td>Cardiac Defibrillator Implant without Cardiac Cath</td>
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<tr>
<td>516*</td>
<td>Percutaneous Cardiovascular Procedures with AMI</td>
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</tr>
<tr>
<td>517*</td>
<td>Percutaneous Cardiovascular Procedures with Stent without AMI</td>
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<tr>
<td>518*</td>
<td>Percutaneous Cardiovascular Procedures without Stent with AMI</td>
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**MDC 6: DISEASES AND DISORDERS OF THE DIGESTIVE SYSTEM**

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<tr>
<td>146</td>
<td>Rectal Resection with CC</td>
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<td>147</td>
<td>Rectal Resection without CC</td>
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</tr>
<tr>
<td>148</td>
<td>Major Small and Large Bowel Procedure with CC</td>
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</tr>
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<td>149</td>
<td>Major Small, Large Bowel Procedure Without CC</td>
<td>S</td>
</tr>
<tr>
<td>159</td>
<td>Hernia Procedures except Inguinal and Femoral, Age &gt;17 with CC</td>
<td>S</td>
</tr>
<tr>
<td>160</td>
<td>Hernia Procedures except Inguinal and Femoral, Age &gt;17, without CC</td>
<td>S</td>
</tr>
<tr>
<td>164</td>
<td>Appendectomy with Complicated Principal Diagnosis with CC</td>
<td>S</td>
</tr>
<tr>
<td>165</td>
<td>Appendectomy with Complicated Principal Diagnosis without CC</td>
<td>S</td>
</tr>
<tr>
<td>Code</td>
<td>Procedure Description</td>
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<tr>
<td>166</td>
<td>Appendectomy without Complicated Principal Diagnosis with CC</td>
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<tr>
<td>167</td>
<td>Appendectomy without Complicated Principal Diagnosis without CC</td>
<td>S</td>
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<tr>
<td>174</td>
<td>G.I. Hemorrhage with CC</td>
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</tr>
<tr>
<td>175</td>
<td>G.I. Hemorrhage without CC</td>
<td>M</td>
</tr>
<tr>
<td>176</td>
<td>Complicated Peptic Ulcer</td>
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<td>180</td>
<td>G.I. Obstruction with CC</td>
<td>M</td>
</tr>
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<td>181</td>
<td>G.I. Obstruction without CC</td>
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<td><strong>MDC 7: DISEASES AND DISORDERS OF THE HEPATOBILIARY SYSTEM AND PANCREAS</strong></td>
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<td>191</td>
<td>Pancreas, Liver and Shunt Procedure with CC</td>
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<td>193</td>
<td>Biliary Tract Procedure except Only Cholecystectomy with or without C.D.E. with CC</td>
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</tr>
<tr>
<td>194</td>
<td>Biliary Tract Procedure except Only Cholecystectomy with or without C.D.E. without CC</td>
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<td>195</td>
<td>Cholecystectomy with C.D.E. with CC</td>
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<tr>
<td>196</td>
<td>Cholecystectomy with C.D.E. without CC</td>
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<td>197</td>
<td>Cholecystectomy without C.D.E. with CC</td>
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<tr>
<td>198</td>
<td>Cholecystectomy without C.D.E. without CC</td>
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<td>199</td>
<td>Hepatobiliary Diagnostic Procedure for Malignancy</td>
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<td>200</td>
<td>Hepatobiliary Diagnostic Procedure for Non-malignancy</td>
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<td>201</td>
<td>Other Hepatobiliary or Pancreas O.R. Procedures</td>
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<td>493*</td>
<td>Laparoscopic Cholecystectomy without C.D.E. with CC</td>
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<tr>
<td>494*</td>
<td>Laparoscopic Cholecystectomy without C.D.E. without CC</td>
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<tr>
<td>512*</td>
<td>Simultaneous Pancreas/ Kidney Transplant</td>
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<td>513*</td>
<td>Pancreas Transplant</td>
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<td><strong>MDC 8: DISEASES AND DISORDERS OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE</strong></td>
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<td>209</td>
<td>Major Joint and Limb Reattachment Procedures of Lower Extremity</td>
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<tr>
<td>210</td>
<td>Hip and Femur Procedures except Major Joint, Age &gt;17 with CC</td>
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<td>211</td>
<td>Hip and Femur Procedures except Major Joint, Age &gt;17 without CC</td>
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<tr>
<td>212</td>
<td>Hip and Femur Procedures except Major Joint, Age 0-17</td>
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<tr>
<td>213</td>
<td>Amputation for Musculoskeletal System and Connective Tissue Disorders</td>
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<td>218</td>
<td>Lower Extremity Procedure, Age &gt;17 with CC</td>
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<td>219</td>
<td>Lower Extremity Procedure, Age &gt;17 without CC</td>
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<td>220</td>
<td>Lower Extremity Procedure, Age 0-17</td>
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<td>223</td>
<td>Major Shoulder and Elbow Procedure, or Other Upper Extremity Procedure with CC</td>
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<tr>
<td>224</td>
<td>Shoulder, Elbow, or Forearm Procedure, except Major Joint Procedure without CC</td>
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<td>230</td>
<td>Local Excision and Removal of Internal Fixation Devices of Hip and Femur</td>
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<tr>
<td>231</td>
<td>Local Excision and Removal of Internal Fixation Devices except Hip and Femur</td>
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<tr>
<td>233</td>
<td>Other Musculoskeletal System and Connective Tissue O.R. Procedure with CC</td>
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<tr>
<td>234</td>
<td>Other Musculoskeletal System and Connective Tissue O.R. Procedure without CC</td>
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<tr>
<td>235</td>
<td>Fractures of Femur</td>
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<tr>
<td>236</td>
<td>Fractures of Hip and Pelvis</td>
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</tr>
<tr>
<td>237</td>
<td>Sprain, Strain, Dislocations of Hip, Pelvis, Thigh</td>
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<tr>
<td>238</td>
<td>Osteomyelitis</td>
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<tr>
<td>471*</td>
<td>Bilateral/ Multiple Major Joint Procedure of Lower Extremity</td>
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</tr>
<tr>
<td>485*</td>
<td>Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma</td>
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<tr>
<td>491*</td>
<td>Major Joint and Limb Reattachment of Upper Extremity</td>
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<tr>
<td>496*</td>
<td>Combined Anterior/ Posterior Spinal Fusion</td>
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<td>497*</td>
<td>Spinal Fusion with CC</td>
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<td>498*</td>
<td>Spinal Fusion without CC</td>
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<td>499*</td>
<td>Back and Neck Procedures except Fusion with CC</td>
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<td>500*</td>
<td>Back and Neck Procedures except Fusion without CC</td>
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<td>519*</td>
<td>Cervical Spinal Fusion with Complications</td>
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<tr>
<td>520*</td>
<td>Cervical Spinal Fusion without Complications</td>
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### MDC 9: DISEASES AND DISORDERS OF THE SKIN, SUBCUTANEOUS TISSUE AND BREAST

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<tr>
<td>257</td>
<td>Total Mastectomy for Malignancy with CC</td>
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<tr>
<td>258</td>
<td>Total Mastectomy for Malignancy without CC</td>
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</tr>
<tr>
<td>259</td>
<td>Subtotal Mastectomy for Malignancy with CC</td>
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<td>260</td>
<td>Subtotal Mastectomy for Malignancy without CC</td>
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<tr>
<td>261</td>
<td>Breast Procedure for Non-malignancy, except Biopsy</td>
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<tr>
<td>263</td>
<td>Skin Graft And/or Debridement for Skin Ulcer or Cellulitis with CC</td>
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</tr>
<tr>
<td>264</td>
<td>Skin Graft And/or Debridement for Skin Ulcer or Cellulitis without CC</td>
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</tr>
<tr>
<td>265</td>
<td>Skin Graft And/or Debridement except for Skin Ulcer and Cellulitis with CC</td>
<td>S</td>
</tr>
<tr>
<td>266</td>
<td>Skin Graft And/or Debridement except for Skin Ulcer and Cellulitis without CC</td>
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### MDC 10: ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES AND DISORDERS

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<tr>
<td>285</td>
<td>Amputation of Lower Limb for Endocrine, Nutritional, and Metabolic Disorders</td>
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<tr>
<td>286</td>
<td>Adrenal and Pituitary Procedures</td>
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<td>288</td>
<td>O.R. Procedures for Obesity</td>
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</tr>
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<td>289</td>
<td>Parathyroid Procedures</td>
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</tr>
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<td>290</td>
<td>Thyroid Procedures</td>
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<tr>
<td>292</td>
<td>Other Endocrine, Nutritional, Metabolic O.R. Procedure with CC</td>
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### MDC 11: DISEASES AND DISORDERS OF THE KIDNEY AND URINARY TRACT

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<tr>
<td>512</td>
<td>Simultaneous Pancreas/Kidney Transplant</td>
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<tr>
<td>302</td>
<td>Kidney Transplant</td>
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<tr>
<td>303</td>
<td>Kidney, Ureter, Major Bladder Procedures for Neoplasm</td>
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</tr>
<tr>
<td>304</td>
<td>Kidney, Ureter, Major Bladder Procedures for Non-neoplasm with CC</td>
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</tr>
<tr>
<td>305</td>
<td>Kidney, Ureter, Major Bladder Procedures for Neoplasm without CC</td>
<td>S</td>
</tr>
<tr>
<td>306</td>
<td>Prostatectomy with CC</td>
<td>S</td>
</tr>
<tr>
<td>307</td>
<td>Prostatectomy without CC</td>
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<td>310</td>
<td>Transurethral Procedures with CC</td>
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<td>311</td>
<td>Transurethral Procedures without CC</td>
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<tr>
<td>315</td>
<td>Other Kidney and Urinary Tract O.R. Procedure</td>
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</tr>
<tr>
<td>317</td>
<td>Admission for Renal Dialysis</td>
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<tr>
<td>323</td>
<td>Urinary Stones with CC, and/or ESW Lithotripsy</td>
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</tr>
<tr>
<td>324</td>
<td>Urinary Stones without CC</td>
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### MDC 12: DISEASES & DISORDERS OF THE MALE REPRODUCTIVE SYSTEM

<table>
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<tr>
<td>334</td>
<td>Major Male Pelvic Procedures with CC</td>
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<td>335</td>
<td>Major Male Pelvic Procedures without CC</td>
<td>S</td>
</tr>
<tr>
<td>336</td>
<td>Transurethral Prostatectomy with CC</td>
<td>S</td>
</tr>
<tr>
<td>337</td>
<td>Transurethral Prostatectomy without CC</td>
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<td>338</td>
<td>Testes Procedures for Malignancy</td>
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<td>344</td>
<td>Other Male Reproductive System O.R. Procedures for Malignancy</td>
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### MDC 13: DISEASES & DISORDERS OF THE FEMALE REPRODUCTIVE SYSTEM

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<tr>
<td>353</td>
<td>Pelvic Evisceration, Radical Hysterectomy, and Radical Vulvectomy</td>
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<tr>
<td>356</td>
<td>Female Reproductive System Reconstructive Procedures</td>
<td>S</td>
</tr>
<tr>
<td>365</td>
<td>Other Female Reproductive System O.R. Procedures</td>
<td>S</td>
</tr>
</tbody>
</table>

### MDC 14: PREGNANCY, CHILDBIRTH AND THE Puerperium

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>370</td>
<td>Cesarean Section with CC</td>
<td></td>
</tr>
<tr>
<td>371</td>
<td>Cesarean Section without CC</td>
<td></td>
</tr>
<tr>
<td>372</td>
<td>Vaginal Delivery with Complicating Diagnoses</td>
<td></td>
</tr>
<tr>
<td>373</td>
<td>Vaginal Delivery without Complicating Diagnoses</td>
<td></td>
</tr>
<tr>
<td>374</td>
<td>Vaginal Delivery with Sterilization And/or D &amp; C</td>
<td></td>
</tr>
<tr>
<td>375</td>
<td>Vaginal Delivery with O.R. Procedure except Sterilization and/or D &amp; C</td>
<td>Delivery</td>
</tr>
<tr>
<td>377</td>
<td>Postpartum and Postabortion Diagnoses with O.R. Procedure</td>
<td>S</td>
</tr>
<tr>
<td>378</td>
<td>Ectopic Pregnancy</td>
<td>S</td>
</tr>
</tbody>
</table>
### MDC 15: NEWBORNS AND OTHER NEONATES WITH CONDITIONS ORIGINATING IN THE PERINATAL PERIOD

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition Description</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>385</td>
<td>Neonates, Died or Transferred to Another Acute Care Facility</td>
<td>Neonate</td>
</tr>
<tr>
<td>386</td>
<td>Extreme Immaturity or Respiratory Distress Syndrome, Neonate</td>
<td>Neonate</td>
</tr>
<tr>
<td>387</td>
<td>Prematurity with Major Problems</td>
<td>Neonate</td>
</tr>
<tr>
<td>388</td>
<td>Prematurity without Major Problems</td>
<td>Neonate</td>
</tr>
<tr>
<td>389</td>
<td>Full Term Neonates with Major Problems</td>
<td>Neonate</td>
</tr>
<tr>
<td>390</td>
<td>Full Term Neonate with Other Significant Problems</td>
<td>Neonate</td>
</tr>
<tr>
<td>391</td>
<td>Normal Newborn</td>
<td>Neonate</td>
</tr>
</tbody>
</table>

### MDC 16: DISEASES & DISORDERS OF BLOOD, BLOOD FORMING ORGANS, AND IMMUNOLOGICAL DISORDER

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition Description</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>392</td>
<td>Splenectomy, Age &gt;17</td>
<td>S</td>
</tr>
<tr>
<td>393</td>
<td>Splenectomy, Age 0-17</td>
<td>S</td>
</tr>
<tr>
<td>394</td>
<td>Other O.R. Procedure of Blood and Blood Forming Organs</td>
<td>S</td>
</tr>
<tr>
<td>397</td>
<td>Coagulation Disorders</td>
<td>M</td>
</tr>
</tbody>
</table>

### MDC 17: MYELOPROLIFERATIVE DISEASES AND DISORDERS, AND POORLY DIFFERENTIATED NEOPLASMS

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition Description</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>400</td>
<td>Lymphoma and Leukemia with Major O.R. Procedure</td>
<td>S</td>
</tr>
<tr>
<td>401</td>
<td>Lymphoma and Non-acute Leukemia with O.R. Procedure with CC</td>
<td>S</td>
</tr>
<tr>
<td>402</td>
<td>Kidney, Ureter, Major Bladder Procedures for Neoplasm without CC</td>
<td>S</td>
</tr>
<tr>
<td>405</td>
<td>Acute Leukemia Without Major O.R. Procedure, Age 0-17</td>
<td>M</td>
</tr>
<tr>
<td>406</td>
<td>Myeloproliferative Disease with Major O.R. Procedure with CC</td>
<td>S</td>
</tr>
<tr>
<td>407</td>
<td>Myeloproliferative Disease with Major O.R. Procedure without CC</td>
<td>S</td>
</tr>
<tr>
<td>408</td>
<td>Myeloproliferative Disease with Other O.R. Procedure</td>
<td>S</td>
</tr>
<tr>
<td>410</td>
<td>Chemotherapy Without Acute Leukemia as Secondary Diagnosis</td>
<td>M</td>
</tr>
<tr>
<td>473</td>
<td>Acute Leukemia Without Major O.R. Procedure, Age &gt;17</td>
<td>M</td>
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</tbody>
</table>

### MDC 18: INFECTIOUS AND PARASITIC DISEASES

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition Description</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>415</td>
<td>O.R. Procedure for Infectious and Parasitic Diseases</td>
<td>S</td>
</tr>
<tr>
<td>416</td>
<td>Septicemia, Age &gt;17</td>
<td>M</td>
</tr>
<tr>
<td>417</td>
<td>Septicemia, Age 0-17</td>
<td>M</td>
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</table>

### MDC 19: MENTAL DISEASES AND DISORDERS

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition Description</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>424</td>
<td>(Age &lt; 18) O.R. Procedure with Principal Diagnosis of Mental Illness</td>
<td>S</td>
</tr>
<tr>
<td>425</td>
<td>(Age &lt; 18) Acute Adjustment Reaction and Disturbances of Psychological Dysfunction</td>
<td>M</td>
</tr>
<tr>
<td>426</td>
<td>(Age &lt; 18) Depressive Neuroses</td>
<td>M</td>
</tr>
<tr>
<td>427</td>
<td>(Age &lt; 18) Neuroses except Depressive</td>
<td>M</td>
</tr>
<tr>
<td>428</td>
<td>(Age &lt; 18) Disorders of Personality and Impulse Control</td>
<td>M</td>
</tr>
<tr>
<td>429</td>
<td>(Age &lt; 18) Organic Disturbances and Mental Retardation</td>
<td>M</td>
</tr>
<tr>
<td>430</td>
<td>(All Ages) Psychoses</td>
<td>M</td>
</tr>
<tr>
<td>431</td>
<td>(Age &lt; 18) Childhood Mental Disorders</td>
<td>M</td>
</tr>
<tr>
<td>432</td>
<td>(Age &lt; 18) Other Mental Disorder Diagnoses</td>
<td>M</td>
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</table>

### MDC 21: INJURIES, POISONINGS AND TOXIC EFFECTS OF DRUGS

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition Description</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>440</td>
<td>Wound Debridement for Injuries</td>
<td>S</td>
</tr>
<tr>
<td>442</td>
<td>Other O.R. Procedures for Injuries with CC</td>
<td>S</td>
</tr>
<tr>
<td>443</td>
<td>Other O.R. Procedures for Injuries without CC</td>
<td>S</td>
</tr>
<tr>
<td>444</td>
<td>Traumatic Injury Age &gt;17 with CC</td>
<td>M</td>
</tr>
<tr>
<td>445</td>
<td>Traumatic Injury Age &gt;17 without CC</td>
<td>M</td>
</tr>
<tr>
<td>446</td>
<td>Traumatic Injury Age 0-17</td>
<td>M</td>
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</table>

### MDC 8: DISEASES AND DISORDERS OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition Description</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>471</td>
<td>Bilateral/ Multiple Major Joint Procedure of Lower Extremity</td>
<td>S</td>
</tr>
<tr>
<td>MDC 17: MYELOPROLIFERATIVE DISEASES AND DISORDERS, AND POORLY DIFFERENTIATED NEOPLASMS</td>
<td></td>
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<tr>
<td>---------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>473 * Acute Leukemia Without Major O.R. Procedure, Age &gt;17   M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDC 4: DISEASES AND DISORDERS OF THE RESPIRATORY SYSTEM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>475 * Respiratory System Diagnosis with Ventilator Support   M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRE-MDC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>480 Liver Transplant                                         S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>481 Bone Marrow Transplant                                   S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>482 * Tracheostomy for Face, Mouth and Neck Diagnoses        S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>483 * Tracheostomy except for Face, Mouth and Neck Diagnoses</td>
<td></td>
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<tr>
<td>MDC 24: MULTIPLE SIGNIFICANT TRAUMA</td>
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<tr>
<td>484 * Craniotomy for Multiple Significant Trauma             S</td>
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<tr>
<td>485 * Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>486 Other O.R. Procedures for Multiple Significant Trauma    S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>487 Other O.R. Procedures for Multiple Significant Trauma    S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDC 25: HUMAN IMMUNODEFICIENCY VIRUS INFECTIONS</td>
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<tr>
<td>488 HIV with Extensive O.R. Procedure                       S</td>
<td></td>
<td></td>
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<tr>
<td>489 HIV with Major Related Condition                        S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDC 8: DISEASES AND DISORDERS OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE</td>
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<td></td>
</tr>
<tr>
<td>490 * Major Joint and Limb Reattachment of Upper Extremity   S</td>
<td></td>
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</tr>
<tr>
<td>MDC 17: MYELOPROLIFERATIVE DISEASES AND DISORDERS, AND POORLY DIFFERENTIATED NEOPLASMS</td>
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<td></td>
</tr>
<tr>
<td>492 * Chemotherapy with Acute Leukemia as Secondary Diagnosis M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDC 7: DISEASES AND DISORDERS OF THE HEPATOBILIARY SYSTEM AND PANCREAS</td>
<td></td>
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<tr>
<td>493 * Laparoscopic Cholecystectomy without C.D.E. with CC   S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>494 * Laparoscopic Cholecystectomy without C.D.E. without CC S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRE-MDC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>495 * Lung Transplant                                        S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDC 8: DISEASES AND DISORDERS OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE</td>
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<td></td>
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<tr>
<td>496 * Combined Anterior/ Posterior Spinal Fusion            S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>497 * Spinal Fusion with CC                                   S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>498 * Spinal Fusion without CC                                S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>499 * Back and Neck Procedures except Fusion with CC         S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 * Back and Neck Procedures except Fusion without CC      S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDC 22: BURNS</td>
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<td></td>
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<tr>
<td>504 Extensive 3rd Degree Burns with Skin Graft               S</td>
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<td></td>
</tr>
<tr>
<td>505 Extensive 3rd Degree Burns without Skin Graft            M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>506 Full Thick Burn, Graft, Inhalation Injury without CC     M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>507 Full Thick Burn, Graft, Inhalation Injury without CC     M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>508 Full Thick Burn, Inhalation Injury with CC and Trauma    M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>509 Full Thick Burn, Inhalation Injury without CC            M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>510 Non-extensive Burns with CC or Significant Trauma       M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRE-MDC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>512 * Simultaneous Pancreas/ Kidney Transplant              S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>513 * Pancreas Transplant                                    S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDC 5: DISEASES AND DISORDERS OR THE CIRCULATORY SYSTEM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>514 * Cardiac Defibrillator Implant with Cardiac Cath        S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>515 * Cardiac Defibrillator Implant without Cardiac Cath     S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>516 * Percutaneous Cardiovascular Procedures with AMI        S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>517 * Percutaneous Cardiovascular Procedures with Stent without AMI S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>518 * Percutaneous Cardiovascular Procedures without Stent without AMI S</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ICU Revenue Codes

For patients hospitalized in an ICU bed, one of the following revenue codes must be included on the inpatient claim submitted to DHS to be excluded from IHA. The revenue codes are subject to changes made by the NUBC and HIPAA requirements.

<table>
<thead>
<tr>
<th>Rev Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>172</td>
<td>Nursery/Premie or Level II</td>
</tr>
<tr>
<td>173</td>
<td>Nursery-Level III</td>
</tr>
<tr>
<td>174</td>
<td>Nursery-Level IV</td>
</tr>
<tr>
<td>175</td>
<td>Nursery/ICU</td>
</tr>
<tr>
<td>200</td>
<td>ICU General</td>
</tr>
<tr>
<td>201</td>
<td>ICU Surgical</td>
</tr>
<tr>
<td>202</td>
<td>ICU Medical</td>
</tr>
<tr>
<td>203</td>
<td>ICU Peds</td>
</tr>
<tr>
<td>206</td>
<td>*Post/Intermediate ICU (use of Rev Code 206 may vary by hospital)</td>
</tr>
<tr>
<td>207</td>
<td>ICU Burn</td>
</tr>
<tr>
<td>208</td>
<td>ICU Trauma</td>
</tr>
<tr>
<td>209</td>
<td>ICU Other</td>
</tr>
<tr>
<td>210</td>
<td>CCU</td>
</tr>
<tr>
<td>211</td>
<td>CCU Myocardial Infarction</td>
</tr>
<tr>
<td>212</td>
<td>CCU Pulmonary Care</td>
</tr>
<tr>
<td>213</td>
<td>CCU Heart Transplant</td>
</tr>
<tr>
<td>214</td>
<td>*Post Intermediate CCU (use of Rev Code 206 may vary by hospital)</td>
</tr>
<tr>
<td>219</td>
<td>CCU Other</td>
</tr>
<tr>
<td>233</td>
<td>Nursing incremental, ICU</td>
</tr>
<tr>
<td>234</td>
<td>Nursing incremental, CCU</td>
</tr>
</tbody>
</table>

*Revenue Codes 206 and 214: hospitals need to determine if these revenue codes are used and in which situations. If one of these codes is on the claim, the admission will be exempt from IHA if no other criteria places the case in an inclusion category, (e.g., admission to long-term hospitals).

Legal References

Minnesota Statutes, section 256B.04
Minnesota Statutes, section 256D.03
Minnesota Statutes, section 256L.03, subd. 3(b)
Minnesota Rules, parts 9505.0500 to 9505.0540
Minnesota Rules, parts 9500.1090 to 9500.1140
42 CFR 456.50 to 456.245
42 CFR 482.30
Chapter 14

Hospital Services

Hospital services include inpatient and outpatient services provided in a facility qualified to participate in Medicare. Hospital services must be medically necessary and provided by or under the supervision of a physician, dentist, or other provider having medical staff privileges in the hospital.

Definitions

**Critical Access Hospital**: Facilities designated as a Critical Access Hospital must meet criteria established in federal legislation as well as those required by the state. The facility must be a non-profit or public hospital that is located in a rural area. The hospital must provide 24-hour emergency care services and not have more than 15 acute care inpatient beds. The hospital may have up to 10 additional swing beds. Swing beds are not considered part of the acute care hospital services but provide long-term care services.

Critical access hospitals also have an average length of stay limitation of 96 hours, and location and distance requirements apply. For additional information, review the MDH site *Minnesota Rural Hospital Flexibility Program and Critical Access Hospital Information* at [http://www.health.state.mn.us/divs/chs/rhpc/cah/index.html](http://www.health.state.mn.us/divs/chs/rhpc/cah/index.html).

**Emergency Room**: Emergency room care must:

- Be provided in a hospital with a designated emergency room department; and
- Reflect direct patient care, including active patient assessment, monitoring, and treatment by hospital medical personnel such as physicians, nurses, or lab and x-ray technicians.

Medical records must document the emergency diagnosis and the extent of direct patient care.

Emergency room care does not include unattended waiting time.

Emergency room care/emergency services are covered for a medical emergency, which means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; continuation of severe pain; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or death. Labor and delivery is a medical emergency if it meets this definition.

- The recipient must be seen by the medical professional on the same day that the recipient contacted the medical professional in order for the situation to be considered an emergency.
• The situation is not considered an emergency if the recipient contacts the medical professional and is not given an appointment for the same day of the call.
• Prescheduled services are not considered an emergency.
• Services provided as follow-up to initial emergency care are not considered emergency services.

**Inpatient:** A patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist who:

• Receives room, board, and professional services in the institution for a 24-hour period or longer; or
• Is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged, or is transferred to another facility and does not actually stay in the institution for 24 hours.

**Outpatient:** A patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

**Outpatient Hospital Services:** Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided:

• To outpatients;
• By or under the direction of a physician or dentist;
• By an institution that is licensed or formally approved as a hospital by an officially designated authority for state standard-setting; and
• Meets the requirements for participation in Medicare as a hospital.

**Outpatient Observation:** Observation status is a method of billing for care received in a hospital facility that is not dependent on location, medical department, or whether a patient bed is assigned to the patient. DHS uses Medicare criteria for billing observation status.

Observation services will be paid for up to 48 hours. Observation services will be considered for unusual circumstances up to 72 hours with documentation.

**Patient:** An individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.
Eligible Providers

An eligible facility, meeting the definition of and licensed as a hospital, qualified to participate in Medicare. A hospital that is part of the Federal Indian Health Service, designated by the federal government to provide acute care.

Eligible Recipients

All MHCP recipients are eligible to receive inpatient and outpatient hospital services.

Additional Services

Professional services (e.g., anesthesiologist, physician) are covered in addition to outpatient or inpatient hospital services. Lab, radiology, supplies, injectible drugs, etc., may also be separately covered services when outpatient hospital services are provided. Refer to the specific service chapters of this manual for coverage and billing policy.

Coverage Limitations

Services provided in an outpatient or inpatient hospital setting are subject to the same requirements that apply to other providers, including:

- Requests for authorization (refer to the Authorization chapter (Ch. 5) of this manual);
- Inpatient Hospital Authorization (IHA) for non-exempt DRGs, providers, and/or patient populations; and
- Consent forms/statements of acknowledgment for hysterectomies, voluntary sterilizations, and therapeutic abortions.

Covered Outpatient Hospital Services

An outpatient hospital clinic is a non-emergency service providing diagnostic, preventive, curative and rehabilitative services on a scheduled basis.

In medically indicated situations when the recipient's physical or mental disability is such that it is not in the best interest of the recipient to be physically moved to multiple outpatient hospital clinic sites, the outpatient hospital facility may bill a specialty clinic facility fee for each distinctly different specialty clinic service that is brought to the recipient at one clinic site.

DHS guidelines for claim completion are in the UB-92 claim completion trifold and the Minnesota Hospital and Healthcare Partnership (MHHP) UB-92 Manual.
If a recipient is admitted to the hospital as an inpatient and Inpatient Hospital Authorization (IHA) is denied and/or the patient does not meet inpatient criteria, services may be billed as outpatient hospital services if:

- The recipient was in the hospital for less than 24 hours (total);
- The stay has not been billed as an inpatient stay; and
- The admission hour and discharge hour must be indicated on the claim. Code "99", (hour unknown) is not acceptable.

If a recipient is admitted to the hospital as an inpatient from an outpatient department of the hospital (e.g., emergency room, ambulatory surgical center, observation status whether or not a bed is used), charges from the outpatient services must be included in the inpatient hospital stay. The date of admission submitted on the UB-92 is the date outpatient services began.

**Inpatient Only Procedures**

**Dually Eligible Medicare and Medicaid Recipients**
The CMS identified Inpatient Only procedures provided to patients who are dually eligible Medicare and Medicaid recipients, must be provided in an inpatient setting for DHS to pay the coinsurance and deductible amount. DHS will not make payment if the inpatient only procedure is performed in an outpatient setting for a dually eligible Medicare/Medicaid recipient.

**Medicaid Only Recipients**
Providers may choose the appropriate place of service for those patients who are eligible for Medicaid only.

**Medicaid Recipients with TPL**
Providers are to follow the place of service rule of the primary payer. DHS will not make payment if the place of service rule of the primary payer is not followed.

Recipients with private health insurance primary to GHO are responsible to pay the GHO copay for covered services. Hospitals must bill in the usual manner, reporting the insurance payment on the claim. If the GHO allowable will cover all or part of the balance billed, the GHO copay will be deducted from that amount and reported as the copay amount. The GHO recipient should only be asked to pay the GHO amount for services covered by MHCP.

**Cardiac Rehabilitation (93798, 93799)**

Cardiac Rehabilitation is described by the U.S. Public Health Service as consisting of “comprehensive, long-term programs involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling”. It further states that these programs “are designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients”.

- Cardiac rehabilitation services are the aftercare for myocardial infarction, coronary bypass surgery, stable angina, and other similar diagnoses.
• Cardiac rehabilitation services are for the following additional indications, heart valve replacement, angioplasty, heart or heart-lung transplant and congestive heart failure

• Cardiac rehabilitation services include a recovery program primarily consisting of monitored exercise or exercise therapy with patient instruction and diagnostic testing services.

• A physician must be in the exercise area and immediately available for an emergency at all times the exercise program is being conducted. Services of non-physician personnel must be furnished under the direct on-site supervision of a physician.

Outpatient hospitals and physician directed clinics which have a Medicare approved cardiac rehabilitation program may provide cardiac rehabilitation services to MHCP recipients.

**Mental Health Partial Hospitalization (X5330, X5331)**

Mental health partial hospitalization is a covered service for adults and adolescents if the hospital has received DHS approval for its partial hospitalization program (refer to the Mental Health Services chapter (Ch. 16) of this manual).

Bill mental health partial hospitalization using HCPCS codes:

• X5330 - Mental health partial hospitalization, adult; or
• X5331 - Mental health partial hospitalization, adolescent.

**Outpatient Observation Services**

Observation services will be paid for up to 48 hours. Observation services up to 72 hours for unusual circumstances will be considered with additional documentation.

The following observation services may be covered:

• Services reasonable and necessary to treat or diagnose a patient.
• Services independent of other procedures. As an example, an E & M procedure code is not required in addition to observation, for payment of observation.

The following observation services will **NOT** be covered:

• In addition to a surgical procedure, unless the observation is monitoring or treatment beyond what is considered normal. The unusual observation line must reflect a ”22” modifier. An explanation of the unusual circumstances must accompany the observation service.
Preceding an inpatient admission as those observation services are considered part of the inpatient DRG.

When performed for the convenience of the patient, patient’s family or provider.

**Observation Billing Policy**

The facility component of observation services are:

- Billed on the UB-92 using revenue code 762. No procedure code is required with a 762 revenue code.
- Billed separately from surgical services.

For observation services that continue from one day to the next (over midnight), bill the beginning observation service date.

For observation provided on two consecutive days, interrupted by a discharge, bill two distinct line items, each reflecting the specific service dates.

For observation provided in two consecutive days but separate months, bill the beginning observation service date.

For observation, one hour = one unit. Round fractions of time less than 30 minutes down. Round fractions of time greater than 30 minutes up.

Fetal monitoring is to be billed using 762 revenue code.

G0244 will be covered with the diagnoses of chest pain, asthma or congestive heart failure. G0244 will not be paid in addition to another observation service.

**Prolonged Intravenous Therapy**

Prolonged IV therapy begins when the IV needle is in place, continues through the administration, and ends when the insertion site care is complete.

The following are billable in addition to the prolonged IV therapy:

- Blood;
- Blood products;
- Biologicals;
- Chemotherapy agents;
- Other drugs that require prolonged infusion; and
- Specialty catheters not routinely supplied.
Blood Transfusions

Blood transfusions require the actual number of units provided related to the specific product or procedure. Multiple units are not reported when the number of units included in the code description is multiple and the number of units used is equal to or below the unit measurement of the code (this is reported as one unit).

Pulse Oximetry

Pulse oximetry is considered part of the ER, ASC, outpatient specialty clinic, and part of the APC payment. Currently, the service can only be billed separately when an E& M visit is all that is otherwise completed.

UB-92 Billing Instructions for Outpatient Claims

Outpatient hospital claims (type of bill 13X or14X): This does not apply to Critical Access Hospitals.

FLs listed are not all inclusive. Please refer to the UB-92 manual for complete information.

PROVIDER NAME, ADDRESS AND TELEPHONE NUMBER (FL1)
- Provider name, address, and telephone number-required.

PATIENT CONTROL NUMBER (FL3)
- Patient control number-optional. Enter patient control number (patient’s account number) assigned by the provider. This is a provider specific entry and will appear on the remittance advice when entered.

TYPE OF BILL (FL4)
- Required.
- Choose the appropriate type of bill based on UB-92 descriptions.
- Effective service date 08/01/00, type of bill 83X is not appropriate for outpatient hospital facility billing.
- Type of bill 83X continues to be appropriate for free standing ASC billing.
- DHS uses the type of bill third digit to consider monthly (recurring/series) services billing versus daily billing. (Except for Observation billing. See Observation billing section.)

STATEMENT COVERS PERIOD (FL6)
- Statement covers period-required, is completed by entering the from and through dates of service. Complete this form locator using a 6-digit format. Claims for outpatient services CANNOT span more than one calendar month period. Except for Observation billing. (See Observation billing section.) Outpatient claims that include services for multiple months will be denied, except for Observation services.

PATIENT NAME (FL12)
- Patient name-required. Hyphenated names are accepted.

PATIENT ADDRESS (FL13)
• Patient address-required.

PATIENT DATE OF BIRTH (FL14)
• Patient date of birth – required.

GENDER CODE (FL15)
• Gender code-required.

ADMISSION TYPE (FL19)
• Admission type-required.

SOURCE OF ADMISSION (FL20)
• Source of admission-required.

PATIENT DISCHARGE STATUS (FL22)
• Patient discharge status-required.

MEDICAL RECORD NUMBER (FL23)
• Medical record number-optional field.

CONDITION CODES (FL24 THROUGH 30)
• Required if applicable condition codes.
• The 'G0' (zero) condition code applies to UB-92 billing. It is not applicable to the HCFA-1500. The 'G0' condition code will allow payment of an additional evaluation and management (E & M) service.

OCCURRENCE CODES (FL32-35)
• Occurrence codes – required if applicable.

OCCURRENCE CODE AND DATE SPAN (FL36)
• Occurrence code and date span – required if applicable. Enter code(s) and dates that identify occurrences that happened over a span of time.

INTERNAL CONTROL NUMBER/DOCUMENT CONTROL NUMBER (FL37)
• Internal control number/document control number-required for replacement claims only.

VALUE CODES AND AMOUNTS (FL39-41)
• Value codes and amounts – required if applicable.

REVENUE CODES (FL42)
• A revenue code is required on each line. Choose the appropriate revenue code for the service/good provided.
• DHS pays line items without procedure codes at $0.00 and assumes the service is a bundled service/good. Observation billing is the only exception to this policy. Revenue code 762 (observation) may be paid without a procedure code.
• DHS edits surgical procedures according to the CPT surgical procedure code range rather than revenue code 360.

REVENUE DESCRIPTION (FL43)
• Revenue description- desired but not required.

PROCEDURE CODE (FL44)
• Procedure code is required for line item payment, on each line of a UB-92 claim, except for observation billed with a 762 revenue code. A procedure code is not required when observation is submitted as a 762 revenue code. All other lines submitted without a procedure code will be considered “bundled” services or goods and will be paid at zero.
• Procedure codes are required on all lines except:
  ▪ Bundled services/goods line items. If bundled services are listed and a HCPCS code is included, DHS will pay the line at $0.00 rather than deny.
Observation is billed with a 762 revenue code.

- Medical procedures are billed utilizing the HCPCS coding scheme. The HCPCS coding scheme consists of three levels:
  - Level I codes are found in the American Medical Association’s Current Procedural Terminology (CPT).
  - Level II (alphanumeric national codes) are found in the HCPCS manual that may be obtained from Minnesota’s Bookstore.
  - Level III (alphanumeric state/local codes) are found in the HCPCS manual and in the MHCP Provider manual.
- Dental procedures are billed using CPT or CDT-4 coding scheme. CPT will continue to be required for outpatient hospital dental procedures.

MODIFIERS (FL44)

- Modifiers-required if applicable.
- DHS processes a line item that reflects two modifiers without reference to the order in which the modifiers are submitted.
- Modifier billing on the UB-92 may be different from the billing on the HCFA-1500.
- This is not an all inclusive list of modifiers billed on the UB-92. DHS will follow the same billing guidelines as Medicare for those modifiers that are not listed below.

Modifiers 21 and 22

- Modifiers 21 and 22 may be utilized to identify those services that are prolonged /extensive in relation to the procedure code description. Bill on paper and attach a report detailing the prolonged/extensive nature of the service.

Modifier 25

- Modifier 25 identifies a significant, separately identifiable (E & M) provided by the same physician on the same day of a procedure or other service. DHS follows Medicare guidelines relating to Modifier 25.

Modifier 27

- Use this modifier to report separate and distinct E&M encounters performed in multiple settings for the same date of service.

Modifier 50

- Bilateral surgical services are to billed on one line with a “50” modifier. Bilateral nonsurgical services may be billed on one line with a “50” modifier or on two lines with the appropriate left and right modifiers. Please do not submit a “50” modifier on those procedures that state “bilateral” or “unilateral or bilateral” within the procedure code description.

Modifier 99

- Identifies that multiple modifiers apply to the service provided.
- No other modifier must be present on the line with modifier 99.
- Requires an explanation detailing all of the modifiers appropriate to the service.
- Do not submit multiple lines to identify multiple modifiers.

Modifier TC

- Modifier TC is not required on the UB-92. DHS assumes TC for radiology billed on the UB-92.

LINE ITEM SERVICE DATE (FL45)

- Line item service date-required for non-bundled line items.
• Bundled line items may be billed without service dates as long as the header from and through dates are equal (e.g., 01/01/02-01/01/02). DHS will copy the single header date to the line item(s) on these claims. Claims with greater than one header from and through date (e.g., 1/01/02-01/02/02) will continue to require line item service dates.

LINE ITEM SERVICE UNITS (FL46)
• Line item service units-required on each line of UB-92 claim.

LINE ITEM CHARGES (FL47)
• Submit your usual and customary charge for each service provided.
• Surgical facility charges, same patient/same surgical setting, may be submitted one of two ways:
  ▪ Enter the individual line item charge for each surgical facility component; or
  ▪ Enter the surgical facility charges combined and the combined charge listed on one of the surgical charge lines. The remaining surgical facility charge lines must have a zero charge.
• A mixture of combined surgical facility charges and individual line item surgical facility charges billed on the same day/same patient will cause the claim to deny.

NON-COVERED CHARGES (FL 48)
• Non-covered charges – required if applicable.

PAYER IDENTIFICATION (FL50)
• Payer identification – required.

PROVIDER ID NUMBER (FL51)
• Provider ID number – required. This is the pay-to-provider number.

PRIOR PAYMENTS (FL 54)
• Prior payments- required when applicable. Do not enter any prior MHCP payments or spenddown amounts in this form locator.

INSURED NAME (FL58)
• Insured name – required.

PATIENT RELATIONSHIP TO THE INSURED (FL 59)
• Patient relationship to the insured.

CERTIFICATE/SOCIAL SECURITY/HEALTH INSURANCE CLAIM/IDENTIFICATION NUMBER (FL60)
• Certificate/Social Security/Health Insurance claim/identification number – required. Without this correct number, the provider cannot be reimbursed for services provided.

INSURED GROUP NAME (FL61)
• Insured group name- required if applicable.

INSURANCE GROUP NUMBER (FL62)
• Insurance group number-required if applicable.

TREATMENT AUTHORIZATION CODE (FL63 A, B, C)
• Treatment authorization code-required if applicable.
• DHS will not deny a claim because of another insurance authorization number on the claim.
• If DHS requires authorization on a service provided, a valid DHS authorization number is required on the claim.

DIAGNOSIS CODES (FL67 through 76)
• Diagnosis codes-required.
• E diagnosis codes are appropriate to outpatient hospital facility billing and may be billed as a secondary or admitting diagnosis.

PROVIDER NUMBER (FL82)
• Provider number-required.
• Physical therapy and occupational therapy claims require the physician's UPIN or 9-digit MHCP provider number on line A. The name of the physician may be entered on line B. If the UPIN is entered, the number must also be on file with DHS Provider Enrollment (651) 282-5330 or 1-800-657-3991.

OTHER PHYSICIAN IDENTIFICATION (FL83)
• Other physician identification-required if applicable.

REMARKS (FL84)
• Remarks-required if applicable.

PROVIDER REPRESENTATIVE SIGNATURE (FL 85-86)
• Provider representative signature-required.

General UB-92 Billing Instructions

• Claim attachments
  ▪ Medicare Explanation of Benefits (EOB). Please circle on the EOB the recipient name related to the claim submitted. It is not necessary to "black out" all other Medicare EOB names.
  ▪ Authorized services must be billed on a separate claim from non-authorized services.
  ▪ An entire claim will be denied if one line of the claim is denied. A claim denial will be for reasons such as, but not limited to, data validity errors and patient ineligibility.
  ▪ DHS is currently coding UB-92 Version 6.0 flat file format. Covered and non-covered services may be billed on the same claim.

Non-covered Outpatient Hospital Services

The following outpatient hospital services are not covered and are ineligible for payment:

• Services provided by an employee of the hospital, such as an intern or a resident;
• Services lasting 24 hours or more, except for Observation status;
• Detoxification that is not medically necessary to treat an emergency; and
• Outpatient hospital services that immediately precede an inpatient hospital admission.

Non-APC Facilities

The following facilities are not subject to APC payment methodology:

• Community Mental Health Centers (CMHC);
• Hospice;
• Comprehensive Outpatient Rehabilitation Facilities (CORFs);
• Critical Access Hospitals (CAH);
• Federally Qualified Health Centers (FQHC);
• Rural Health Centers (RHC);
• Non-surgical Indian Health Centers (IHS); and
• Free Standing Ambulatory Surgery Centers.

Urgent Care facilities will follow Medicare guidelines for the facility charge.

Copay Billing Policies

Effective October 1, 2003, copays apply to some services provided to MA and GAMC recipients. Copay guidelines are listed in Chapter 2. Additional information is available in the Chapter 20.

Note: The non-emergency visit to a hospital-based emergency room copay will be deducted from the outpatient hospital facility claim. DHS will use the type of admission in conjunction with the revenue code to determine whether or not the visit was considered an emergency visit or a non-emergency visit. DHS will consider a type of admission equal to “1” in conjunction with a 45x revenue code to be an emergency.

Covered Inpatient Hospital Services

Inpatient hospital services are covered if determined medically necessary through the Inpatient Hospital Authorization (IHA)/recertification process. See Inpatient Hospital Authorization chapter (Ch. 13).

Detoxification as an inpatient service is covered under MHCP if certain medical criteria are met and the Inpatient Hospital Authorization (IHA) number is issued by the medical review agent. See Inpatient Hospital Authorization chapter (Ch. 13). Inpatient hospitalization may be medically necessary due to conditions resulting from withdrawal or conditions occurring in addition to withdrawal and the conditions require constant availability of a physician and registered nurse and/or complex medical equipment found only in an inpatient hospital setting. The medical records of patients admitted for detoxification are subject to retrospective review by the medical review agent. Inpatient medical detoxification and/or treatment of sequelae resulting from drug or alcohol ingestion are billed as any other acute inpatient admission. Do not use Basic Billing Instructions for Chemical Dependency Services designated for admissions covered under CCDTP.

Inpatient hospital services provided to a MinnesotaCare enrollee must be billed to the enrollee's prepaid health plan.

DHS will reimburse inpatient hospital claims for eligible MinnesotaCare enrollees after the $10,000 inpatient hospital benefit has been met by the health plan. Eligible MinnesotaCare
enrollees are adults with children under the age of 21 who are at or below 175% of the Federal Poverty Guideline.

All of the following documentation must be attached to the claim:

- A cover letter; and
- An explanation of benefits from the health plan paper clipped to the claim form.

The Inpatient Hospital Authorization (IHA) number obtained from CDMI must be entered on the UB-92 in FL 63, line A, if IHA is required for the condition being treated.

Submit these claims to:

Department of Human Services  
444 Lafayette Road North  
St. Paul, MN 55155-3849

**MinnesotaCare Program XX and BB Only:** When a MinnesotaCare enrollee's $10,000 inpatient hospital benefit has been reached, the inpatient hospital must bill the patient directly. The MinnesotaCare enrollee is responsible for payment once their PPHP has met the $10,000 inpatient benefit limit.

**Provider Assistance in Enrolling GHO Applicants**

The date of an initial MHCP application necessary to begin a determination of GHO eligibility is the date the applicant provided a name, address, and social security number, signed and dated, to the county. If the applicant is unable to provide this minimal information when health care is delivered due to a medical condition or disability, a provider may act on the applicant’s behalf to establish the date of application. The provider should provide the county with their 9-digit MHCP provider ID number and a temporary unique identifier for the applicant. The temporary unique identifier can be the patient ID, chart number, or any other identifier that applies only to that patient. The provider should also include provider contact information for the county if more information is needed.

**Provider requests do not have to be on a specific form.** Counties will accept any written request, including:

- Combined Application Form (CAF) Part I,
- Health Care Application (HCAPP), or
- Other written request containing the minimum required information or temporary identifier if the minimum information is not known, on the hospital’s FAX or letterhead.

However, for your convenience, DHS has developed the one-page Request to Apply for Minnesota Health Care Programs form that can be used to set the application date for all Minnesota Health Care Programs. This form is available online at [http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3417B-ENG](http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3417B-ENG)

Providers may use this form or develop their own form to submit requests to counties. It is particularly important to use this or a similar request form for the GAMC and GHO programs because eligibility
begins no earlier than the date of application or the date of admission as an inpatient, whichever is later. GHO applicants may set the date of application by submitting minimal information on this request form or a similar request, which must include:

- Name
- Social Security Number, if known
- Address
- Dated signature of applicant/authorized representative

The DHS form includes these informational categories. If you do not use the DHS form, this information is needed on any request to set the date of MHCP application.

**Provider/Hospital Procedures**

- In limited circumstances, hospitals can set the date of application without the signature of the patient or patient’s authorized representative. County agencies will accept requests without a signature ONLY if:
  - The patient is medically unable to participate in completing the request, AND
  - No one else is available to act on the patient’s behalf.
- If the hospital does not know the patient’s name, a unique identifier (such as the patient’s chart number) can be used until identifying information becomes available.
- In all cases, GHO eligibility cannot be determined until the applicant or authorized representative returns the application to the county agency. The completed MHCP application (available on the DHS Web site at http://www.dhs.state.mn.us/HealthCare/AsstProg/mhcpdefault.htm) must be returned to the county within 45 days of the initial request to set the date of application.

After assisting to set the date of application, the provider should follow up with the county as soon as the person’s name, other identifying information and discharge date are known. The applicant must also complete the remainder of the application and provide necessary verification before eligibility can be determined. The county must assist the applicant in obtaining verification if necessary.

**After Hours, Weekend and Holiday Hospital Admissions**

FAX or deliver the request to the county on the date of admission, even if no county staff is available to receive the request. **In-person delivery:** This would include methods such as placing the request in a designated after-hours mail drop. County agencies will honor requests retrieved from drop off boxes or FAX machines at the start of the next county business day as documentation that the request was sent on the date of admission. Late submissions will result in delayed eligibility start dates.

**County Contacts**

County addresses and telephone numbers are online at www.dhs.state.mn.us/HealthCare/county-numbers.htm.

**Non-covered Inpatient Hospital Services**

The following inpatient hospital services are not covered:

- Leave days, leaves of absence, and reserve beds;
• Inpatient chemical dependency treatment (covered under the CCDTF and administered at the county or tribal level); and
• Laboratory, x-ray, and any additional services provided immediately preceding an inpatient hospital admission must be billed with the inpatient claim and are paid under the DRG.

Remittance Pay Types

The following are pay type codes found on the RA for Minnesota hospitals located outside the seven-county metropolitan area that qualify for the Inpatient Hospital Payment Increase for 16 DRGs (diagnosis related groups) at the seven-county metropolitan average:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>Payment per day</td>
</tr>
<tr>
<td>M</td>
<td>Payment per admission</td>
</tr>
<tr>
<td>N</td>
<td>Outlier</td>
</tr>
<tr>
<td>R</td>
<td>Payment for GAMC short stay mental health diagnostic categories S1, S2, S3, S4, S5, FF, GG, and chemical dependency diagnostic category T3</td>
</tr>
<tr>
<td>U</td>
<td>Transfer payment</td>
</tr>
</tbody>
</table>

Inpatient Billing

• If a patient received outpatient hospital services (e.g., emergency room, ambulatory surgery, observation status whether or not a bed was used) preceding the inpatient admission, the date and hour of the inpatient admission documented on the UB-92 inpatient bill must be the date and hour outpatient services began. Code "99" (hour unknown) is not acceptable.

• Inpatient hospital billing cannot be submitted until the patient is discharged. However, for patient lengths of stay over 30 days, hospitals may bill replacement claims for each bill after the initial bill incorporating the previously billed/paid stay. Interim bills must include the Patient Status Code 30 on (FL22), still an inpatient.

• Submit separate claims for a mother and her newborn. Inpatient Hospital Authorization (IHA) is not required for deliveries in DRG 370-375 or births in DRG 385-391. Inpatient Hospital Authorization must be sought if the newborn is discharged after the birth hospitalization and readmitted at a later date and is not in an exempt DRG or other exempt group.

• Submit separate claims for recipients with admissions to a Medicare designated rehabilitation distinct part unit, using the MHCP rehabilitation provider number. IHA must be sought for rehabilitation distinct part admissions. If a patient is transferred between acute inpatient care and inpatient rehabilitation, each rehabilitation admission requires a different IHA number even though the acute care admission is exempt from IHA.
If the admissions to a rehabilitation distinct part unit are not issued separate IHA numbers by the medical review agent, indicate the days in the acute inpatient setting as leave of absence days. Similarly, if the admissions to acute inpatient are not issued separate IHA numbers or do not meet criteria for separate payment (see Inpatient Hospital Authorization [Ch. 13] of this manual), indicate the days in the rehabilitation setting as leave of absence days. For example, a recipient is admitted to an acute inpatient hospital, transferred to the rehabilitation distinct part unit, readmitted into the acute inpatient hospital, and a few days later is again admitted into the inpatient rehabilitation setting. If the admissions meet criteria for two acute inpatient hospitalization payments but the medical review agent did not issue a new IHA number for the second admission to the inpatient rehabilitation hospitalization, the provider must bill:

- One separate claim for each acute inpatient hospitalization, each with its own IHA number if required, and each with the hospital's MHCP provider ID number (ending in 00); and

- One claim for both inpatient rehabilitation hospitalizations, indicating dates of the second acute inpatient hospitalization as leave days (refer to the State or MHHP UB-92 Manual for the leave of absence span code), with its own IHA number, and with the hospital's inpatient rehabilitation MHCP provider ID number (ending in 01).

- When Medicare Part A benefits are exhausted and inpatient hospital claims are submitted to MHCP, indicate Medicare [Part A] with a payer code C in FL 50, line A; Medicare [Part B] with payer code J in FL 50, line B; and Medicaid with payer code D, line C. Paper clip EOMBs from Medicare Part A and Medicare Part B to the claim.

- When Medicare Part A benefits are exhausted, IHA must be obtained and the IHA number must be entered on line A, FL 63 of the UB-92 unless the admission is exempt from IHA.

- When recipients have a spenddown satisfaction date, inpatient claims must be submitted using the first date of eligibility (the spenddown satisfaction date) as the from date in FL 6. The date of admission in FL 17 must contain the date of the recipient's admission to the inpatient hospital.

- A hospital may choose to remove CRNA costs from inpatient rates and have separate payment made for CRNA services. DHS must be notified, in writing, of the hospital's request to remove CRNA costs from the rates.

Inpatient CRNA services are not separately billable for hospitals that choose to retain CRNA costs in the rates.

Inpatient CRNA services provided by an employee of the hospital that has chosen to
remove CRNA cost must bill inpatient CRNA services in the HCFA-1500 format, and:

- Enter the 7-digit base hospital provider number where the CRNA services were performed with the CRNA suffix "67" added in box 33 or the Physician Grp # field on ITS;
- Enter the provider number of the CRNA who performed the service in box 24K or the Treating Provider Number field on ITS; and
- Enter the 7-digit base hospital provider number where the CRNA services were performed with the suffix "00" added in box 17a or the ID Number of Referring Physician field on ITS.

Inpatient CRNA services provided by a CRNA who is independent or employed by a physician must bill inpatient CRNA services in the HCFA-1500 format, and:

- Enter the CRNA or physician provider number in box 33 or the Physician Grp # field on ITS;
- Enter the provider number of the CRNA who performed the service in box 24K or the Treating Provider Number on ITS; and
- Enter the 7-digit base hospital provider number where the CRNA services were performed with the suffix "00" added in box 17a, or the ID Number of Referring Physician field on ITS.

For full DRG payment, the Admission Source (FL 20) should be ‘6’ for claims of patients admitted to an acute care hospital from a State operated Regional Treatment Center or community based psychiatric bed under contract with DHS.

For full DRG payment, the Patient Status (FL 22) should be ‘10’ for claims of patients discharged to an acute care hospital from a State operated Regional Treatment Center or community based psychiatric bed under contract with DHS.

Legal References

Minnesota Statutes, section 144.50
Minnesota Statutes, section 256B.0625, subd. 1; subd. 4
Minnesota Statutes, section 256B.32
Minnesota Statutes, section 256D.03, subd. 4
Minnesota Statutes, section 256L.03, subd. 3
Minnesota Statutes, sections 256.9685; 256.9686; 256.969; 256.9695
Minnesota Rules, parts 9500.1090 to 9500.1140; 9505.0300; 9505.0500 to 9505.0540
42 CFR 440.10
42 CFR 440.20
Chapter 15

Chemical Dependency

The Consolidated Chemical Dependency Treatment Fund (CCDTF) is the mechanism for provision of fee-for-service chemical dependency services for MA and GAMC recipients. Each county and Indian reservation is responsible for:

- Assessment and placement of recipients who need chemical dependency treatment services;
- Establishing contracts with facilities and programs to provide chemical dependency services; and
- Certification of claim forms prior to billing DHS.

For Prepaid MinnesotaCare and PMAP recipients who need chemical dependency services, the health plan is responsible for the assessment, placement, and the provision or contracting of chemical dependency treatment services. MinnesotaCare adults and non-pregnant women (Program XX) are responsible for the inpatient hospital copayment.

Payment will not be made for chemical dependency services provided to an eligible recipient who has not been assessed as needing chemical dependency treatment services and referred by the responsible county, prepaid health plan, or American Indian reservation.

Chemical Dependency Services: A planned program of care for the treatment of chemical dependency or chemical abuse to minimize or prevent further chemical abuse. Diagnostic, evaluation, prevention, referral, detoxification, and aftercare services not included in the licensed rehabilitative program are not MHCP covered services.

Chemical Abuse: A pattern of inappropriate and harmful chemical use which could be linked to specific situations in a recipient's life, such as loss of a job, death of a loved one, or sudden change in life. Chemical abuse does not involve a pattern of pathological use, but it may progress toward it.

Chemical Dependency: A pattern of pathological use, accompanied by the physical manifestations of increased tolerance to the chemical or chemicals being used or withdrawal syndrome following cessation of chemical use.

Rule 25: Minnesota Rules, parts 9530.6600 - 9530.6655, which establish criteria for the appropriate level of chemical dependency care for MHCP recipients.

Rule 35: Minnesota Rules 9530.4100 - 9530.4450, residential treatment licensing rule.
Rule 43: Minnesota Rules 9530.5000 - 9530.6400, outpatient treatment licensing rule.

Assessor: A person qualified under Rule 25 to perform an assessment of chemical use.
Chemical Use Assessment: An interview and written report of the recipient's specific strengths and problems related to chemical use which enables the assessor to determine a level of chemical involvement. The following levels are included in this rating:

- Level 0 - no apparent problem
- Level 1 - risk status
- Level 2 - chemical abuse
- Level 3 - chemical dependency

Referral: If the assessor determines the recipient meets the criteria for chemical abuse (Level 2) or chemical dependency treatment (Level 3), placement should be made in an appropriate program.

Eligible Providers

The following enrollment criteria must be met in order for inpatient and outpatient chemical dependency treatment programs to be eligible for MHCP payment:

- Meet Rule 35 or Rule 43 licensure;
- Contact the Chemical Dependency Division at DHS to enroll as a provider and receive a CCDTF provider number; and
- Obtain a host county contract to provide chemical dependency treatment services;

The Chemical Dependency Division coordinates MHCP enrollment with the Provider Enrollment Unit.

Eligible Recipients

All MHCP recipients who, after receiving a chemical use assessment, meet the criteria for chemical abuse (Level 2) or chemical dependency treatment (Level 3).

Covered Services

Extended Rehabilitation

Extended rehabilitation must include at least 15 hours per week of group, collateral, and individual therapy or counseling. Extended rehabilitation may be provided to those residing in supervised living arrangements or board and lodging facilities.

Outpatient Rehabilitation

Outpatient rehabilitation must include at least 10 hours of group, collateral, and individual therapy or counseling. Outpatient rehabilitation may be provided to those residing in supervised living arrangements or their own home.
Primary Rehabilitation/Free-Standing Facility

Primary rehabilitation provided by a freestanding facility must be a licensed chemical dependency rehabilitation program with the following components:

- Not located in an acute care hospital;
- Provides intensive therapeutic services following detoxification; and
- Provides at least 30 hours a week (per recipient) of chemical dependency services including group and individual counseling, and patient education.

Primary Rehabilitation/Hospital Setting

Primary rehabilitation provided in a hospital setting must be a licensed chemical dependency rehabilitation program with the following components:

- Located in an acute care hospital;
- 24 hour nursing surveillance and physician availability;
- Provides intensive therapeutic services following detoxification; and
- Provides at least 30 hours a week per recipient of chemical dependency services including group and individual counseling, and patient education.

Transitional Rehabilitation

Transitional rehabilitation must include at least five hours per week of group, collateral, and individual therapy or counseling. Transitional rehabilitation may be provided to those residing in halfway houses.

Detoxification

Detoxification is only covered by MHCP if an inpatient hospitalization is medically necessary due to conditions in addition to, or resulting from, withdrawal. For example, conditions resulting from injury, accident, or medical complications during detoxification, such as delirium, which requires constant availability of a physician or complex medical equipment found only in hospital settings would be covered.

Managed Care Recipients

Recipients of prepaid health plans who meet the criteria for extended rehabilitation or transitional rehabilitation must be referred by the prepaid health plan to the county for placement under CCDTF.

Refer to the Minnesota Health Care Programs Benefits by Program Chart in Chapter 2 for a list of covered services by health care program.
Legal References

Minnesota Statutes, section 254A.03; 254B
Minnesota Statutes, section 256B.031
Minnesota Statutes, chapter 256L
Minnesota Rules, parts 9530.6600 to 9530.7031; 9505.0540, subp. 2; parts 9530.5000 to 9530.6400
42 CFR 440.130(d)
Chapter 16

Mental Health Services

Background

There are many mental health services and funding resources available to residents of Minnesota. Minnesota’s publicly provided mental health system is state-supervised and county-administered, reflected in the Minnesota Comprehensive Mental Health Acts (MS 245.461 to 245.486 and MS 245.487 to 245.488) which designates the county as the local mental health authority. Mental health services may be obtained through different federal, state and local government agencies as well as through private organizations, agencies, individual providers and health plans.

DHS serves people through the Minnesota Health Care Programs (MHCP), which includes Minnesota’s Medicaid Program (also called Medical Assistance or MA), General Assistance Medical Care (GAMC) and MinnesotaCare. These three programs are a major source of public funding for mental health services in Minnesota. Information regarding recipient eligibility for these programs is available in the MDHS Health Care Programs Manual (Eligibility Policy) at http://www.dhs.state.mn.us/county. Information about Minnesota’s Federal Medicaid Waivers is available at http://www.dhs.state.mn.us/healthcare/waivers. Information regarding MHCP is available at http://www.dhs.state.mn.us/hlthcare and the Health Care Programs and Services chapter (ch. 2). Additional information is also located in the Prepaid Health Plan chapter (ch. 3). Information regarding services covered by MA, GAMC or MinnesotaCare is available by viewing the MHCP Benefit Table at http://www.dhs.state.mn.us/provider/manual/chapter02.htm. For information regarding co-pays see Provider Update #CPY-04-01 (http://www.dhs.state.mn.us/Provider/upd/cpy0401.htm).

Court Ordered Mental Health Services

During the 2001 legislative session language was added that mandates all state-regulated health-plans, including managed care and indemnity plans (but not self-insured plans except state employee health plans) who provide mental health services (as defined in MS 62Q.535, subd. 1) to

“provide mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan (ITP) for care in the most appropriate, least restrictive environment.”

For complete information view MS 62Q.535, Bulletin #01-53-04 (Health Plans Pay for Court-Ordered Mental Health Services) and Bulletin #02-53-12 (Health Plans and Court-ordered Mental Health Services Questions and Answers).

Services excluded under the above provision are court ordered services solely for legal purposes and not related to the recipient’s diagnosis or treatment of mental illness.
Note: The court ordered service provision does not apply to services reimbursable under MHCP fee-for-service (FFS).

Reimbursement for Mental Health Services

Mental health services under MHCP are delivered and reimbursed through one of two models: FFS or prepaid health care programs.

FFS: DHS establishes service standards for recipient eligibility; provider qualifications; specific service parameters for scope, frequency and duration of services; documentation; and level of care. In order to receive reimbursement for services under FFS, eligible providers need to enroll as an MHCP provider, meet any additional provider eligibility requirements, e.g., licensure or certification for Adult Rehabilitative Mental Health Services (ARMHS), and bill MHCP to obtain reimbursement.

Prepaid health care programs: DHS contracts with health plans and county based purchasing (CBP) entities to reimburse providers for services provided to eligible recipients. Each health plan has an established provider network. Providers must be members of the network or have a relationship with the health plan in order to receive reimbursement from the health plan and must comply with health plan policies. Refer to Prepaid MHCP (ch. 3).

Mental Health Service Exceptions

The following mental health services are not included in the contracts DHS has with prepaid health plans: Mental Health Targeted Case Management, Children’s Mental Health Residential Treatment Services, Adult Crisis Response Services and ARMHS. Providers of these four services must be enrolled MHCP providers and meet provider eligibility requirements of those services. Providers of the above services must submit requests for reimbursement directly to MHCP under the FFS claiming procedures. Recipients enrolled in a prepaid health plan must access all other mental services through their health plan network.

Recipients who have a serious and persistent mental illness or severe emotional disturbance and are eligible to receive mental health case management services are NOT required to enroll in a prepaid health plan, and if enrolled, have the option to disenroll. Recipients must work with their counties workers for this option. Refer to Bulletin # 02-21-04 for information about children in foster care and PMAP enrollment.
The service continuum for mental health is composed of four key components. These include the diagnostic assessment, ITP, service delivery and reassessment. The **diagnostic assessment** is an essential component in identifying appropriate and culturally specific service needs. It is also the key to accessing necessary mental health services. An essential element of every diagnostic assessment is the **functional assessment** that makes diagnoses on Axis IV and V and clearly summarizes the individual strengths and needs of the recipient. (For a complete description see Diagnostic Assessment section in this chapter. Note: for some programs (e.g., Mental Health Targeted Case Management and ARMHS) a Functional Assessment is a separate process done in addition to, but coordinated with, a diagnostic assessment. This Functional Assessment is often conducted by another provider (for more information on this process, see functional assessment requirements in the ARMHS section). The **ITP** is a written plan of intervention, treatment and services developed on the basis of the diagnostic assessment. The concrete goals and objectives in the ITP are related to the strengths and areas of need identified by the diagnostic assessment. **Service delivery** is the act of implementing the ITP to achieve the goals and objectives identified in it. **Reassessment** is determining the extent to which the services have met the goals and objectives, leading to an updating of the ITP.
Diagnostic Assessment

A diagnostic assessment is a written evaluation, conducted by a mental health professional of a recipient's current life situation and sources of stress, including reasons for referral; history of the recipient's current mental health problem, including important developmental incidents, strengths, and vulnerabilities; current functioning and symptoms; diagnosis including whether or not the recipient has a serious and persistent mental illness or severe emotional disturbance; and needed mental health services.

Individual Treatment Plan (ITP)

MHCP only covers services in accordance with the recipient's ITP, except diagnostic assessments, and for emergencies. The recipient's ITP must be:

- Based on the information and outcome of the diagnostic assessment;
- Involve the recipient in the development, review and revision of the ITP;
- Developed by the mental health professional who provides the psychotherapy, no later than the end of the first psychotherapy session, or five days if the recipient is in a day treatment program;
- Signed by the recipient (including revisions), unless the request is not appropriate to the recipient's mental health status. In the case of a child, the child's parent, primary care giver, or other authorized person must sign the ITP. If a recipient refuses to sign the ITP or their mental health status contraindicates the request, the mental health professional must document the circumstances in the ITP; and
- Reviewed at least once every 90 days and if necessary revised. Exception: ARMHS allows review at least once every 180 days and an individual community support plan (ICSP) to be used instead of an ITP for ARMHS, if there is the involvement of a mental health case manager, and with approval of the recipient. The ICSP must include the criteria in MS 256B.0623, subd. 10 (2).

Two ITP samples are provided at the end of this chapter. Professional standards must be followed when completing an ITP.

Refer to MS 256B.0623 for additional information about developing an ITP for ARMHS. For information about an adult crisis treatment plan, refer to Adult Mental Health Crisis Response Services.

Documentation of Services

Mental health service records must be developed and maintained as a condition of payment by MHCP. The recipient’s record should include:

- Each occurrence of a mental health service including the date, type, length and scope of the mental health service;
- The name of the person who gave the service;
• Contact made with other persons interested in the recipient including the contact person’s name and the date of the contact;
• Any contact with the recipient’s other mental health providers, case manager, family members, primary caregiver, legal representative or if applicable, the reason why the person wasn’t contacted if they should have been; and
• As appropriate, required clinical supervision.

All documentation must be completed promptly after the provision of the service. Chapter 1 of this manual, under the section Requirements for Providers, defines the documentation requirements for MHCP unless otherwise specified in this chapter.

Coordination of Services

It is the responsibility of the mental health provider to ask the recipient if he/she is currently receiving mental services from another mental health provider. If the recipient is receiving services from more than one mental health provider, the persons providing the services must coordinate benefits and document, in the recipient's record, that coordination occurred. DHS will not make this information available to providers beyond what can be obtained through the Eligibility Verification System (EVS).

Definitions

**Hour:** A 60-minute session of mental health service. At least 45 minutes of the period must be spent in face-to-face contact with the recipient. The other 15 minutes may be spent in recipient-related activities. Examples of recipient-related activities are scheduling, maintaining clinical records, consulting with others about the recipient's mental health status, preparing reports, receiving the clinical supervision directly related to the recipient's psychotherapy session, and revising the recipient's ITP. If the period of service is longer or shorter than one hour, up to one-fourth of the time may be spent on recipient-related activities. For applying this definition to ARMHS, refer to the AMHRS, section of this chapter. For applying this definition to the Children's Rehabilitative Mental Health Services, refer to that section of this chapter.

**Psychotherapy Session:** A planned and structured face-to-face treatment episode between the vendor or provider of psychotherapy and one or more individuals. A psychotherapy session may consist of individual psychotherapy, family psychotherapy, or group psychotherapy. Refer to the service charts at the end of this chapter for authorization thresholds.

**Mental Illness:** An organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current edition of the ICD-9-CM, code range 290.0 to 302.99 or 306.0 to 316.0.

**Severe Emotional Disturbance (SED):** A child who has an emotional disturbance and who meets one of the following criteria:

• The child has been admitted to inpatient treatment/residential treatment or is at risk of being admitted, within the last three years;
• The child is a MN resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact;
• A mental health professional has determined the child has one of the following:
  ▪ Psychosis or clinical depression;
  ▪ Risk of harming self or others as a result of emotional disturbance; or,
  ▪ Psychopathological symptoms as a result of being a victim of physical/sexual abuse or psychic trauma within the past year.
• A mental health professional has determined the child has a significantly impaired home, school or community functioning lasting at least one year or presents a risk of lasting at least one year, as a result of emotional disturbance.

**Child with Emotional Disturbance:** An organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

• Is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III; and
• Seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

"Emotional disturbance" is a general term and is intended to reflect all categories of disorder described in the DSM-MD, current edition as "usually first evident in childhood or adolescence."

**Serious and Persistent Mental Illness (SPMI):** The condition of an adult or child (at least 18, but under age 21), must have a mental illness diagnosis, and meet at least one of the following criteria:

• The recipient has undergone two or more episodes of inpatient care for mental illness within the preceding 24 months;
• The recipient has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months duration within the preceding 12 months;
• The recipient has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder, evidences a significant impairment in functioning, and has a written opinion from a mental health professional stating he/she is likely to have future episodes requiring inpatient or residential treatment, unless community support program services are provided; or
• The recipient has, in the last three years, been committed by a court as a mentally ill person under Minnesota statutes, or the adult's commitment as a mentally ill person has been stayed or continued; or
• The recipient was eligible under one of the above criteria, but the specified time period has expired or the recipient was eligible as a child with severe emotional disturbance; and the recipient has a written opinion from a mental health professional, in the last three years, stating that he/she is reasonably likely to have future episodes requiring inpatient treatment or residential treatment.
or residential treatment, of a frequency described in the above criteria, unless ongoing case management or community support services are provided.

**Mental Health Services**

Mental health services are provided to persons with mental illness and to children with emotional disturbance. Services include:

**Outpatient Mental Health Services**
- Diagnostic assessment
- Medication Management
- Psychotherapy
- Interactive Psychotherapy Procedures
- Explanation of findings
- Psychological Testing
- Neuropsychological Services

**Rehabilitative Mental Health Services**
- Day treatment
- Partial hospitalization
- Mental health rehabilitative services

**Crisis Services**
- Emergency room crisis services
- Mobile crisis response services for adults and children

**Case Management Services**
- Mental health targeted case management

* In addition to the ED or MI diagnosis, some services require that a recipient meet the criteria for severe emotional disturbance (SED) or serious and persistent mental illness (SPMI) in order to receive services.

**Outpatient Mental Health Services**

**Eligible Recipients**

A recipient must have a diagnosis of mental illness, based on a recent diagnostic assessment (within 180 days), in order to be eligible for mental health services. A child who does not have a diagnosis of mental illness must have a diagnosis of emotional disturbance or severe emotional disturbance.

Prior to the completion of the diagnostic assessment, providers may bill MHCP for explanation of findings, psychological testing, and one psychotherapy session. If the diagnostic assessment
does not result in a diagnosis of mental illness the provider may receive payment for the
diagnostic assessment, but will not receive payment for continuing mental health services.

Eligible Providers

Eligible providers include specific types of agencies or entities and individuals who are licensed
for independent practice. Eligible providers also include mental health practitioners who provide
mental health services, but are not eligible to enroll as MHCP providers.

Mental Health Provider Agencies:

- County Human Service Agency (provider type 45)
- Indian Health Service Provider and tribally owned and operated 638 facilities that
  provide mental health services (provider type 51)
- Outpatient hospital accredited by the joint commission on accreditation of health
  organizations and licensed under MS 144.50 to 144.55 (Outpatient hospitals are licensed
  by the Minnesota Department of Health.) (provider type 01)
- Physician-directed clinic
- Community mental health center (CMHC) as defined under MS 245.62, 256B.0625,
  subd. 5 and Minnesota Rules 9520.0750 to 9520.0870 (provider type 10)
- An entity operated by or under contract to the county to provide day treatment (provider
  type 46) and FCSS, TSFC, HBMHS or Adult Mental Health Crisis Response Services
  (provider type 47)
- School District (provider type 09)
- Certified providers of ARMHS and children’s rehabilitative mental health services:
  FCSS, TSFC, HBMHS effective 07/01/2003) (provider type 47)

Mental health professionals providing clinical services in the treatment of mental illness are
eligible for enrollment as providers of outpatient mental health services. Professionals listed
below are eligible for enrollment as providers of outpatient mental health services to provide
clinical services in the treatment of mental illness or emotional disturbance:

- **Licensed Psychologist (LP)** - licensed under MS 148.88 to 148.98, who has stated to the
  Board of Psychology competencies in the diagnosis and treatment of mental illness. (provider
  type 42)

- **Licensed Psychological Practitioner (LPP)** - licensed under MS 148.908 and granted a
  variance from supervision requirements by the Board of Psychology in accordance with MS
  148.925, subd. 7. (provider type 41)

- **Licensed Independent Clinical Social Worker (LICSW)** - under MS 148B.21, subd. 6.
  (provider type 14)

- **Psychiatrist** - a physician licensed under MS 147 and certified by the American Board of
  Psychiatry and Neurology or eligible for board certification in psychiatry. (provider type 20
  with psychiatric specialty)
• **Psychiatric Nursing (e.g. Clinical Nurse Specialist)** – a registered nurse who is licensed under MS 148.171 to 148.285, and certified as a clinical nurse specialist in psychiatric or mental health nursing by a national nurse certification organization, or has a master’s degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness. (provider type 68 with mental health specialty)

• **Licensed Marriage and Family Therapist** - licensed under MS 148B.29 to 148B.39. (provider type 25)

Only enrolled providers are eligible to receive MHCP payment for outpatient services see Fee-for-Service Billing section for exceptions.

**Mental health practitioners** who provide services in the treatment of mental illness, under supervision of a mental health professional are not eligible for enrollment, but must be qualified in at least one of the following ways:

- Obtained a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and:
  - 2,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness or children with emotional disturbances; or
  - Is fluent in the non-English language of the ethnic group to which at least 50% of the practitioner's clients belong, completes 40 hours of training in the delivery of services to persons with mental illness or children with emotional disturbances, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;
- Completed 6,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness;
- Enrolled as a graduate student in one of the behavioral sciences or related fields formally assigned to the center for clinical training by an accredited college or university; or
- Obtained a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university.

**Clinical Supervision**

Clinical supervision is the process of control and direction of a client's mental health services by which a mental health professional accepts responsibility for the supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the work of the supervisee.

MHCP has more than one standard of supervision requirements in the delivery of mental health services. The following standard is for all Mental Health Services except **Adult Day Treatment**, **Adult Crisis Response Services**, **Adult Rehabilitative Services**, **Children’s Rehabilitative Services**, and **Mental Health Targeted Case Management**.
The clinical supervisor must be an enrolled MHCP provider and accept full responsibility for the supervisee's actions and decisions. The process must meet the following conditions:

- The clinical supervisor must be on the premises, present and available, more than 50% of the time in a five day work period while the supervisee is providing a mental health service;
- The recipient's diagnostic assessment and ITP, or change in diagnosis or ITP must be provided by and reviewed by the clinical supervisor; and
- Every 30 days the clinical supervisor must review and sign the recipient's record of care for all services provided in the preceding 30 days.

**Covered Services**

**Diagnostic Assessment**

A diagnostic assessment is a written evaluation, conducted by a mental health professional of a person's:

- Current life situation and sources of stress, including reasons for referral;
- History of the person's current mental health problem, including important developmental incidents, strengths, and vulnerabilities;
- Current functioning and symptoms;
- Diagnosis including whether or not the person has a serious and persistent mental illness or severe emotional disturbance; and
- Needed mental health services.

A diagnostic assessment can be performed independently by an enrolled mental health professional if the provision of this service falls within the practice scope of the mental health professional. Individuals who have completed requirements for licensure as a mental health professional with the exception of clinical supervision and graduate students in a field placement or internship, may conduct diagnostic assessments under clinical supervision of a mental health professional in some settings – see the section titled Non-enrollable Service Providers at the end of this chapter for complete information. The mental health professional conducting the diagnostic assessment must:

- Address the components listed above;
- Conduct a face-to-face interview with the recipient;
- Conduct a mental status examination describing the recipient's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude toward their symptoms;
- Review pertinent records;
- Consider the recipient's need for referral for psychological testing, psychiatric consultation, a neurological examination, a physical examination, a determination of the effectiveness of prescribed drugs, and a chemical dependency assessment. The mental health professional must refer the recipient to a psychiatrist for a psychiatric consultation.
or medication evaluation if the recipient has not had a psychiatric consultation or medication evaluation within 180 days of the current diagnostic assessment and one or more of the following criteria apply:

- **Adult:** The recipient is given a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder.
- **Child:** The recipient is given a diagnosis of mood disorder, obsessive compulsive disorder, psychosis, clinical depression, or risk of harming self or others as a result of emotional disturbance;

The recipient’s treatment plan includes the use of medication or residential treatment;

The mental health professional must refer the recipient given a diagnosis of attention deficit hyperactivity disorder (ADHD) or undifferentiated attention deficit disorder to a psychiatrist or a physician who is competent to prescribe and monitor the effects of psychoactive medication for a pediatric population with ADHD or undifferentiated attention deficit disorder; or

- **Adult or Child:** The mental health professional conducting the diagnostic assessment must specify, in the recipient's record, the consideration of biological factors which may be contributing to the recipient's mental illness or emotional disturbance and the recipient's referral or the reason why the referral was not made.

**Limitations of Diagnostic Assessment:** Limitations apply whether all components of the diagnostic assessment are provided by one mental health professional, more than one mental health professional, or in a multiple provider setting.

- A provider may receive MHCP payment for only one diagnostic assessment per recipient per calendar year unless:
  - The recipient's mental health status has changed markedly since the most recent diagnostic assessment by the same provider; or,
  - The provider conducting the diagnostic assessment, after referring the recipient to a psychiatrist for a psychiatric consultation, needs to revise the recipient's diagnostic assessment as a result of the report of the psychiatric consultation. The reason for the referral must be documented in the recipient's record.

- MHCP will not cover more than four diagnostic assessments per recipient per calendar year.

- A recipient may choose another provider for a diagnostic assessment, but the MHCP limitation of four diagnostic assessments per recipient per calendar year still applies.

- Diagnostic assessments are limited to two hours per assessment, unless the recipient meets the requirements for extension of time (see "Extension of Time" section).
• The mental health professional conducting the diagnostic assessment must complete the assessment no later than the second meeting between the recipient and the mental health professional providing the recipient's psychotherapy. The activities necessary to complete a recipient's diagnostic assessment may be spread out over more than one day, but the date of service on the claim must be the date the diagnostic assessment was completed.

• MHCP will not cover a diagnostic assessment provided on the same day the recipient participates in a psychotherapy session unless the psychotherapy session is necessary because of an emergency, or the psychotherapy session is the one session permitted prior to the determination of mental illness.

• The written evaluation of a diagnostic assessment provided by a mental health professional in a multiple provider setting (e.g., outpatient hospital, group practice, or CMHC) must be available to other providers in the same setting who provide mental health services to the same recipient.

• MHCP will only cover a neurological examination, psychiatric consultation, physical examination, determination of the need for prescribed drugs, evaluation of the effectiveness of prescribed drugs, and psychological testing in conjunction with a diagnostic assessment if billed as separate procedures.

• If the mental health professional who conducts the diagnostic assessment is not the provider who referred the recipient or the provider conducting psychotherapy, the provider conducting the diagnostic assessment must request the recipient to authorize release of information to the provider who referred the recipient and the provider conducting psychotherapy. The provider conducting the diagnostic assessment must inform the recipient that any mental health professional who provides mental health services to the recipient will need access to the diagnostic assessment in order to develop an ITP and receive payment from MHCP.

Extension of Time to Complete a Diagnostic Assessment: The two-hour time limit for completing the diagnostic assessment does not apply if the recipient meets the criteria for an extension of time. If criteria are met, MHCP will cover a diagnostic assessment up to eight hours in length. The provider conducting the diagnostic assessment must document the circumstances requiring extended time in the recipient's record.

In order to meet the criteria for an extension of time, the recipient must have a diagnosis of mental illness and at least one of the conditions from each list:

List 1:

• Mental retardation or related condition;
• Hearing impairment;
• Speech and language impairment;
• A child whose case record documents severe oppositional behavior, exhibits severe oppositional behavior during the diagnostic assessment, and has not had a diagnostic assessment in the past; or
• A child whose mental illness results in behavior which unreasonably interferes with the provider's ability to conduct the diagnostic assessment and whose case record documents the behavior.

List 2:

• An extension of time for an initial diagnostic assessment is necessary to develop the recipient's ITP;
• An extension of time for an initial diagnostic assessment has been authorized by the recipient's case manager; or
• An extension of time for a substantial revision of the recipient's ITP is necessary due to important changes in the recipient's behavior or living arrangement.

Redetermination of Diagnostic Assessment: A diagnostic assessment that results in a diagnosis of mental illness or emotional disturbance is the criteria used to determine a recipient's eligibility for mental health services. The diagnostic assessment of a recipient who is receiving mental health services, other than case management, must be reviewed once every 12 months to determine whether the recipient continues to have a diagnosis of mental illness or emotional disturbance. If the recipient's mental health status has changed markedly since the most recent diagnostic assessment, a new diagnostic assessment must be completed. Only updating is necessary if the recipient's mental health status has not changed markedly since the recipient's most recent diagnostic assessment. Updating involves a written summary by a mental health professional of the recipient's current mental health status and service needs.

Medication Management

Medication management is the prescription, use, and review of psychotropic medication with no more than minimal psychotherapy. Medication management is a service to determine a client's need for a prescribed drug, or to evaluate the effectiveness of a drug prescribed in a client's ITP. MHCP covers medication management provided by a physician or a clinical nurse specialist who qualifies as a mental health professional. A registered nurse may provide medication management under the supervision of a physician. The registered nurse must qualify as a mental health practitioner and be employed by or under contract with the physician providing clinical supervision. MHCP covers medication management with the following limitations:

• 52 sessions per recipient per calendar year; and
• No more than one session per week per recipient (six days between each session).

To bill for a client who is not taking a psychotropic medication, select the appropriate CPT code for "evaluation and management services, office, or other outpatient services" that reflects the level of service provided.

Medication Management billing information
90862 CPT medication (pharmacological) management: Use this code to bill medication management services as defined in the CPT manual and provided by a physician or CNS-MH.
- If other medical services are provided in addition to medication management (except psychotherapy), use an appropriate evaluation and management billing code (e.g. 99213, 99214, 99215).
- If psychotherapy is provided in addition to medication management, use the appropriate psychotherapy with evaluation and management billing code (e.g. 90805, 90807, 90809).

M0064 HCPCS medication monitoring/management: Use this code when a physician or CNS-MH conducts a brief office visit for sole purpose of monitoring or changing drug prescriptions used in treatment of mental, psychoneurotic, and personality disorders. The office visit is generally less than 10 minutes. This code should be used for a lesser level of service (than 90862) such as a simple dosage adjustment.
- If the physician or CNS-MH provides services in addition to the medication monitoring, use evaluation and management billing code 99212.
- M0064 and 90862 may not be billed on the same day for the same recipient
- If other medical services are provided in addition to medication monitoring/management (except psychotherapy), use an appropriate evaluation and management billing code (e.g. 99213, 99214, 99215).

99211 CPT Evaluation and Management: Use this code to bill for medication management services provided by a registered nurse (not a CNS-MH). The use of this code does NOT require a modifier.

Psychotherapy

Psychotherapy is a planned and structured face-to-face treatment of a recipient’s mental illness through the psychological, psychiatric, or interpersonal method most appropriate to the needs of the client and in conformity with current community standards of mental health practice. The treatment is based on a diagnosis of mental illness resulting from a diagnostic assessment and is directed to accomplish measurable goals and objectives specified in the client's ITP. A psychotherapy session may consist of one of the following types:

Individual Psychotherapy: Psychotherapy designed for one client. MHCP covers a combined total of 26 hours of the following individual psychotherapy services per recipient per calendar year. See the service charts at the end of this chapter for specific authorization thresholds.

Hypnotherapy: Psychotherapeutic treatment through hypnosis, induced by a mental health professional trained in hypnotherapy. (Bill as a component of individual psychotherapy).

Biofeedback Training: Designed to assist a client to regulate a bodily function controlled by the autonomic nervous system, such as heartbeat or blood pressure, by using an instrument to monitor the function and signal the changes in the function. Biofeedback training service hours count toward the 26-hour individual psychotherapy threshold.
Family Psychotherapy: Designed for the client and one or more persons whose participation is necessary to accomplish the client's treatment goal, such as persons related to the client by blood, marriage, or adoption; or the client's foster parents, primary caregiver, or significant other. Facility staff members at the client's residence are not considered as persons whose participation is necessary to accomplish the client's treatment goals.

MHCP covers two types of family psychotherapy: With the recipient present or without the recipient present. If the mental health professional believes the recipient's absence from the family psychotherapy session is necessary to accomplish the treatment goal in the ITP, the mental health professional must document the reason for and the length of time the recipient was absent. The mental health professional must also document the reason(s) a member of the recipient's family is excluded.

The treatment plan for family psychotherapy must identify treatment goals for one individual recipient showing needed family participation and should not include treatment goals for multiple family members unless they relate directly to the treatment of the individual recipient.

MHCP payment for family psychotherapy is per psychotherapy session, regardless of MHCP eligibility status or the number of family members who participate in the family psychotherapy session. Providers may only submit claims for the recipient who is the primary subject of the family psychotherapy session regardless of the number of other family members. When more than one family member is also a recipient (e.g. two or three siblings, each receiving treatment within a specific timeframe), bill for each recipient only for the time spent conducting psychotherapy for that recipient. MHCP covers 26 hours of family psychotherapy per recipient per calendar year for adults and for children.

Group Psychotherapy: MHCP covers two group sizes of group psychotherapy:

- Psychotherapy provided by one mental health professional for more than three, but no more than eight clients; and
- Psychotherapy provided by two mental health professionals for at least nine, but no more than 12 clients, who because of the nature of their emotional, behavioral, or social dysfunction can derive mutual benefit from interaction in a group setting.

The group size applies regardless of the participants' eligibility for MHCP. When a recipient participates in a group psychotherapy session conducted by two mental health professionals, the recipient's record must document that co-therapy is medically necessary. MHCP covers a combined total of 78 hours per recipient per calendar year of group psychotherapy and group psychotherapy for crisis intervention. Documentation must show how the group psychotherapy session applied to the recipient’s treatment goals.

Group Psychotherapy for Crisis Intervention: Designed for a recipient who is experiencing acute social, interpersonal, or environmental stress that threatens the recipient's current level of adjustment or causes significant subjective distress. MHCP covers group psychotherapy for crisis intervention on a daily basis with the following limitations:
- Group psychotherapy must be necessary to meet the recipient's crisis;
- At least three, but no more than nine, clients must participate, regardless of the participants' eligibility for MHCP; and
- For each crisis episode, up to three hours per week within a period of two calendar weeks is covered per recipient, unless authorization is obtained for additional hours per week.

**Multiple Family Group Psychotherapy**: Designed for at least three, but no more than five families. MHCP payment is limited to one session of up to two hours per week for no more than 10 weeks.

**Interactive Psychotherapy Procedures**

Distinct diagnostic and medical psychotherapeutic procedures using physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the physician and client who has lost, or has not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the mental health professional if he/she were to use ordinary adult language for communication. Interactive psychotherapy is typically furnished to children. MHCP covers the following interactive procedures:

- Interactive diagnostic assessment;
- Interactive individual psychotherapy; and
- Interactive group psychotherapy.

These services count towards the same coverage and authorization limits as a regular diagnostic assessment, individual psychotherapy session, and group psychotherapy session.

**Explanation of Findings**

Explanation of findings is the analysis and explanation of a diagnostic assessment, psychological test, treatment program, consultation with special mental health consultants, or other accumulated data and recommendations to the client's family, primary caregiver, or other responsible persons (e.g., case manager, health care providers, qualified mental retardation professional, child protection worker, vulnerable adult worker, guardian, local education agency representatives, school, or community corrections agency). The following MHCP coverage limitations apply:

- Limited to four hours per recipient per calendar year;
- No more than one hour may be billed for the date of service unless the recipient meets the criteria for an extended diagnostic assessment;
- If criteria for an extended diagnostic assessment exist, the provider may allocate the calendar year total of four hours in any manner necessary. MHCP covers the actual time spent, or four hours, whichever is less; and
  - The mental health professional providing the service must obtain authorization to release recipient information from the recipient or guardian.
Refer to the list of excluded services in this chapter regarding explanation of findings.

**Psychological Testing**

Psychological tests and other psychometric instruments are used to determine the status of the client's mental, intellectual, and emotional functioning. DHS does not publish or maintain a list of covered tests. Typically, these would be tests received in Buros' "Mental Assessments Handbook," most recent edition. Tests must meet psychological standards for reliability and validity. Tests must also be suitable for the diagnostic purposes for which they are employed. The following components of psychological testing are all-inclusive and cannot be billed separately:

- A face-to-face interview to validate the test;
- Administration;
- Scoring the psychological test(s);
- Interpretation of results; and
- A written report documenting results of the test(s).

Psychological testing must be conducted by a licensed psychologist with competence in psychological testing as reported to the Board of Psychology. The administration and scoring of the test may be provided, under clinical supervision of a licensed psychologist, by a psychometrist, psychological assistant, or as part of a computer assisted psychological testing program. The face-to-face interview and interpretation of test results must be conducted by the licensed psychologist. The report must be signed by the licensed psychologist who conducted the face-to-face interview and placed in the recipient's record. For tests that are scored by machine or computer, report the time it would take to score the test manually. The report must be released, upon authorization from the recipient or guardian, to other persons responsible for providing services for the recipient.

When billing on the paper CMS-1500 claim form, the name of the psychological test performed must be entered in box 19. When billing electronically using the MN-ITS Professional claim, enter the test name(s) on the Claim Tab, Claim Notes field. Abbreviate the name(s) of the test(s) if necessary.

For MMPIs that are computer scored and interpreted, a face-to-face interview is required and the psychologist must document his/her opinion as to the validity of the test results.

**Neuropsychological Services**

Neuropsychological assessment, neuropsychological rehabilitation, and neuropsychological case/team consultation services must be conducted by an enrolled licensed psychologist approved by Provider Enrollment to bill for these services under DHS criteria for provider eligibility. Provider eligibility for payment of these clinical neuropsychology services requires a diplomate in clinical neuropsychology from the American Board of Clinical Neuropsychology (ABCN) or the American Board of Professional Psychology (ABPP). MHCP providers must
send a copy of their diplomate to Provider Enrollment with a cover letter requesting approval to bill for these services.

For neuropsychological assessment, the provider must have declared a competency in neuropsychological rehabilitative services or a closely related competency to the Board of Psychology. Provider Enrollment will notify providers in writing if approved to bill for these services.

**Neuropsychological Assessment:** Psychological assessment procedures (e.g., testing, clinical interview) integrated with data from medical records are used to determine a client's level of cognitive, emotional, and behavioral functioning as it relates to the organic integrity of the brain following an injury or disease. The services must be authorized. The following components of neuropsychological testing and assessment are all-inclusive and cannot be billed separately:

- Face-to-face interview;
- Administration;
- Scoring the test(s);
- Interpretation of results; and
- A written report documenting results of the test(s).

The following neuropsychological services require authorization:

**Neuropsychological Rehabilitation:** Skills based interventions provided to a client with a current (within 180 days) diagnosis of neurological disorder resulting in cerebral dysfunction. Neuropsychological rehabilitation identifies the internal and external restrictions of the client's cognitive, emotional, behavioral, and social impairments. Providers use this information to design and implement a rehabilitation program to help the client to either restore neuropsychological abilities, or to acquire and use compensatory methods to improve post injury adjustment and adaptive living skills. The interventions must be authorized. MHCP covers neuropsychological rehabilitation training with the following limitations:

- May be conducted on a one-on-one basis, or a group modality; and
- With authorization, an eligible recipient may receive up to 20 hours of individual neuropsychological rehabilitation, and up to 78 hours of group neuropsychological rehabilitation per calendar year.

**Cognitive Remediation Training:** Skills based interventions provided to a client with a current (within 180 days) diagnosis of neurological disorder resulting in cerebral dysfunction. Cognitive remediation training identifies the internal and external restrictions of the client's cognitive, emotional, behavioral, and social impairments. Providers use this information to design and implement a rehabilitation program to help the client to either restore neuropsychological abilities, or to acquire and use compensatory methods to improve post injury adjustment and adaptive living skills. The interventions must be authorized and provided by a doctoral prepared clinical neuropsychologist or a multidisciplinary rehabilitation team under the clinical supervision of a doctoral prepared clinical neuropsychologist. In addition to a recent diagnostic assessment, the recommendation for cognitive remediation training must be supported by the
results of a recently conducted neuropsychological assessment. MHCP covers cognitive remediation training with the following limitations:

- Must be provided by a specialized cognitive remediation training program located in an outpatient hospital, a comprehensive outpatient rehabilitation facility (CORF), or a rehabilitation agency;
- May be conducted on a one-on-one basis (for one to three clients), or a group modality (for four to nine clients);
- An eligible recipient may receive up to four hours per day and 390 hours per calendar year; and
- Documentation of cognitive remediation training services may be provided on a daily basis, by use of a checklist of available therapies in which the recipient participated and on a weekly basis, by summary of the information required in the recipient's record.

**Mental Health Provider Travel Time**

Medicaid covers provider travel time if a recipient’s ITP requires provision of mental health services outside of the provider’s normal place of business. This does not include travel time that is included in other billable services, and is covered only when the mental health service being provided to a recipient is covered under Medicaid. Refer to Bulletin #02-53-09 for additional information.

**Mental Health Targeted Case Management**

Mental health targeted case management (MH-TCM) services assist eligible MA recipients to gain access to needed medical, social, educational, and financial services.

**Eligible Recipients**

MA recipients with a determination of serious and persistent mental illness (SPMI) or a child with severe emotional disturbance (SED) are eligible to receive MH-TCM. For recipients who have not been given a diagnostic assessment or the diagnostic assessment is older than 180 days, a new one must be obtained within 10 days after receiving the referral for MH-TCM services.

MHCP payment may be available without a current diagnostic assessment when all of the following criteria are met:

- The recipient is referred for and accepts case management services;
- At the time of referral, the recipient refuses to obtain a diagnostic assessment for reasons related to his/her mental illness or a child's parent refuses to obtain a diagnostic assessment for the child;
- The case manager determines the recipient is eligible for MH-TCM services; and
- The recipient obtains a new or updated diagnostic assessment, resulting in SED or SPMI, within four months of the first day MH-TCM services began.
A recipient's eligibility for MH-TCM services must be determined every 36 months by the county or Minnesota tribes. Continued eligibility is based on an updated or new diagnostic assessment resulting in SED or SPMI. A new diagnostic assessment is required only when the recipient's mental health status has changed markedly from the most recent diagnostic assessment.

A recipient may be referred for MH-TCM services to the county or the tribe by the following:

- A physician or mental health provider with consent from the recipient;
- A family member;
- A social worker employed by or under contract with the county;
- A legal representative;
- Other interested persons with or without consent of the recipient; or
- Self-referral.

For information about billing for recipients receiving MH-TCM outside the county of responsibility refer to Provider Update 139.

MH-TCM Providers

County or multi-county agencies authorized under the laws of Minnesota as responsible for determining eligibility for MA and for administering a program of social services for children. Additionally, County or multi-county agencies and Minnesota Tribes are responsible for determining eligibility for MH-TCM services. The determination must be based on a diagnostic assessment resulting in a determination of SED or SPMI.

The county or tribe may choose to provide MH-TCM services directly or contract with an appropriate entity to perform MH-TCM services on behalf of the county or tribe.

MH-TCM services for children may be provided by an entity meeting program standards set out in Minnesota statutes governing FCSS as defined in the Children’s Mental Health Act. Providers must submit a copy of the relevant sections of a contract with the county to provide FCSS and receive approval from Provider Enrollment.

A case management service provider can be either a case manager or a case manager associate. Case manager supervisors must also meet the criteria for mental health professionals. Additional information on MH-TCM provided by IHS or 638 facilities is in Bulletin #02-53-03.

For a detailed description of case manager and case manager associate qualification, supervision and clinical supervision, continuing education and mentoring requirements, refer to Bulletin #01-53-02.

Documentation of Case Management Service Activity

The case manager uses the diagnostic assessment as the basis for the functional assessment and the individual community support plan.
Functional Assessment: Mental health symptoms and needs, use of drugs or alcohol, vocational and educational functioning, social functioning and use of leisure time, self-care and independent living capacity, interpersonal functioning and family relationships, medical and dental health, need for financial assistance, current living conditions and housing needs, and other needs.

Individual Community Support Plan: A written plan of action for meeting the needs of the recipient, developed by the recipient and the case manager. A child's plan includes activities involving the child's family or primary caregiver. This plan is coordinated with the ITP.

MH-TCM Reimbursement

- To receive payment for an eligible child under age 18, the provider must document at least one face-to-face contact with the child, the child's parents, or the child's legal representative during each month of service.
- To receive payment for an eligible adult age 18 and older, the provider must document:
  - At least one face-to-face contact with the adult or the adult's legal representative during each month of service; or
  - At least one telephone contact with the adult or the adult's legal representative each month and document one face-to-face contact with the adult or the adult's legal representative within the preceding two months.

Payment to an IHS or 638 facility is based on a face-to-face encounter.

MH-TCM Limitations

If a recipient is in a residential facility or hospital which is funded by MA (Nursing Facility [NF], Intermediate Care Facility for persons with Mental Retardation or Related Conditions [ICF-MR], or Inpatient Hospital), federal policy continues to limit MHCP payment for MH-TCM to:

- The last 180 days before discharge; and
- Those activities that do not duplicate the discharge planning commonly provided by the facility or hospital.

Coordination of Services

- Recipients with a diagnosis of mental retardation or a related condition and mental illness or a determination of SED will be assigned a case manager for persons with mental retardation. If MH-TCM services are also requested, the case managers must work together to ensure the recipient receives necessary services.
- Recipients assessed as chemically dependent and diagnosed as mentally ill or determined to have SED must have their MH-TCM services coordinated with similar services by the case manager.
Children’s Mental Health Residential Treatment Services

Eligible Recipients

This benefit is available for all MA and MinnesotaCare eligible children placed in residential treatment by counties for whom the service is medically necessary. The children must:

- Be screened by the county before placement in these facilities in accordance with MS 245.4885. The screening must establish whether the proposed treatment:
  - Is necessary;
  - Is appropriate to the child’s individual treatment needs;
  - Cannot be effectively provided in the community; and
  - Provides a length of stay as short as possible consistent with the individual child’s need.

- Be appropriate for this level of care.
- Meet the criteria for severe emotional disturbance.

Eligible Providers

Eligible providers include those licensed by the state of Minnesota and providing children’s mental health residential treatment services under Minnesota Rule 9545.0905 to 9545.1125. The facilities must be under contract with a lead county to provide children’s mental health residential treatment.

Covered Service

Children’s mental health residential treatment is a 24-hour-a-day program under the clinical supervision of a mental health professional, in a community setting, other than an acute care hospital or regional treatment center inpatient unit.

For additional information regarding eligible recipients and submitting claims see Bulletin #01-73-01. Current per diem rates are published quarterly in DHS bulletins.

Rehabilitative Mental Health Services

Day Treatment

Day treatment is a structured program consisting of group psychotherapy and other intensive therapeutic services provided by a multidisciplinary team. Day treatment providers must submit an application and receive written approval from Provider Enrollment. Day treatment services stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal is to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. Day treatment services are not part
of inpatient or residential treatment services. The treatment must be provided to a group of recipients by a multidisciplinary team, under the clinical supervision of a mental health professional.

**Place of Service:** Day treatment has different place of service requirements for children and adults.

- **Child or Adult:**
  - A licensed outpatient hospital accredited by the Joint Commission on the Accreditation of Hospitals;
  - A CMHC; or
  - An entity under contract with the county to operate a program meeting requirements under Minnesota law.

- **Adult Only:**

  Day treatment for adults may additionally be provided in community-based locations to meet the therapeutic needs of the client. (Similar services to day treatment exist for children that allow service provision in non-facility based settings, such as HBMHS, TSFC, and FCSS).

**Limitations:** MHCP also has different coverage limitations for children and adults.

- **Child:**
  - MHCP coverage is limited to 390 hours in a calendar year, unless authorization is obtained for additional hours within the same calendar year;
  - MHCP payment is limited to 15 hours per week;
  - The program must be available at least one day a week for a minimum of three contact hours;
  - MHCP payment is limited to three hours per day per recipient;
  - The three contact hours must include at least one hour, but no more than two hours of individual or group psychotherapy;
  - The three contact hours may be divided into flexible time segments according to the recipient's needs;
  - The remainder of the three contact hours may consist of recreation, socialization, and independent living skills therapy, only if included in the recipient's ITP;
  - Documentation of day treatment may be provided on a daily basis, by use of a checklist of available therapies in which the recipient participated and on a weekly basis, by summary of the information required in the recipient record; and
  - One additional individual or family psychotherapy session per week may be appropriate for a child under age 21 receiving day treatment.
• **Adult:**

MHCP covers day treatment for adults with the following limitations:

- MHCP coverage is limited to 115 hours in 365 days, unless authorization is obtained for additional hours within the same 365 day time period;
- MHCP payment is limited to 15 hours per week;
- Providers will be able to flexibly design service delivery to their clients based upon the needs identified in the diagnostic assessment and ITP; and
- One additional half-hour session of individual psychotherapy per week may be appropriate for an adult receiving day treatment services.

DHS requires day treatment providers to adopt a standard for clinical supervision.

For children receiving day treatment, the program must follow clinical supervision standards as stated for mental health services in this chapter.

For adults receiving day treatment, the program may follow clinical supervision standards as stated previously for all other mental health services, or as defined for children’s HBMHS, or as provided under Rule 29 (Minnesota Rules 9520.0800, subp. 2 to 6). An adult day treatment program must demonstrate compliance with these clinical supervision requirements by obtaining certification from the commissioner under Minnesota Rules 9520.0750 to 9520.0870 (Rule 29) or by documenting in its own records that it complies with one of the above methods.

For an explanation of the Rule 29 supervision standard, visit the following web site: [http://www.revisor.leg.state.mn.us/arule/9520/0800.html](http://www.revisor.leg.state.mn.us/arule/9520/0800.html)

**Partial Hospitalization**

Partial hospitalization is a time limited, structured program of psychotherapy and other therapeutic services as defined by Medicare and provided in an outpatient hospital facility or CMHC that meets Medicare requirements to provide partial hospitalization programs (PHP) services. The goal of PHP is to resolve or stabilize an acute episode of mental illness. Partial hospitalization consists of multiple and intensive therapeutic services provided by a multidisciplinary staff to treat the client's mental illness. Examples of services: individual, group, and family psychotherapy services; individualized activity therapies; and patient training and education.

**Recipients**

A PHP is an appropriate alternative or adjunct to inpatient hospitalization for a recipient who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission and has appropriate family or community resources needed to support the recipient's
residence in the community. A PHP may be an appropriate “step-down” placement for recipients being discharged from an inpatient mental health stay. For inpatient psychiatric admission guidelines, see chapter 13: http://www.dhs.state.mn.us/provider/manual/ch13_ipaiguide.htm).

**Providers**

Providers of partial hospitalization services must be either an enrolled outpatient hospital or a CMHC enrolled in Medicare and certified in accordance with MS 256B.0625, subd. 5, and submit proof of Medicare certification to the department. Refer to Bulletin #03-53-02, Attachment D for additional information. Providers must follow Medicare guidelines for PHP content, physician certification requirements, and documentation.

To be eligible for MHCP payment, a partial hospitalization program must have submitted the appropriate documentation and received a letter of approval from Provider Enrollment.

The treatment must be provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. Partial hospitalization services include, at a minimum, one session of psychotherapy and at least two other services (e.g. activity therapy and patient training). To be effective, PHP services are usually provided at least 5 to 6 hours per day for an adult, 4 to 5 hours per day for a child. It is this level of intensity that partly defines partial hospitalization.

To be consistent with Medicare standards, follow these recommendations in providing PHP services:
- 5 to 6 hours per day for an adult age 18 or over,
- 4 to 5 hours per day for a child under age 18,
- at least 4 days but not more than 5, out of 7 (calendar) days
- a minimum or 20 service components in a week (7 calendar days)

**Authorization Requirements**

Recipients are admitted to a partial hospitalization program based on a physician referral. For services provided on or after August 6, 2003, the following authorization requirements apply:

- A recipient may receive up to 21 calendar days of PHP services without authorization. Authorization must be requested and approved by CDMI to receive reimbursement for services provided after the 21st day following admission.
- *A reduction of intensity to fewer than the minimum required hours must be medically necessary and approved by CDMI, Inc.* Authorization is required to provide fewer than three hours of service per day for a child under age 18 or fewer than five hours per day for an adult age 18 and over. There may be rare circumstance when a recipient requires fewer or reduced services on a given day such as when a recipient is unable to tolerate a full day.
- Payment is limited to six hours per day with no authorization bypass.
- Within a course of treatment, authorization is required for service dates beginning the 22nd day following admission. Note: Medicare guidelines require physician recertification by the 18th day.
• Authorization is required for readmission to a PHP within 45 days of a previous discharge. Most individuals will not experience a second acute episode of mental illness within 45 days of discharge from a PHP. However, if a recipient requires readmission within 45 days of discharge, the provider must support the medical necessity of the readmission as an appropriate treatment with thorough documentation.

Note: Providers must accurately complete the patient status information on the claim. Incorrectly indicating a discharge instead of continuing service will subject the claim to denial. See billing instructions (may be obtained from provider enrollment).

PHP and Other Services

Therapy outside the PHP is reimbursed only for physician services, medication management, and physician visits to a recipient in a PHP.
• Bill these visits using "Evaluation and Management (E&M) services, office or other outpatient services" and assure that the appropriate level of service is selected that reflects the care provided.
• Bill the service with place of service code "22," indicating it was performed in the outpatient hospital department or “53” indicating it was performed in the CMHC.
• If the purpose of the visit is to provide psychotherapy only or hybrid psychotherapy/E&M services, the appropriate psychotherapy code should be used instead (e.g., 90816 through 90829). The use of psychotherapy codes requires compliance with the authorization requirements discussed in chapter 16.

Children’s Rehabilitative Mental Health Services

MA covered children’s rehabilitative mental health services:
• HBMHS (billed with modifier YA),
• FCSS (billed with modifier YD), and
• TSFC (billed with modifier YB)

Eligible Recipients

MHCP recipients under age 21 who are eligible for Child and Teen Checkups (C&TC) and have a determination of having SED or SPMI based on a recently completed or updated diagnostic assessment (180 days) are eligible to receive rehabilitative mental health services if they are deemed necessary and appropriate services on the ITP.

Eligible Providers

2003 legislation authorized the DHS to develop and implement a provider entity application and certification process for MHCP providers of FCSS, HBMHS, and TSFC. Effective 7/1/03, the Children’s Therapeutic Services and Supports application and certification process replaces the
county contracting requirements for MHCP FCSS, HBMHS and TSFC providers. Refer to Bulletin #03-53-04 for information on transition period and legislative changes.

The following three documents were developed about the CTSS application and certification process:

- **Children’s Therapeutic Services and Supports Provider Certification Process** explains what must be done by a provider submitting an application, by the agency reviewing (county or state) the submitted application and recommending certification, and by the Minnesota Department of Human Services (DHS) certifying the provider entity. It also gives an overview of the timelines for primary and local certification to become an enrolled Minnesota Health Care Programs provider of children’s mental health rehabilitation services;

- **Children’s Therapeutic Services and Supports Provider Entity Application Guideline** guides the provider through the application and the reviewing agency through the evaluation of the submitted materials;

- **Children’s Therapeutic Services and Supports Provider Entity Primary Certification Application** requests information about the provider’s administrative and clinical infrastructure, and service delivery system. It also includes assurance statements a provider entity must sign.

These documents are located on the DHS web site in the Children’s Mental Health section at www.dhs.state.mn.us/CFS/programs/childmentalhealth/.

The psychotherapy components of rehabilitative mental health services must be provided by mental health professionals. The skills training components of rehabilitative mental health services can be provided by mental health professionals or mental health practitioners.

A provider who employs mental health practitioners to provide HBMHS, FCSS, or TSFC must require the practitioners to participate in continuing education. The continuing education must be related to serving the needs of children with SED and the child's family in the child's residence. The topics covered in orientation and training must conform to Minnesota Rules 9535.4068 (informally known as DHS Rule 15). The provider must document completion of the required continuing education on an annual basis. For HBMHS, mental health practitioners must complete 15 hours of continuing education per calendar year. For FCSS & TSFC, mental health practitioners must complete 20 hours of continuing education per calendar year.

**Clinical Supervision**

Mental health practitioners who have a consulting relationship with a mental health professional may provide skills training components of HBMHS, FCSS, TSFC and crisis assessment services if the following supervision requirements are met:

- The clinical supervisor, who is a mental health professional enrolled in MHCP, must accept full professional responsibility.
- The clinical supervisor must be present on-site at least for one observation during the first 12 hours in which the practitioner provides services.
- After the first 12 hours, the clinical supervisor is required to be present on-site for observation as clinically appropriate.
• The observation must be a minimum of one clinical unit for HBMHS and one clinical hour for FCSS and TSFC.
• The on-site observation must be documented in the child's record and signed by the mental health professional.

**Place of Service**

Rehabilitative mental health services are provided primarily in the child's residence. Services may also be provided in the child's school, the home of a relative or natural parent, recreational setting, or the child's day care. Residence does not include a group home, regional treatment facility, regional treatment center or other institutional group setting, an acute care hospital, or a foster family home in which the foster parent is not the primary caregiver and does not reside with the child.

**Coordination of Benefits**

Mental health professionals and practitioners providing rehabilitative mental health services to a child who has a developmental disability, substance abuse problem, or physical condition requiring regular medical care, must ensure coordination of the child's care with multiple agencies.

Mental health professionals and practitioners providing TSFC must work with other providers rendering health services to the child and foster family. Providers should ensure coordination and nonduplication of services consistent with county board coordination procedures.

**Children's Home Based Mental Health Services (HBMHS)**

**Eligible Providers**

In addition to county board or a provider under contract to a county board, an outpatient hospital, CMHC, an entity approved by the commissioner as specified in Minnesota Rules 9520.0750 to 9520.0870 and a children's mental health collaborative may provide HBMHS directly or contract with an entity to provide HBMHS.

A provider under contract to the county board to provide rehabilitative mental health services must provide the required services and may not contract for the services with another party. The providers who render the services must be employees of the entity under contract with the county board.

*Refer to 2003 Legislative changes to Eligible Providers.

**HBMHS Provider Responsibilities**

To be eligible for MHCP payment, HBMHS providers must meet the following requirements:

• The services must be provided by mental health professionals and practitioners who are skilled in the delivery of mental health services to children with SED and foster families, where applicable.
• The services must be designed to meet specific mental health needs of the child and the child's family according to the child's ITP. The county board or provider under contract to the county board must ensure the mental health professional develop, sign, and periodically review the ITP for necessity and appropriateness of care.
• The provider must assist the child or the child's family in arranging crisis services. Crisis services must be available 24 hours per day, seven days per week.
• The HBMHS provider's caseload must be of reasonable size to enable the provider to meet the needs of the children and their families.
• The services must be coordinated with the child's case manager if the child is receiving case management services.

Covered Services

HBMHS are available to a child under age 18 who has a determination of having a SED or an adult between the ages of 18 and 21 who has a determination of a SPMI who has been referred for HBMHS. HBMHS are a culturally appropriate, structured program of intensive mental health services provided to a child who is at risk of out-of-home placement because of an event or condition which intensifies the child's SED, or who is returning from out-of-home placement because of the SED. The purpose of the services are to resolve an acute episode of emotional disturbance affecting the child or the child's family, in order to reduce the risk of out-of-home placement or to reunify and reintegrate the child into the family after an out-of-home placement.

Components

A provider of HBMHS must be capable of providing all of the components listed for that service. However, a provider is responsible to provide a component only if it is specified in the child's ITP. The components are:

• Diagnostic assessment;
• Individual psychotherapy, family psychotherapy, and multiple family group psychotherapy;
• Individual, family, or group skills training designed to improve the basic functioning of the child with SED and the child's family in the activities of daily and community living, and to improve the social functioning of the child and the child's family in areas important to the child's maintaining or reestablishing residency in the community (residence, work, school, or peer group). Individual, family, and group skills training must:
  ▪ Consist of activities designed to promote skill development of both the child and the child's family in the use of age appropriate daily living skills, interpersonal and family relationships, and leisure and recreational services;
  ▪ Consist of activities which assist the family to improve the family's understanding of normal child development and to use parenting skills that will help the child achieve the goals outlined in the child's ITP;
  ▪ Promote family preservation and unification, promote the family's integration with the community, and reduce the use of unnecessary out-of-home placement or
institutionalization of the child.

- Travel by a mental health professional or practitioner to and from the site where services are provided to an eligible child and family, if applicable.

**Thresholds:**

- Up to 192 hours of individual, family, or group skills training within a six-month period.
- No more than a combined total of 48 hours within a six month period of individual, family, or multiple family group psychotherapy;
- No more than a combined total of 240 hours within a six month period of psychotherapies and skills training;
- Up to 128 hours of travel per recipient within a six month period;
- Up to 60 hours of day treatment within a six month period provided concurrently with HBMHS if the child is being phased out of day treatment and into HBMHS or vice versa;
- One session of individual psychotherapy per month for the child or one session of family psychotherapy per month for the child's family while the child is receiving HBMHS if the mental professional providing HBMHS anticipates the child or child's family will need outpatient psychotherapy upon completion of HBMHS. The mental health professionals must work together to facilitate the child's transition from HBMHS services to outpatient psychotherapy; and
- Up to 35 hours of services provided to a child within a six-month period who is residing in a hospital, group home, residential treatment facility, regional treatment center, or who is participating in a partial hospitalization program if the services are coordinated with the ITP and the discharging planning team to ensure a smooth transition to the child's residence.

Authorization is required only when services provided for a recipient are in a pattern that deviates from MHCP recommended practice patterns, coverage or thresholds.

**Children's Family Community Support Services (FCSS)**

**Eligible Providers***

A county board or a provider under contract to a county board is an eligible provider of rehabilitative mental health services. The county board or contracted provider may employee individuals or teams as providers.

Individual providers include mental health professional, mental health practitioner, mental health behavioral aide. Individual providers are part of a mobile crisis response team, preschool program multi-disciplinary team and therapeutic camp program multi-disciplinary team.*Refer to 2003 Legislative changes to Eligible Providers.

**Mental health behavioral aides** are paraprofessional working under the direction of mental health professionals or mental health practitioners (under the clinical supervision of a mental health professionals) to implement the mental health services identified in a child’s ITP and individual behavior plan.
A Level I mental health behavioral aide must:

- be at least 18 years of age;
- have a high school diploma or general equivalency diploma (GED) or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and
- meet orientation and training requirements.

A Level II mental health behavioral aide must:

- be at least 18 years of age;
- have an associate or bachelor’s degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents; and
- meet orientation and training requirements.

**Mobile Crisis Response Team** providing mental health mobile crisis intervention and stabilization under FCSS:

- must be at least two mental health professionals, or at least one mental health professional and a mental health practitioner, under the clinical supervision of the mental health professional;
- is experienced in mental health assessment, mobile crisis intervention techniques and clinical decision making under emergency conditions; and
- provides on-site, intensive face-to-face, short-term mental health services.

**Preschool program multi-disciplinary team** must include at least one mental health professional and one or more of the following under the clinical supervision of a mental health professional on the team:

- a mental health practitioner, or
- a program person (teacher, assistant teacher or aide who meets the qualifications and training standards of a Level 1 mental health behavioral aide).

**Therapeutic camp program multi-disciplinary team** includes:

- at least one program staff person meeting the qualification and training standards of a Level 1 mental health behavioral aide and under the direction of a mental health professional, and
- at least one mental health professional, or one mental health practitioner under the clinical supervision of a mental health professional.

**FCSS Provider Responsibilities:** To be eligible for MHCP payment, FCSS must meet the following requirements:
• The services must be provided by mental health professionals and practitioners who are skilled in the delivery of mental health services to children with SED and foster families, where applicable.

• The services must be designed to meet specific mental health needs of the child and the child's family according to the child's ITP. The county board or provider under contract to the county board must ensure the mental health professional develop, sign, and periodically review the ITP for necessity and appropriateness of care. The ITP must become a subsection of the individual family community support plan.

• The provider must assist the child or the child's family in arranging crisis services. Crisis services must be available 24 hours per day, seven days per week. Crisis assistance services for a child receiving these services through FCSS must be coordinated with emergency services.

• The services must be coordinated with the child's case manager if the child is receiving case management services. If the child does not have a case manager or refuses case management services, the county board or provider under contract to the county board must ensure coordination of FCSS components.

• FCSS providers must be able to recruit mental health professionals and practitioners, have adequate administrative ability to ensure availability of services, and must ensure adequate preservice and in-service training.

• The county board or provider under contract to the county board must ensure FCSS are given in a manner consistent with the core values in Child Adolescent Service System Program (CASSP), "A System of Care for Severely Emotionally Disturbed Children and Youth."

• In addition to the responsibilities listed above, a provider that offers services provided by a mental health behavioral aide must: recruit, train and supervise the aide as specified in Minnesota Rule 9505.0323, subp. 5a and 8; conduct a background study of each potential candidate for mental health behavioral aide position that includes a search of information from the criminal justice data communications network in any state where the subject of the study has resided; not hire the mental health behavioral aide candidate if the candidate’s background information meets the disqualification conditions under MS 245A.04, subd. 3d.

• In addition to the responsibilities listed above, a provider that offers mental health mobile crisis intervention and crisis stabilization services must ensure that the services are available 24 hour a day, seven days a week.

MHBA Training and Continuing Education Requirements

A FCSS provider who employs mental health behavioral aides must require the MHBA to complete 30 hours of pre-service training. Topics covered during pre-service training include those specified in Minnesota Rules 9535.4068, subpart 1 and 2, and parent teaming training.

The pre-service training must include 15 hours of face-to-face training in mental health services delivery and 8 hours of parent teaming training. Components of parent teaming training include partnering with parents; fundamentals of family support; fundamentals of policy and decision making; defining equal partnership; complexities of parent and service provider partnership in
multiple service delivery systems due to system strengths and weaknesses; sibling impacts; support networks; and community resources.

Mental health behavioral aides must receive 20 hours of continuing education every two calendar years. Topics covered include those specified in Minnesota Rules 9535.4068, subp. 2. The continuing education must be related to serving the needs of children with severe emotional disturbance and the child’s family in the child’s home environment.

NOTE: Refer to Bulletin #02-53-06 for information about parent teaming.

**Components:** A provider of FCSS must be capable of providing all of the components listed for that service. However, a provider is responsible to provide a component only if it is specified in the child's ITP. The components are:

- Diagnostic assessment;
- Individual, family, or group skills training designed to improve the basic functioning of the child with SED and the child's family in the activities of daily and community living, and to improve the social functioning of the child and the child's family in areas important to the child's maintaining or reestablishing residency in the community (residence, work, school, or peer group).
- Crisis assistance services;
- Mental health behavioral aide;
- Mental health mobile crisis intervention and stabilization;
- Therapeutic components of preschool program;
- Therapeutic components of therapeutic camp programs; and,
- Travel time by a mental health professional, practitioner or mental health behavioral aide to and from the site where services are provided to an eligible child and family, if applicable.

Additional information about travel time is referenced in Bulletin #02-53-09.

**Component Description: Level I or Level II Mental Health Behavioral Aide Services**

Medically necessary services provided by mental health behavioral aides are designed to improve the functioning of the child and support the family in activities of daily and community living. Delivery of services must be documented by mental health behavioral aide via written progress notes and must implement goals in the treatment plan for the child’s severe emotional disturbance that allow the child to replace inappropriate skills with developmentally and therapeutically appropriate daily living skills, social skills, leisure and recreational skills. Targeted activities may include:

- Assisting the child as needed with skill development in dressing, eating, and toileting.
- Assisting, monitoring and guiding the child to complete tasks, including facilitating the child’s participation in medical appointments.
- Observing and intervening to redirect inappropriate behavior.
• Assisting the child in using age appropriate self-management skills as related to the child’s emotional disorder or mental illness, including problem solving, decision making, communication, conflict resolution, anger management, social skills, and recreational skills.
• Implementing de-escalation techniques as recommended by the mental health professional.
• Implementing any other mental health service that the mental health professional has approved as being within the scope of the behavioral aide’s duties.
• Assisting the parents to develop and use parenting skills that help the child achieve the goals outlined in the child’s ITP or individual behavioral plan.

Services must be provided in the child’s residence, pre-school, school, day care, and other community or recreational setting. “Residence” does not include residential treatment setting licensed under Minnesota Rules 9545.0900 to 9545.1090 (informally known as DHS RULE 5), a group home licensed under Minnesota Rules 9545.1400 to 9545.1480 (informally known as DHS Rule 8), a regional treatment facility, an acute care hospital or a foster care setting in which the license holder is not the primary caregiver and does not reside with the child.

**ITP for MHBA Services**

In addition to normal ITP development practices the following actions must be completed.

• Mental health professionals must approve the services provided by mental health behavioral aides in the ITP.

• When developing the child’s ITP, mental health professionals or mental health practitioners must collaborate with the child’s family through parent teaming to consider the needs of the child and the child’s family to determine the scope, duration, and frequency of services required for the child and child’s family.

• In developing the ITP, mental health professionals or mental health practitioners must assess the complexity of the tasks mental health behavioral aides will deliver in order to determine which level of mental health behavioral aide is most appropriate in delivering the required services and the number of hours of service.

• In the event a Level II mental health behavioral aide is required to provide the services but is unavailable, documentation must be made in the ITP to reflect the need for additional instruction of a Level I mental health behavioral aide.

**Individual Behavior Plan (IBP) for MHBA Services**

The IBP is to provide specific instructions to the MHBA in delivery of service and to outline the responsibilities of the MHBA in assisting the child to achieve treatment outcomes.
Mental health professionals must approve the services in the individual behavior plan before they are provided by mental health behavioral aides. The individual behavior plan must include:

- detailed instructions on the service to be provided;
- time allocated to each service;
- methods of documenting the child’s behavior;
- methods of monitoring the progress of the child in reaching objectives; and
- goals to increase or decrease targeted behavior as identified in the ITP.

**Direction of MHBA**

Direction refers to the activities of mental health professionals, or mental health practitioners under the supervision of a mental health professional, to guide the work of MHBAs. Direction is based on the ITP. The practitioner or professional giving direction begins with the goals of the ITP, and instructs the MHBA in how to construct therapeutic activities and interventions that will lead to goal attainment. The person giving direction also instructs the MHBA about diagnosis, functional status, and other characteristics of the client that are likely to affect service delivery. Direction must also include determining that the MHBA has the skills to interact with clients and their families in ways which convey personal and cultural respect, and that the MHBA activity solicits information relevant to treatment from the family while being able to clearly explain the activities s/he is doing with the client and their relationship to treatment goals. Direction is more didactic than supervision and requires the practitioner or professional providing it to continuously evaluate the MHBA’s ability to carry out the activities of the ITP/IBP.

Direction of mental health behavioral aides includes all of the following:

- one total hour of on-site observation by a mental health professional during the first twelve hours of service provided to a child;
- ongoing on-site observation by a mental health professional or mental health practitioner for at least one total hour every forty hours of service provided to a child; and
- immediate accessibility of the mental health professional or the mental health practitioner to the mental health behavioral aide during service provision.

When providing direction, mental health professionals or mental health practitioners must:

- review progress notes prepared by mental health behavioral aides for accuracy and consistency with diagnostic assessment, treatment plan and behavior goals. Progress notes must be approved and signed by mental health professionals or mental health practitioners;
• identify changes in treatment strategies, revise the individual behavior plan and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

• demonstrate family friendly behaviors that support healthy collaboration among child, child’s family and providers as treatment is planned and implemented;

• ensure that mental health behavioral aides are able to effectively communicate with the child, child’s family and the provider; and

• record the results of any evaluation and corrective actions taken to modify the work of mental health behavioral aides.

Additional direction may be provided if a MHBA requires more frequent instruction to carry out the therapeutic activities identified in the ITP and IBP. There is no authorization threshold for direction at this time.

MHBA Responsibilities

• implement mental health services identified in the ITP and individual behavior plan;

• write progress notes;

• demonstrate family friendly behaviors that support healthy collaboration among child, child’s family and providers as treatment is planned and implemented;

• communicate effectively with the child, child’s family, mental health practitioner and mental health professional; and

• complete pre-services and continuing education requirements.

Component Description: Children’s Mental Health Mobile Crisis Intervention and Crisis Stabilization

Children’s mental health mobile crisis intervention and crisis stabilization services are intensive face-to-face, short-term mental health services initiated during a crisis to help the child return to the child’s baseline level of functioning. This service is provided on-site by a mobile crisis response team outside of urgent care, inpatient or outpatient hospital settings.

Prior to initiating on-site intervention by the mobile crisis response team, an initial assessment of the crisis must be made using the resources of the crisis assistance or emergency services as defined in MS 245.4871. The following components must be performed as part of mental health mobile crisis intervention and crisis stabilization services:
• Immediate intervention to provide relief of distress based upon a determination that the child’s behavior is a serious deviation from the child’s baseline level of functioning.

• Culturally appropriate assessment evaluating the child’s current life situation and sources of stress, the child’s current mental health problems, strengths and vulnerabilities, and the child’s current functioning and symptoms.

• A written, short-term mobile crisis intervention plan within 72 hours of the initial intervention. The purpose of the short-term mobile crisis intervention plan is to describe mental health services needed by the child to reduce or eliminate the crisis. The team must involve the child and child’s family in developing and implementing the plan.

• If the child shows positive change toward restoration to a baseline level of functioning or decrease in personal distress, the team must document that treatment goals have been met and that no further services are required; or

• If the child is stabilized but requires less than eight hours of mental health mobile crisis intervention services or a referral to a less intensive mental health services such as other FCSS, the team must document the referral sources, treatment goals, need for the services, and the types of the service to be provided.

• A written long-term intervention plan if more than eight hours of crisis intervention services are needed. The team must involve the child and child’s family in developing and implementing the plan. The purpose of the long-term intervention plan is to identify strategies to reduce symptomology of emotional disturbance or mental illness contributing to the crisis; coordinate linkage and referrals to community mental health resources; prevent placement in a more restrictive setting. The team must document the referral sources, treatment goals, need for the services, and the types of the services to be provided.

If the child and family refuse to approve the plan, the team must note their refusal to approve the plan and the reason(s) for refusal.

**Mobile crisis team billing:** More than one staff person can bill for services when providing crisis intervention services as a mobile crisis response team. When more than one team member needs to be on-site to provide the intervention, each team member providing face-face services may bill. If one team member is off-site and works with a team member who is on-site, Crisis Intervention, may be billed, as appropriate, by the team member who is off-site for the time spent working directly with the on-site member.

**Component Description: Therapeutic Components of Preschool Program**

A structured program of treatment and care for, a child who is at least 33 months of age but who has not yet attended the first day of kindergarten, that includes mental health services provided in a preschool program by a multidisciplinary staff under the clinical supervision of a mental health professional. The intent of this service is to provide early intervention services. Early
intervention will identify the needs and strengths of the child and family, this will assist in focusing on education and training goals to develop skills and strategies in reducing and resolving the symptomology of the child’s emotional disturbance.

Pre-school Program Definition

A pre-school program is defined as a day program licensed under Minnesota Rules 9503.0005 to 9503.0175 that is enrolled as a FCSS provider and provides mental health services to a child who is at least 33 months old but who has not yet attended the first day of kindergarten.

Therapeutic Components of a Pre-School Program

The therapeutic components of a pre-school program must be available at least one day a week for a minimum two-hour time block. The program may be longer than two hours per day but MA payment is limited to two hours of treatment per day. The two-hour time block may include individual or group psychotherapy and to the extent they are included in the child’s ITP any of the following or combination of the following developmentally and therapeutically appropriate activities: recreation therapy, socialization therapy, and independent living skills therapy.

The team may recommend and coordinate community service resources and multiple service delivery systems such as county social services, school, the children’s mental health collaborative, child protection and corrections.

Documentation Requirements

Daily documentation of treatment must include a checklist of available therapies in which the child participated. Weekly documentation must include a summary of measurable goals and progress in meeting the treatment plan.

Direction

As different levels of service provision may be required for this service a multidisciplinary team may include a program staff person who meets the qualification and training standards of a Level I MHBA. Direction of the program staff person by the mental health professional must meet the requirements in Minnesota Rules 9505.0326, subp. 5a (F). (see requirements under Direction of MHBA)

Component Description: Therapeutic Components of a Therapeutic Camp Program

A short-term structured program of treatment and care that includes mental health services provided by a multidisciplinary staff under the clinical supervision of a mental health professional.
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Therapeutic Camp Program Definition

A structured recreational program of treatment and care provided by an enrolled FCSS provider that:

- is licensed as a day program under Minnesota Rules 9503.0005 to 9503.0175;
- is accredited as a camp by the American Camping Association; or
- meets the criteria of a day program under Minnesota Rules 9503.0005 to 9503.0175 except it operates no more than 30 days in any 12-month period.

Therapeutic Components of a Therapeutic Camp Program

Medical Assistance payment for therapeutic components of a therapeutic camp program is limited to 20 hours of treatment in any calendar year. The 20-hour time block may include individual or group psychotherapy, and to the extent they are included in the child’s ITP any of the following or combination of the following developmentally and therapeutically appropriate activities: 1) recreation therapy, 2) socialization therapy, and 3) independent living skills therapy. Daily documentation of treatment must include a checklist of available therapies in which the child participated, and weekly documentation must include a summary of measurable goals including the child’s progress in meeting the objectives of the treatment plan.

Direction of Program Staff

Direction of the program staff person by the mental health professional must meet the requirements of Minnesota Rules 9505.0326, subp. 5a(F). The team may recommend and coordinate community service resources and multiple service delivery systems such as county social services, school, the children’s mental health collaborative, child protection and corrections.

Thresholds:

- Up to 68 hours of individual, family, or group skills training within any six month period, and not more than 68 hours in a calendar year;
- Up to 24 hours of crisis assistance within any six month period, and not more than 24 hours in a calendar year (except in the case of an emergency);
- Up to a combined total of 92 hours of skills training and crisis assistance services within any six month period, and not more than 92 hours in a calendar year;
- Up to 40 hours of travel per recipient in any six month period, and not more than 40 hours in a calendar year; and
- Up to 60 hours of day treatment within a six-month period provided concurrently with FCSS if the child is being phased out of day treatment and into FCSS or vice versa.
- 100 hours of Level I and Level II MHBA services within any six month period, and not more than 100 hours in a calendar year;
- 192 hour of crisis intervention and crisis stabilization services within a calendar year;
• 72 hours of therapeutic components of a pre-school program in a calendar year.

Authorization is required only when services provided for a recipient are in a pattern that deviates from MHCP recommended practice patterns, coverage or thresholds.

**Children’s Therapeutic Support of Foster Care (TSFC)**

**Eligible Providers**

A county board or a provider under contract to a county board is an eligible provider of rehabilitative mental health services. *Refer to 2003 Legislative changes to Eligible Providers.*

**Covered Services:** TSFC services are available to a foster family that provides foster care to a child with SED and needs services to provide a therapeutic family environment or support for the child's improved functioning. The diagnostic assessment may be a service provided under C&TC. TSFC is a set of intensive treatment services for foster families to enable a child to improve or maintain emotional or behavioral functioning in order to reduce or prevent the reliance upon more intensive, restrictive, and costly services, or to reunify and reintegrate the child with the child's family after out-of-home placement.

**TSFC Provider Responsibilities:** To be eligible for MHCP payment, TSFC must meet the following requirements:

- The services must be provided by mental health professionals and practitioners who are skilled in the delivery of mental health services to children with SED and foster families, where applicable.
- The services must be designed to meet specific mental health needs of the child and the child's family according to the child's ITP. The county board or provider under contract to the county board must ensure the mental health professional develop, sign, and periodically review the ITP for necessity and appropriateness of care. The ITP must become a subsection of the individual family community support plan.
- The services must be designed to meet the mental health needs of the child and the child's foster family. The mental health professional and practitioners must work with the foster family and the child's other services to develop the ITP and train and support the foster family through the child's stay as long as deemed necessary in the ITP. The foster family and, unless clinically inappropriate, the child must participate in all of the treatment planning for the child. The ITP must be reviewed at least every three months to ensure treatment goals continue to be necessary and appropriate.
- The provider must assist the child or the child's family in arranging crisis services. Crisis services must be available 24 hours per day, seven days per week.
- The caseload of the mental health practitioner providing TSFC must not exceed eight children. The number of foster children in the foster family receiving TSFC must not exceed two without DHS approval.
- The services must be coordinated with the child's case manager if the child is receiving case management services.
• TSFC providers must submit a letter to Provider Enrollment prior to rendering services ensuring adequate capacity to recruit and train mental health professionals and practitioners with a copy of the county board contract, if applicable.
• The county board or provider under contract to the county board must ensure TSFC services are rendered in a manner consistent with core values in "Program Standards for Treatment of Foster Care."

**Components:** A provider of TSFC must be capable of providing all of the components listed for that service. However, a provider is responsible to provide a component only if it is specified in the child's ITP. The components are:

- Diagnostic assessment;
- Individual psychotherapy, family psychotherapy, group psychotherapy, and multiple group psychotherapy;
- Individual, family, or group skills training designed to improve the basic functioning of the child with SED and the child's family in the activities of daily and community living, and to improve the social functioning of the child and the child's family in areas important to the child's maintaining or reestablishing residency in the community (residence, work, school, or peer group). For TSFC, the individual, family, and group skills training must: be designed to enhance the therapeutic family environment by assisting foster families to improve their understanding of normal child development and the nature of the foster child's SED; train foster families in interventions designed to meet the special and individual needs of the child; educate foster families regarding the availability of support networks; and facilitate integration and reunification goals through visitation and other activities; and
- Travel by a mental health professional or practitioner to and from the site where services are provided to an eligible child and family, if applicable.

**Thresholds:**

- Up to 192 hours of individual, family, or group skills training within a six month period, and not more than 192 hours in a calendar year;
- A combined total of up to 48 hours of individual, family, or multiple family group psychotherapy within a six month period, and not more than 48 hours in a calendar year;
- A combined total of up to 240 hours of psychotherapy and skills training within a six month period, and not more than 240 hours in a calendar year;
- Up to 128 hours of travel per recipient in any six month period, and not more than 128 hours in a calendar year;
- Up to 60 hours of day treatment within a six month period provided concurrently with TSFC if the child is being phased out of day treatment and into TSFC or vice versa; and
- One additional session of individual psychotherapy per month for the child or one session of family psychotherapy per month for the child's family while the child is receiving TSFC if the mental health professional providing TSFC anticipates the child or child's family will need outpatient psychotherapy upon completion of TSFC. The mental health professionals must work together to facilitate the child's transition from TSFC services to outpatient psychotherapy.
Authorization is required only when services provided for a recipient are in a pattern that deviates from MHCP recommended practice patterns, coverage or thresholds.

**Adult Rehabilitative Mental Health Services (ARMHS)**

MA covers ARMHS as defined in MS 256B.0623, subd. 2, if provided to eligible recipients and provided by a qualified provider entity meeting the standards in MS 256B.0623, subd. 4, and by a qualified individual provider working within the provider's scope of practice and identified in the recipient's ITP, and determined to be medically necessary according to MS 62Q.53.

ARMHS: Rehabilitative mental health services that enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness.

ARMHS are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

- ARMHS instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living services. Basic living and social skills is a separately billable service as defined below.
- These services may be provided to a recipient on a one-to-one basis in the recipient's home or another community setting or in groups.

**Medication education services:** Services provided individually or in groups that educate a recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses. Medication education is a separately billable service as defined below.

**Transition to community living services:** Services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services may be billed as Social and Living Skills or Community Intervention, as appropriate.

**Covered ARMHS Services**

The above terms are further defined for MA coverage. ARMHS consist of three billable components:
• Basic Living and Social Skills
• Community Intervention
• Medication Education

Providers

With the exception of Medication Education, ARMHS may be provided by mental health professionals, mental health practitioners, or mental health rehabilitation workers. Medication Education services may be provided by physicians, pharmacists, physician’s assistants, or registered nurses. Provider and staff qualifications are defined later in this section. In addition to mental health professionals as defined under Outpatient Mental Health Services, the following provider type is considered a mental health professional when providing or supervising ARMHS services:

• Certified Mental Health Rehabilitation Counselor or Psychosocial Rehabilitation Practitioner – a rehabilitation counselor or psychosocial rehabilitation practitioner who holds a valid nationally recognized certification and meets all standards established in the Adult Mental Health Act, MS 245.462, subd. 18 (6)* and is employed by or contracted with a MHCP certified adult mental health rehabilitation agency. This individual is not eligible to bill MHCP for conducting diagnostic assessments and may not refer recipients to the adult mental health rehabilitation agency but may otherwise provide mental health professional services and supervision of adult mental health rehabilitative services to adults within the agency. (provider type 26)

* holds a master’s degree from an accredited college or university in a behavior science or related field and has at least 4000 hours of supervised post-master’s experience in the delivery of clinical services for the treatment of mental illness.

Settings

ARMHS are provided for most recipients in a recipient's home or community. Services may be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules 9520.0500 to 9520.0670 (Rule 36), or an acute care hospital.

With the exception of Community Intervention, ARMHS may be provided in group settings if appropriate to each participating recipient's needs and treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient who is concurrently receiving a service identified in this section. The service and group must be specified in the recipient's treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.
Basic Living and Social Skills

ARMHS Basic Living and Social Skills are activities that restore a recipient’s skills essential for managing his or her illness, treatment, and the requirements of everyday independent living. Basic living and social skills may be provided to maintain a recipient’s functioning if the recipient is likely to regress significantly or is at significant risk to lose independent living. These skills need to be restored to prevent recipients from requiring inpatient or residential placement or to live independently in the community. Basic Living and Social Skills instruct, assist, and support a recipient in areas such as:

- interpersonal communication skills
- community resource utilization and integration skills
- crisis assistance
- relapse prevention skills
- health care directives
- budgeting and shopping skills
- healthy lifestyle skills and practices
- cooking and nutrition skills
- transportation skills
- medication monitoring
- mental illness symptom management skills
- household management skills
- employment-related skills
- transition to community living

Community Intervention

Community Intervention is provided with the intent to alleviate or reduce a recipient’s barriers to community integration or independent living or to minimize the risk of hospitalization or other more restrictive living arrangement.

Community Intervention is conducted on behalf of a recipient and must be directed exclusively to the treatment of the recipient.

Community Intervention may be conducted with an agency, an institution, an employer, a landlord, or the recipient’s family with or without the presence of the recipient. These services may include the involvement of a recipient’s relatives, guardians, friends, employers, landlord, treatment providers, and other significant people, in order to change situations and allow the recipient to function more independently.

Community Intervention is provided on an individual basis only and may be conducted in person or by telephone.

Community Intervention services are NOT the following:

- routine communication between members of a treatment team;
• routine staffings;
• care conferences;
• clinical supervision;
• treatment plan development; or
• consultation with other professionals.

Medication Education

Medication Education services focus on educating a recipient about mental illness and symptoms, the role and effects of medications in treating symptoms of mental illness, and the side effects of medications. This service must be coordinated with, but not duplicative of, medication management services and may be provided individually or in groups. Medication education consists of activities that instruct recipients, families, and/or significant others in the correct procedures for maintaining a recipient’s prescription medication regimen. The recipient must be present to bill for this service.

If Medication Education is provided in a pharmacy setting, the designated area must be apart from the dispensing area. Medication Education is not intended to replace any aspect of dispensing medications. Information provided to a recipient as part of a prescription is an aspect of dispensing medications and is separately reimbursed as part of the dispensing fee under MA. Medication Education may be provided by a pharmacist, physician, physician’s assistant, or registered nurse who is employed by or subcontracted with a certified ARMHS provider. The ARMHS provider entity bills for Medication Education.

ARMHS Recipients Eligibility

An eligible recipient is an individual who:
• is age 18 or older;
• is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which ARMHS are needed;
• has substantial disability and functional impairment in three or more of the areas listed in MS 245.462, subd. 11a, so that self-sufficiency is markedly reduced; and
• has had a recent diagnostic assessment by a qualified professional that documents ARMHS are medically necessary to address identified disability and functional impairments and individual recipient goals.

Until June 30, 2005, a diagnostic assessment completed within the past three years preceding admission to an ARMHS program is acceptable for initial implementation of these services.

Just as for all other mental health services, recipients must have a diagnosis of mental illness (see definition in this chapter) to receive ARMHS services. This includes individuals with other health problems or developmental delays.

Recipient File

Providers of ARMHS must maintain a file for each recipient that contains the following information:
• diagnostic assessment or verification of its location that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;
• functional assessments;
• ITPs signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;
• recipient history;
• signed release forms;
• recipient health information and current medications;
• emergency contacts for the recipient;
• case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;
• contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;
• summary of recipient case reviews by staff; and
• written information by the recipient that the recipient requests be included in the file.

Diagnostic Assessment

The ARMHS provider must complete or obtain a diagnostic assessment as defined in MS 245.462, subd. 9, for each recipient within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. Until July 1, 2005, an agency may obtain a diagnostic assessment conducted by a mental health professional within three years prior to admission. The diagnostic assessment is acceptable if it suggests a recipient's need for community support services, basic living skills, or community integration services; however, each element of the diagnostic assessment must be reviewed by a mental health professional. A written summary of the review should address changes (or no changes) for each element of the diagnostic assessment, state the recipient's current mental health status, indicate whether ARMHS are appropriate services for treating the recipient’s condition, and any other service needs.

If the recipient's mental health status has changed significantly since the most recent diagnostic assessment, a new diagnostic assessment is required. If no diagnostic assessment has been completed within the past three years, then a full diagnostic assessment must be completed.

Functional Assessment

The ARMHS provider must complete a written functional assessment as defined in MS 245.462, subd. 11a, for each recipient. The functional assessment must be completed within 30 days of intake, and reviewed and updated at least every six months after it is developed. If there is a significant change in functioning, the assessment must be updated at that time. A single functional assessment can meet case management and ARMHS requirements if agreed to by the recipient. Unless the recipient refuses, the recipient must have significant participation in the development of the functional assessment.
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ITP

The ARMHS providers must develop and implement an ITP for each recipient.

ITP means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must sign off on the ITP and indicate medical necessity of the goals and/or treatment in the ITP. The ITP must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system.

Providers of ARMHS must develop the ITP within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

The ITP must include:

- a list of problems identified in the assessment;
- the recipient's strengths and resources;
- concrete, measurable goals to be achieved, including time frames for achievement;
- specific objectives directed toward the achievement of each one of the goals;
- documentation of participants in the treatment planning;
- cultural considerations, resources, and needs of the recipient;
- planned frequency and type of services; and
- clear progress notes on outcome of goals.

The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable.

The individual community support plan defined in MS 245.462, subd. 12, may serve as the ITP if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria as listed above.

Eligible ARMHS Provider Entities

Provider entity standards

The provider entity must be a county operated entity certified by the state; or a non-county entity certified by the entity's host county.

The certification process determines whether the entity meets the standards in accordance with MS 256B.0623. The certification must specify which ARMHS the entity is qualified to provide.
If an entity seeks to provide services outside its host county, it must obtain additional certification from each county in which it will provide services. The additional certification is based on the adequacy of the entity's knowledge of that county's local health and human service system, and its ability to coordinate its services with the other services available in that county.

Recertification must occur at least every 3 years.

The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

Providers of ARMHS must comply with the requirements relating to referrals for case management in MS 245.467, subd. 4.

**Treatment Director**

An ARMHS provider entity must have a treatment director who is a mental health practitioner or mental health professional. The treatment director must ensure the following:

- **On Site Visits:**
  - while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by the mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works;
  - the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;
  - progress notes are reviewed from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the ITP and goals;
  - oversee the record of the results of on-site observation and charting evaluation and corrective actions taken to modify the work of the mental health practitioners and mental health rehabilitation workers;
  - the ARMHS provider entity must ensure on-site observations of rehabilitation workers directly delivering services. Either a mental health professional or practitioner may conduct the on-site observation.

  - Newly hired: observed delivering services at least six hours per 40 hours worked during the first 160 hours (FTE Example: one 6 hr day of on-site observation per week for 4 weeks);
  - Ongoing: observed delivering services at least six hours for every six months of employment.
On-site observations must be documented by the mental health practitioner or professional and placed in the ARMHS rehabilitation worker’s personnel file. When a mental health practitioner conducts the on-site observation, the documentation must be reviewed by the treatment director.

• immediate availability by phone or in person for consultation by a mental health professional or a mental health practitioner to the mental health rehabilitation services worker during service provision;
• oversee the identification of changes in individual recipient treatment strategies, revise the plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;
• model service practices which: respect the recipient, include the recipient in planning and implementation of the ITP, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;
• ensure that mental health practitioners and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers.

Personnel File

The ARMHS provider entity must maintain a personnel file on each staff and must contain:

• an annual performance review;
• a summary of on-site service observations and charting review;
• a criminal background check of all direct service staff;
• evidence of academic degree and qualifications;
• a copy of professional license;
• any job performance recognition and disciplinary actions;
• any individual staff written input into own personnel file;
• all clinical supervision provided; and
• documentation of compliance with continuing education requirements.

Provider Staff Qualifications

Individual provider staff must be qualified under one of the following criteria:

• a mental health professional as defined previously in this chapter or:
• a Mental Health Rehabilitation Professional, defined as a person who meets all of the following:
  ▪ holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner,
  ▪ is employed by or contracted with an MHCP certified adult mental health rehabilitation agency, and
  ▪ is qualified under section 245.462, subd. 18, clause (6)*

This individual is not eligible to bill MHCP for conducting diagnostic assessments, or for
providing mental health services except when providing mental health services or
supervising adult mental health rehabilitative services within the agency. (provider type
26)

* holds a master’s degree from an accredited college or university in a behavior science or related field and has at least 4000 hours of supervised post-master’s experience in the delivery of clinical services for the treatment of mental illness.

- **mental health practitioner** under the clinical supervision of a mental health professional as defined in this chapter. Mental health practitioners who provide ARMHS must meet the qualifications for mental health practitioners as described previously in this chapter. For ARMHS, the following clarifications are provided regarding the mental health practitioner's experience requirements:
  - the practitioner's experience must have been supervised, but not necessarily by a mental health professional;
  - the practitioner must have provided mental health services directly to adults with mental illness; and
  - those services must have been community support program services or other services which are defined as mental health services in the Adult Mental Health Act; or

- **a mental health rehabilitation worker.** A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's ITP who:
  - is at least 21 years of age;
  - has a high school diploma or equivalent;
  - has successfully completed 30 hours of training during the past two years in all of the following areas: recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and
  - meets ONE of the qualifications:
    - has an associate of arts degree in one of the behavioral sciences or human services, or is a registered nurse without a bachelor’s degree, or who within the previous ten years has:
      - three years of personal life experience with serious and persistent mental illness;
      - three years of life experience as a primary caregiver to an adult with a serious mental illness or traumatic brain injury; or
      - 4,000 hours of supervised paid work experience in the delivery of mental health services to adults with a serious mental illness or traumatic brain injury.
    OR
    - is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20% of the mental health rehabilitation worker’s clients belong, and:
- receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;
- has 18 hours of documented field supervision by a mental health professional or practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;
- has review and co-signature of charting of recipient contacts during field supervision by a mental health professional or practitioner; and
- has 40 hours of additional continuing education on mental health topics during the first year of employment.

**ARMHS Clinical Supervision**

A mental health professional providing clinical supervision of staff delivering ARMHS must provide the following guidance to mental health practitioners and mental health rehabilitation workers:

- review the information in the recipient's file;
- review and approve initial and updates of ITPs;
- meet individually or in small groups, at least monthly to discuss treatment topics of interest to the workers and practitioners (document in personnel file);
- meet individually or in small groups, at least monthly to discuss treatment plans of recipients, and approve by signature and document in the recipient's file any resulting plan updates (this does not mean that each recipient’s treatment plan must be discussed monthly);
- meet at least twice a month with the directing mental health practitioner, if there is one, to review needs of the ARMHS program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing practitioner (this must be documented);
- be available for urgent consultation as the individual recipient needs or the situation necessitates; and
- provide clinical supervision by full- or part-time mental health professionals employed by or under contract with the provider entity.

**ARMHS Supervision Requirements for a Mental Health Practitioner who is a Treatment Director**

A mental health practitioner who is providing treatment direction for a provider entity must receive supervision at least monthly from a mental health professional to:

- identify and plan for general needs of the recipient population served;
- identify and plan to address provider entity program needs and effectiveness;
- identify and plan provider entity staff training and personnel needs and issues; and
- plan, implement, and evaluate provider entity quality improvement programs.
Continuing Education Requirements

**Mental health practitioners:** must receive ongoing continuing education as required by their professional license; or if not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services.

**Mental health rehabilitation workers:** must receive ongoing continuing education of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served.

Adult Mental Health Crisis Response Services

MA covers adult mental health mobile crisis response services as defined in MS 256B.0624, subd. 2 (c) to (e), when provided to an eligible recipient (see below), by a qualified provider.

**Mental health crisis:** A behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living; an emergency situation; or placement of the recipient in a more restrictive setting including, but not limited to, inpatient hospitalization.

**Mental health emergency:** A behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with MS 62Q.55. A mental health crisis or emergency is determined for MA reimbursement by a physician, a mental health professional, or crisis mental health practitioner.

Initial Screening

Prior to initiating crisis response services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in MS 245.462, subd. 6, for community support programs and 245.469, subd. 1 and 2, for county boards. The screening must gather information, determine whether a possible crisis situation exists, identify parties involved, and determine an appropriate next step, commonly a referral to another resource or a crisis assessment.

If a possible crisis exists, a **crisis assessment**, defined below, must be completed or a more appropriate referral made. Crisis Intervention and Crisis Stabilization services may be provided based on the results of the crisis assessment.

Covered Adult Crisis Response Services

Three adult mental health crisis response services are defined for MA billing:

- Crisis Assessment,
- Mobile Crisis Intervention, and
- Crisis Stabilization services
In addition to the above services, a provider of Adult Mental Health Crisis Response services may also provide and bill for, as appropriate, Community Intervention services. Community Intervention services are defined in the ARMHS section of this chapter and are not otherwise defined here.

Crisis Assessment

A crisis assessment evaluates an immediate presenting situation – any immediate need for which emergency services are needed and, as time permits, the recipient's current life situation, possible risk behaviors, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning. The need for crisis intervention services or referrals to other resources is determined based on the assessment.

The adult mental health crisis assessment is an immediate face-face assessment conducted by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests the adult may be experiencing a mental health crisis or emergency situation.

The mental health crisis assessment may be conducted in a recipient’s home, the home of a family member, or another community location.

Mobile Crisis Intervention Services

When a crisis assessment determines mobile crisis intervention services are needed, they must be provided promptly. As opportunity presents, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on-site providing mobile crisis intervention services.

Adult mental health mobile crisis intervention services are face-face, short-term, intensive mental health services initiated during a mental health crisis or emergency to:

- help a recipient cope with immediate stressors;
- identify and utilize available resources and recipient’s personal strengths;
- lessen the recipient’s suffering;
- develop action plans;
- avoid unnecessary hospitalizations and loss of independent living; and
- return the recipient to his/her baseline level of functioning.

The mobile crisis intervention team must be available to meet promptly, face-face, in a community setting. This service is provided on-site by a mobile team outside of an inpatient hospital setting or nursing facility. Mental health mobile crisis intervention services must be available 24 hours a day, 7 days a week, 365 days per year.

The treatment plan must include recommendations for any needed crisis stabilization services for the recipient. The mobile crisis intervention team must recommend and coordinate the team's services.
with appropriate local resources such as the county social services agency, mental health services, and local law enforcement as necessary.

**Mobile Crisis Intervention Treatment Plan**

The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

The team must document which short-term goals have been met and when no further mobile crisis intervention services are required. If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated, to the extent possible, with the case manager. If providing on-site mobile crisis intervention services, a mental health practitioner must seek consultation and clinical supervision as required. The qualification for the mobile crisis interventions team are described below.

**Mobile crisis team billing**

More than one staff person can bill for services when providing crisis assessment and intervention services as a mobile crisis response team. When more than one team member needs to be on-site to provide the assessment or intervention, each team member providing face-to-face services may bill. If one team member is off-site and works with a team member who is on-site, Crisis Assessment, Crisis Intervention, or Community Intervention may be billed, as appropriate, by the team member who is off-site for the time spent working directly with the on-site member. Community Intervention may also be appropriate if a team member works directly with a family member or significant other while another team member works face-face with a recipient.

**Crisis Stabilization Services**

Adult mental health crisis stabilization services are individualized and designed to restore a recipient to his or her prior functional level. Crisis stabilization services may be provided following mobile crisis intervention services as defined above or as recommended based on crisis assessment intervention service provided in an emergency room or urgent care setting (see definition later in this chapter). Stabilization services may be provided in a recipient's home, the home of a family member or friend, another community setting, or in a short-term supervised, licensed residential program. Crisis stabilization services cannot be provided in hospitals, partial hospitalization or day treatment settings.

Crisis stabilization services must be delivered according to the treatment plan and include a face-to-face contact with the recipient by qualified staff. The staff should consider the need for further assessment, assisting the recipient with referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.
Crisis Stabilization Treatment Plan
A treatment plan must be developed by a mental health professional or practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans and determine medical necessity. The crisis stabilization treatment plan must include, at a minimum:

- A list of problems identified in the assessment;
- A list of the recipient's strengths and resources;
- Concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;
- Specific objectives directed toward the achievement of each goal;
- Documentation of the participants involved in the service planning;
- Planned frequency and type of services initiated including specific providers when applicable;
- A crisis response action plan if a crisis should occur; and
- Clear progress notes on outcome of goals.

The written treatment plan must be completed within 24 hours of beginning services and with the participation of the recipient whenever possible. The recipient or recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian.

Crisis Stabilization Services Provided in a Supervised, Licensed Residential Setting. If crisis stabilization services are provided in a supervised, licensed residential setting, the program must have 24 hour per day residential staffing. The residential staff must have 24 hour per day immediate access, direct or by telephone, to a qualified mental health professional or practitioner. The recipient must be contacted on a face-to-face basis daily by a qualified mental health professional or qualified mental health practitioner.

- **Residential settings up to four adults:** No more than two of the residents are recipients of crisis stabilization services. For at least 8 hours per day, the staff must include at least one individual who meets the crisis stabilization staff qualifications listed below.

- **Residential settings for more than four:** One or more of the residents are recipients of crisis stabilization services. During the first 48 hours a recipient is in the residential program, the program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan. However, at all times during a 24-hour period, at least one of the staff must meet the crisis stabilization staff qualifications below.

An approved crisis stabilization residential provider may receive a per-diem rate of reimbursement for services provided on or after June 1, 2003. Providers must use procedure code H0018 when submitting claims for the per-diem payment.
An individual may receive up to 60 hours of crisis stabilization services or up to 7 days in a residential setting without authorization. Each full day in a crisis stabilization residential setting is the equivalent to 8 hours of non-residential crisis stabilization services. If a recipient experiences an episode of mental health crisis that requires stabilization services beyond 7 days in a residential setting or 60 hours in a non-residential setting, the provider must request authorization from CDMI.

Authorization from CDMI is required for individuals needing crisis stabilization services in a residential setting for longer than 7 days. To receive authorization, providers must submit requests to CDMI in accordance with chapter 5.

Documentation must clearly establish the medical necessity for continued services; that the residential setting is the most appropriate and least costly alternative to other settings; and indicate why the provider anticipates the recipient will respond successfully in the requested time.

**Recipients of Adult Mental Health Crisis Response Service**

A recipient eligible for adult mental health crisis response services is age 18 or older and assessed as experiencing a mental health crisis or emergency. The recipient may receive mental health crisis intervention and stabilization services when determined to be appropriate and medically necessary as the result of the crisis assessment.

**Recipient File**

Providers of crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:

- Individual crisis treatment plans signed by the recipient and the mental health professional or practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;
- Signed release forms;
- Recipient health information and current medications;
- Emergency contacts for the recipient;
- Case records documenting the date and place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;
- Required clinical supervision by mental health professionals;
- Summary of the recipient's case reviews by staff; and
- Any written information by the recipient that the recipient wants in the file.

**Adult Mental Health Crisis Response Provider Standards**

A provider may be either a county board operated entity or an entity under contract with the county board in the county where the potential crisis or emergency is occurring. The provider entity
maintains responsibility for services and billing. A crisis response services provider must meet the standards as defined in MS 256B.0624.

Crisis Assessment, Mobile Crisis Intervention and Crisis Stabilization Staff Qualifications

Mental health professionals or mental health practitioners may provide crisis assessment and mobile crisis intervention services. A mental health professional who provides clinical supervision must be enrolled under MA as required in this chapter. Mental health practitioners must meet ALL of the following clinical supervision requirements:

- the provider entity accepts full responsibility for the services provided;
- the mental health professional (employee or under contract with provider):
  - is immediately available by phone or in person for clinical supervision;
  - is consulted, in person or by phone, during the first three hours when a mental health practitioner provides on-site service;
  - reviews and approves the tentative crisis assessment and crisis treatment plan;
  - documents the consultation; and
  - signs the crisis assessment and treatment plan within the next business day;
- if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-face on the second day to provide services and update the crisis treatment plan; and
- the on-site observation must be documented in the recipient's record and signed by the mental health professional.

Mental health practitioners who provide Adult Mental Health Crisis Response Services must meet the qualifications for mental health practitioners as described previously in this chapter. For purposes of these services, the following clarifications are provided regarding the mental health practitioner's experience requirements:

- the practitioner's experience must have been supervised, however, this supervision does not necessarily have to have been done by a mental health professional;
- the practitioner must have provided mental health services directly to adults with mental illness; and
- the mental health services must have been community support program services or other services defined as mental health services in the Adult Mental Health Act.

Mobile crisis intervention staff qualifications

A mobile crisis intervention team is comprised of at least two mental health professionals, or a combination of at least one mental health professional and one mental health practitioner with the required mental health crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two people with at least one member providing on-site mobile crisis intervention services when needed. Team members must be
experienced in mental health assessment, mobile crisis intervention techniques, and clinical
decision-making under emergency conditions and have knowledge of local services and resources.

Crisis Stabilization Staff Qualifications

Crisis stabilization services must be provided by one of the following qualified individual staff of a
qualified provider entity:

- A mental health professional as defined in this chapter;
- a mental health practitioner under the clinical supervision of a mental health professional as
defined in this chapter and who meet the requirements for crisis assessment and mobile crisis
intervention services; or
- A mental health rehabilitation worker as defined in the ARMHS section of this chapter.

Mental health practitioners and mental health rehabilitation workers must have completed at least 30
hours of training in mobile crisis intervention and stabilization during the past two years.

The Following Sections Apply to Both ARMHS and Adult Crisis Response
Services:

- Documentation of Face to Face Contacts and Client-related Activity
- Billing When Services Are Provided By Qualified State Staff
- Background Checks
- Excluded Services

Documentation of Face-to-Face Contacts and Client-related Activity

As with all mental health services, documentation must meet MA standards in order to be billable to
MHCP. Refer to Requirements for Providers (Ch. 1). Providers must be alert to the need to
document all mental health services in accordance with MA standards. Failure to document
appropriately may result in the recovery of MA payments.

- Case notes (progress notes) that record the recipient contact should identify who was seen,
  for how long, and what was accomplished. NOTE: Billable activity must be linked to
  recipient’s treatment plan.

As described in the Definitions section of this chapter, at least 75 percent of each unit of billable
time must be spent in face-to-face contact conducting mental health services. Up to 25 percent may
be spent on documentation and other client-related activities. Because of the community-based
nature of providing ARMHS and Crisis Response Services, providers need to be very careful in
applying this definition to ARMHS. If face-to-face and client-related activities cannot be done
within a contiguous span of time, the client-related activity must be justifiable, documented and
clearly essential to providing the face-to-face service. The 75 percent / 25 percent rule was written
when the typical practice pattern involved a single hour of therapy in a given day. If a client receives
more than an hour of face-to-face time in a day, the time needed for client-related activities should NOT increase in the same proportion.

Except for services that are appropriately billable as Community Intervention, client-related activity is NOT separately billable.

**Billing when Services are Provided by Qualified State Staff**

When Adult Crisis Response Services or ARMHS are provided by qualified state staff who are assigned to adult mental health initiatives under MS 245.4661, the county or other local entity to which the state staff are assigned may be considered part of the certified local provider entity and bill MHCP for qualifying services. Notwithstanding MS 256.025, subd. 2, payments for ARMHS services provided by state staff shall only be made from federal funds.

**Background Checks**

The “rehab option” statute (MS 256B.0623, subd. 7) requires each personnel file to contain a criminal background check of all direct service staff, but it does not specify what must in the background check, or what the provider can or cannot do if they find problems. Although there appears to be room for local discretion as to what is included in the background check, providers risk liability for lawsuits from abused clients if their check is unreasonably narrow, or if they hire people who have had a history of problems.

MS 148 requires all employers of "psychotherapists" to conduct a background check "concerning the occurrence of sexual contacts by the psychotherapist with patients or former patients of the psychotherapist." Providers need to review the extent to which each rehab worker's job description includes counseling to determine whether this statute applies to a rehab worker.

ARMHS providers may want to consider their county's adult foster care procedures as a model that could be applied to these services.

**Excluded Services**

The following services are excluded from reimbursement as ARMHS or as adult crisis response services:

- recipient transportation services;
- a service provided and billed by a provider not enrolled to provide either or both ARMHS or Adult Crisis Response Services;
- ARMHS or crisis response services performed by volunteers;
- provider performance of household tasks, chores, or related activities, such as laundering clothes, moving the recipient's household, housekeeping, and grocery shopping for the recipient;
- direct billing of time spent "on call" when not delivering services to recipients;
- activities which are primarily social or recreational in nature, rather than rehabilitative, for the individual recipient, as determined by the individual's needs and treatment plan;
• job-specific skills services, such as on-the-job training;
• provider service time included in case management reimbursement;
• outreach services to potential recipients;
• a mental health service that is not medically necessary;
• any ARMHS services provided by a hospital, board and lodging, or residential facility to an individual who is a patient in or resident of that facility; and
• room and board services.

In addition to the above, the following services are excluded from reimbursement as crisis response services:

• Services delivered to a recipient while admitted to an inpatient hospital or nursing facility.

**Crisis Assessment Intervention**

Crisis assessment and intervention provided by a mental health professional in a hospital emergency room or urgent care outpatient hospital setting must include the following:

• Observation and clinical assessment of the recipient's mental health status and level of care required to stabilize the psychiatric condition;
• Assessment of the family and community resources and supports available to the recipient upon discharge;
• Intervention to assist the recipient to improve coping and problem solving abilities; and
• Assessment of the recipient's mental health status and recommendations for both the immediate and the follow-up psychiatric and mental health services needed by the recipient.

**Limitations**

• A maximum of six units (one unit equals 15 minutes) during a continuous 24 hour block of time for assessment, reassessment, intervention, and discharge care while the recipient is seen in the emergency room, urgent care, and/ or when occupying a mental health observation bed;
• For recipients placed in observation beds and not subsequently admitted to the same hospital, two additional units may be billed for discharge assessment;
• Crisis assessment intervention services provided in the hospital emergency room may be billed by the hospital or the mental health professional, depending on the arrangement between the two parties;
• Crisis assessment intervention services provided by a psychiatrist or other attending physician may be billed for the service using the appropriate Evaluation and Management codes, the Emergency Department Service codes, or the crisis assessment intervention code as appropriate to the service rendered; and
• Services provided by mental health practitioners employed by the hospital are included in the outpatient hospital facility fee.
Physician Services and Mental Health Services Under Physicians’ Orders

Visits to a Recipient in an Inpatient Mental Health Unit

Physician visits to a recipient who is an inpatient in an inpatient hospital mental health unit are covered services. Visits should be billed using HCPCS Level I CPT codes for "Evaluation and Management Services, Inpatient Hospital Services." The appropriate level of service should be selected that reflects the care provided. The service should be billed with a place of service "21," indicating it was performed in the inpatient hospital.

Outpatient and Inpatient Case Management Services

If the physician is responsible for the direct inpatient or outpatient care to a recipient and provides services to coordinate and control access to, or initiate and/or supervise other health care services needed by the recipient, the physician is able to bill for those services. The services must be billed using the HCPCS Level I CPT codes for "Evaluation and Management Services, Case Management Services- Team Conference." These services may be billed in conjunction with outpatient or inpatient visits as long as the services are not for a concurrent time period.

Physician-Only Mental Health Services

In addition to the mental health services discussed in the other sections of this chapter, the following types of mental health services (primarily Evaluation and Management services) are limited exclusively to physicians.

Service Name/Description
- Office or other outpatient services;
- Hospital observation services;
- Hospital inpatient services;
- Consultation services;
- Emergency department services; and
- Case management services (this is not mental health-targeted case management).

Hospital Inpatient Services

Use the following guidelines to select the appropriate Evaluation and Management Code (E&M) range, or "908" series code to report inpatient services:
- If the psychiatrist is the admitting physician, use the 99221 series for the initial hospital care visit. Only one physician (e.g., the admitting physician) is eligible to bill using the initial hospital care codes. A preliminary diagnosis and a plan of care are reimbursed as part of this code range.
- If the patient is seen by a medical physician for a physical examination as part of the admission process, a subsequent hospital care code (99231 series) should be used to bill for the physical exam.
- If the psychiatrist requests an opinion or advice regarding psychiatric management of the patient in relation to the patient's general health status, the medical physician may bill a
consultation code (99251 series). If the second physician is asked to assume responsibility for managing the patient's non-psychiatric medical care subsequent to the initial inpatient hospital consultation, the second physician should use the subsequent care series (99231) to bill for the medical management of the patient during the course of the patient's psychiatric hospitalization.

- MHCP will not pay for an E/M series service and a "908" series service (e.g., 99221 and 90819) or two 908 series services on the same day by the same physician. MHCP will reimburse the psychiatrist (only) for individual psychotherapy in the inpatient setting (90816 through 90829), subject to the following limits: (1) MHCP will not reimburse both a "908" series and an E/M series code on the same day; (2) MHCP will not reimburse more than one "908" series code on the same day. Generally speaking, the use of the "908" series inpatient psychotherapy codes (90816 through 90829) should be reserved for those situations in which the psychiatrist is (or will be) providing outpatient psychotherapy services to the patient. The outpatient benefit will not be tied to utilization of the 908 series psychotherapy codes by the psychiatrist in the inpatient setting.

**Hospital Visits Under Physician Order**

MHCP will reimburse a psychologist for psychological interventions provided to a recipient hospitalized as an inpatient in a medical bed with a physician order for the psychological intervention. Use CPT codes 90816 – 90829 to bill for these services.

When billing for hospital visits under a physician's order, the place of service must be "21," inpatient hospital, in box 24B on the CMS-1500 claim form. The mental health professional who provides the service under physician order must bill for it using his/her own individual MHCP provider number. Refer to Billing Policy (Ch. 4) for further billing instructions.

**Consultations Under Physician Order by Mental Health Professionals Who are Not Psychiatrists**

A behavioral assessment provided under physician order by a mental health professional (LP, LPP, LICSW, or CNS-MH only) for a recipient who is hospitalized as an inpatient in a medical bed (e.g., on a non-psychiatric unit) or receiving medical services in an outpatient setting that are not mental health services, may be billed using CPT codes 96150-96154. Refer to the CPT code definition. Bill these codes when the physician requests information concerning the patient's psychological status or for follow-up services, but the consultation does not constitute a full mental health diagnostic assessment.

**Authorization Requirements**

Authorization is required when a recipient is receiving outpatient mental health services, day treatment, partial hospitalization, crisis assessment, crisis response services, mental health targeted case management, or rehabilitative mental health services in a pattern that deviates from MHCP recommended practice patterns, coverage and limitations. For a list of mental health services that allow the authorization thresholds to be exceeded, refer to the December 15, 2003 Minnesota State Register (page 780). Refer to Authorization (ch. 5) for instructions to request authorization. Refer to Provider Update #102 for information about the Children’s Mental Health...
Rehabilitative Services form that must be completed for FCSS, HBMH and TSFC in addition to the authorization form. Service thresholds are indicated in the service charts at the end of this chapter.

**Required Information**

- Number of hours of each service;
- Frequency of each service;
- Diagnosis based on DSM-IV to include ALL pertinent axis;
- History of recipient's condition, including all previous mental health treatment;
- Extenuating circumstances requiring more frequent use of mental health services;
- Treatment goals and results prior to authorization request, including modalities provided;
- Treatment goals to be accomplished if authorization request is approved;
- Anticipated duration of treatment required to reach goals, and summary of provider's proposed discharge plan;
- How mental health services will be packaged for the recipient, (e.g., number and frequency of sessions of group, family, or individual psychotherapy, or environmental intervention);
- Provider's licensure status and pertinent competencies as listed with the licensing board; and
- If the service is to be provided under clinical supervision by a mental health practitioner who qualifies for reduced reimbursement, describe the practitioner's qualifications and list the name, credentials and MHCP provider number of the supervisor.

**Review Criteria**

The following criteria is used to review authorization requests for mental health services described in this chapter:

- A diagnosis of a major mental disorder (a primary DSM IV diagnosis based on the results of a diagnostic assessment);
- A treatment plan;
- Outlining specific goals reasonably attained through the proposed request for authorization;
- A treatment plan clearly documenting the necessity for the type of mental health service requested, including intensity of treatment;
- Medical necessity:
  - Continuing evidence of symptoms or behavior which reflects the risk of danger to self, others, or property and which are manageable through outpatient treatment;
  - Significant impairment in capacity to perform the activities of daily living, including social, family, or occupational/school functioning due to a major mental disorder; or
  - In the case of schizophrenia or other severe chronic mental disorders, outpatient psychotherapy is necessary in order to prevent further deterioration, allow for functioning in daily living, or to keep the individual out of the hospital; and
Evidence that the treatment plan will lead to improvement in or maintenance of the diagnosed condition.

A recipient may have special needs that require more frequent services or more than one modality on a temporary basis, such as:

- The onset of acute psychosis, acute anxiety state, or depression to avoid hospitalization or to transition into an inpatient setting;
- The recipient is a danger to self or others;
- The recipient is receiving one type of psychotherapy (e.g., ongoing individual psychotherapy) and may need an experience available only in another type of psychotherapy (e.g., group or family psychotherapy);
- The initiation of psychotherapy temporarily requires a greater frequency of services in order to establish a relationship between the recipient and provider; or
- The recipient is a child or adolescent with acute anxiety and needs weekly psychotherapy in order to function or progress in meeting treatment goals.

The Following Services are Excluded from Reimbursement as Outpatient or Rehabilitative Mental Health Services

- Mental health services, except psychological testing, provided by a mental health professional (except psychiatrists) to a recipient who is inpatient and has a mental illness diagnosis. These services are part of the hospital's DRG;
- Missed appointments;
- Mileage, refer to Bulletin #02-53-09 for information about eligible provider travel time;
- Reimbursement for transportation costs associated with transporting a recipient (this is a separate service)
- Routine telephone calls;
- Written communication between provider and recipient;
- Aversion therapy;
- Routine reports, charting and record keeping;
- Medical supplies and equipment;
- Community planning or consultation, program consultation/monitoring/evaluation, public information, training and education activities, resource development, and training activities;
- Fund-raising;
- Court ordered services solely for legal purposes or a mental health service not related to the recipient's diagnosis or treatment for mental illness;
- Services dealing with external, social, or environmental factors not directly addressing the recipient's physical or mental health;
- Vocational or educational services not related to the recipient's diagnosis or treatment for mental illness;
- Staff training;
- Child protection services provided by a government entity;
• Adult Rehabilitative Mental Health Services, Adult Crisis Response Services, and Mental Health-Targeted Case Management provided to GAMC and most MinnesotaCare recipients;
• Mental health case management is not covered for recipients receiving similar services through the Veterans Association (VA);
• Mental health case management is not covered for recipients receiving case management services through a home and community based federal waiver when these services duplicate each other;
• Mental health services provided by a school or local education agency, unless the school or agency is an MHCP enrolled provider and the services are medical necessary and prescribed in the child's IEP or ITP;
• Mental health services provided by an entity whose purpose is not health service related, such as the Division of Vocational Rehabilitation or Jobs and Training;
• Mental health services provided to recipients who reside in a long term care facility (skilled nursing facility or intermediate care facility for the mentally retarded), except if ordered by the recipient's physician and specified in the plan of care;
• Explanation of findings when the purpose is to provide clinical direction of employees or students who provide mental health services under the clinical supervision of the mental health professional conducting the explanation of findings;
• Explanation of findings when the purpose is to share information at regularly scheduled interagency coordination of care meetings where the care of multiple recipients is discussed;
• Legal services, including legal advocacy, for the recipient;
• Information and referral services included in the county's community social service plan;
• Outreach services through the community support services program;
• Services not properly documented;
• HBMHS, FCSS, and TSFC services provided to a child who has not had a diagnostic assessment, except the first 30 hours provided to a child who later is assessed and diagnosed with SED at the time the services were initiated;
• HBMHS, FCSS, and TSFC services simultaneously provided by more than one mental health professional or practitioner, unless authorization is obtained;
• Assistance in locating respite care, special needs day care, and assistance in obtaining financial resources, except when these services are provided as part of case management;
• Medication monitoring for children receiving HBMHS, FCSS, or TSFC;
• HBMHS provided to a child who is not living in the child's residence;
• Client outreach for the purpose of seeking persons who potentially may be eligible for FCSS;
• A service that is primarily recreation-oriented, or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hour, leisure time, social hours, meal or snack time, trips to community activities, etc.; and
• FCSS, HBMHS, and TSFC provided concurrently.
MHCP Provider Enrollment Process

MHCP providers must follow requirements set forth in applicable state and federal laws and regulations. Each county, tribe, agency, organization or individual provider who is an enrolled MHCP provider is responsible to know and follow those laws and regulations. Refer to Requirements for Providers chapter (ch.1) for additional enrollment policy.

Provider Enrollment Unit - Application Process

Providers must submit a completed Provider Enrollment Application and Provider Agreement to the DHS Provider Enrollment Unit. Forms are available at www.dhs.state.mn.us/provider/forms.

Mental health day treatment providers, partial hospitalization programs, children’s residential mental health treatment facilities, children’s mental health rehabilitative services and ARMHS providers have additional requirements that must be completed in addition to the above forms prior to enrollment.

Additional enrollment policy information is available for children’s residential mental health treatment facilities in Bulletin #01-73-01; for ARMHS in Bulletin #02-53-02, for Adult Crisis Response Services in Bulletin #02-53-11, for partial hospitalization in Bulletin #03-53-02, and for Children’s Therapeutic Services and Supports in Bulletin #03-53-04.

Right to Appeal Denial of Certification or County Contract

Providers who are required to be certified by or contract with counties as part of the criteria to become authorized providers of mental health services under Medicaid rules may appeal a county refusal to grant the necessary contract or certification. Additional information is in Bulletin #02-53-10 and in MS 256B.81.

Fee-For-Service Billing

Mental health providers must follow the same billing policies as other MHCP providers described in Chapter 4 or specific bulletins. Exceptions to payment policy stated previously in this chapter are listed below.

Prior to the completion of the diagnostic assessment, providers may bill MHCP for explanation of findings, psychological testing and one psychotherapy session. If the diagnostic assessment does not result in a diagnosis of mental illness, the provider may receive payment for the diagnostic assessment, but will not receive payment for continuing mental health services.

Eligibility Verification System (EVS)

Providers are encouraged to use EVS to verify recipient eligibility for MHCP. DHS encourages providers to verify eligibility once per month per recipient. Additional EVS information is in the Billing chapter (ch.4).
Third Party Liability (TPL): Insurance other than Medicaid (MA or PMAP), MinnesotaCare or General Assistance Medical Care (GAMC or PGAMC)

Third party liability refers to the legal obligation of third parties to pay all or part of the costs for medical services furnished under a State plan. The Medicaid program by law is intended to be the payer of last resort. Recipients eligible for Medicaid assign their rights to third party payments to the State Medicaid agency. DHS is required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State plan.

It is up to each provider to establish a system for third party payment resource identification and collection. Private accident and health coverage, including HMO (not PMAP, PGAMC, MinnesotaCare) coverage, is considered primary and must be used according to the rules of the individual’s specific plan. MHCP will not pay for services that could have been covered by the private payer if the applicable rules of that private plan had been followed. Additional TPL information is located in the Billing chapter (ch.4). The MHCP covers some services that do not require the provider of service to bill and collect from a liable third party prior to billing.

For information about TPL billing for individualized education program services see the Minnesota Department of Human Services Individualized Education Program (IEP) Services Technical Assistance Guide.

Coordination of Benefits

The provider needs to determine the appropriate means of reimbursement:

- Fee-for-Service: The provider must bill liable third party payers and receive payment to the fullest extent possible before billing MHCP.

- Prepaid health care program: The provider must be part of the health plan network or have authorization to provide services. The provider must bill liable third party payers and receive payment to the fullest extent possible before billing the health plan.

Non-enrollable Service Providers

Only enrolled providers who meet the qualifications of a mental health professional are eligible to receive MHCP payment for outpatient mental health services, except as specified below:

- Mental health practitioner, under the clinical supervision of a mental health professional, may provide day treatment, partial hospitalization, and the skills training component of HBMHS, TSFC, and FCSS, ARMHS, or Adult Crisis Stabilization services.
- Mental health behavioral aide, mobile crisis response team, preschool multidisciplinary team and therapeutic camp program multi-disciplinary team may provide specific mental health services. Use the supervising mental health professional’s provider number as the treating provider when billing.
• ARMHS rehabilitation worker may provide ARMHS. Use the modifier HM and the supervising mental health professional’s provider number as the treating provider when billing.

Use of HN modifier (for services prior to 01/01/2004, use modifier WW)

• Mental health practitioner, under the clinical supervision of a mental health professional, who meets all of the criteria listed below may provide outpatient mental health services:
  - Obtained at least a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university;
  - Is employed by a private nonprofit entity specializing in mental health services to low income children under age 15; and
  - Has provided outpatient mental health services with a primary emphasis on family oriented mental health services to children under age 15, under clinical supervision, for at least 10 years after receiving a bachelor's degree.

• An LPP who has not been granted a variance from the supervision requirement by the Board of Psychology may provide outpatient mental health services under the clinical supervision of a mental health professional at one-half of the MHCP payment rate of the mental health professional who is providing clinical supervision.

• A person who has completed all requirements for licensure or board certification as a mental health professional, with the exception of supervised experience in delivering mental health services, may provide mental health services at one-half of the MHCP payment rate of the mental health professional who is providing clinical supervision. Mental health services provided under clinical supervision, during field placement or internship are covered if provided by a student in a graduate program leading to completion of the requirements for licensure as a mental health professional. (DHS recognizes LGSW and LISW in the same capacity as persons completing requirements for licensure or board certification as mental health professionals.) In all of the situations described above, the HN modifier must be used when billing. The clinical supervisor must conform to standard (1) as listed in the Clinical Supervision section below. Also, the mental health services must be provided in one of the following locations:
  - Outpatient hospital;
  - Physician-directed clinic;
  - CMHC; or
  - Rule 29 licensed facility.

• Physicians who are completing an internship or residency in psychiatry will be paid by MHCP at one-half the MHCP payment rate for the same outpatient mental health service provided by a physician who is board certified in psychiatry or eligible for certification. The HN modifier must be used when billing.
Children’s Mental Health Residential Treatment Services

Only counties may bill DHS for this service. See Children’s Mental Health Residential Treatment Services section for more information.

Psychotherapy Sessions

The length of an individual psychotherapy session, including hypnotherapy and biofeedback, may be one-half hour, one hour, or one and one-half hours.

The length of a family psychotherapy session will be one hour, or one and one-half hours.

The length of a group psychotherapy session will be one hour, one and one-half hours or two hours.

If the length of a psychotherapy session is less than an hour or a whole number multiple of an hour, payment will be prorated according to the lesser length of time.

Mental Health Coverage Charts

The following charts identify mental health services available to recipients receiving health care benefits through one of the publicly funded Minnesota Health Care Programs (MA, GAMC, or MinnesotaCare). The coverage limitations identified in these charts apply to services paid through the fee-for-service (FFS) reimbursement process only.

In compliance with HIPAA standards requiring nationally recognized, uniform billing codes, DHS replaced local codes. The new billing codes apply to services provided on and after January 1, 2004, unless otherwise specified.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM</td>
<td>Case Manager</td>
</tr>
<tr>
<td>CY</td>
<td>Calendar Year (January 1 through December 31)</td>
</tr>
<tr>
<td>FCSS</td>
<td>Family Community Support Services</td>
</tr>
<tr>
<td>HBMHS</td>
<td>Home Based Mental Health Services</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Mod</td>
<td>Modifier</td>
</tr>
<tr>
<td>POS</td>
<td>Place of Service</td>
</tr>
<tr>
<td>TSFC</td>
<td>Therapeutic Support of Foster Care</td>
</tr>
<tr>
<td>Modifier</td>
<td>Definitions (Some service require one or more modifiers)</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>HA</td>
<td>Child or Adolescent</td>
</tr>
<tr>
<td>HE</td>
<td>Mental Health</td>
</tr>
<tr>
<td>HK</td>
<td>Intensive</td>
</tr>
<tr>
<td>HN</td>
<td>Mental Health Practitioner or Bachelor Degree Level (replaces WW modifier for mental health services)</td>
</tr>
<tr>
<td>HM</td>
<td>Adult MH Rehabilitation Worker or Mental Health Behavioral Aide Level II</td>
</tr>
<tr>
<td>HQ</td>
<td>Group Modality</td>
</tr>
<tr>
<td>HR</td>
<td>Family/Couple with Client Present</td>
</tr>
<tr>
<td>HS</td>
<td>Family/Couple without Client Present</td>
</tr>
<tr>
<td>HW</td>
<td>State Staff (Adult Mental Health Initiative)</td>
</tr>
<tr>
<td>UA</td>
<td>FCSS service package</td>
</tr>
<tr>
<td>U4</td>
<td>Telephone Contact for Case Management</td>
</tr>
<tr>
<td>U8</td>
<td>HBMHS service package</td>
</tr>
<tr>
<td>U9</td>
<td>TSFC service package</td>
</tr>
</tbody>
</table>
### General Mental Health Services Benefits

<table>
<thead>
<tr>
<th>Proc Code</th>
<th>Mod</th>
<th>Brief Description</th>
<th>Allowed Services (before authorization)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801</td>
<td></td>
<td>Diagnostic Assessment - 30 min unit</td>
<td>One 2-hour session (4 units) per CY. Do not bill both for the same recipient.</td>
</tr>
<tr>
<td>90802</td>
<td></td>
<td>Interactive Diagnostic Assessment - 30 min unit</td>
<td>Authorization is required for 90802 when the threshold of 90801 has been used. 90802 is included in the thresholds of 90801.</td>
</tr>
<tr>
<td>90887</td>
<td></td>
<td>Explanation of Findings - 30 min unit</td>
<td>4 hours per CY.</td>
</tr>
<tr>
<td>96100</td>
<td></td>
<td>Psychological Testing - per hour</td>
<td>8 hours per CY.</td>
</tr>
<tr>
<td>90862</td>
<td></td>
<td>Medication Management - Session equals 1 unit</td>
<td>1 unit per 7 days. 52 units per CY.</td>
</tr>
<tr>
<td>H2012</td>
<td></td>
<td>Behavioral Health Day Treatment - 1 hour unit</td>
<td>15 hours per week maximum. Authorization is required for behavioral health day treatment. For adults age 21 and older, authorization is required for mental health day treatment in excess of 115 hours per 365 days. For children through age 20, authorization is required for mental health day treatment in excess of 390 hours per CY. No more than 60 hours may be provided concurrently with HBMHS, TSFC, or FCSS.</td>
</tr>
<tr>
<td>H0046</td>
<td></td>
<td>Mental Health Provider Travel Time – 1 min unit</td>
<td>A child under age 21 eligible for FCSS, HBMHS, and TSFC may exceed the payment limitations for this package with authorization. See related FCSS, HBMHC, and TSFC benefit charts in this section.</td>
</tr>
<tr>
<td>H0035</td>
<td></td>
<td>Partial Hospitalization - 1 hour unit</td>
<td>Authorization is required for the following conditions: 1. Service provided more than 21 days after admission. 2. Readmission within 45 days of a previous discharge from a PHP. 3. For an adult (age 18 and older), fewer than five hours of covered service per day. For a child (through age 17), fewer than three hours of covered service per day.</td>
</tr>
<tr>
<td>HA</td>
<td></td>
<td>Use modifier HA for child under age 18</td>
<td></td>
</tr>
<tr>
<td>H0031</td>
<td></td>
<td>Crisis Assessment/Intervention in an Emergency Room - 15 min unit POS is 23</td>
<td>2 hours per day, or 4 ¼ hours per calendar month, or 8 hours in a CY.</td>
</tr>
</tbody>
</table>
## Mental Health Targeted Case Management Benefits

<table>
<thead>
<tr>
<th>Proc Code</th>
<th>Mod</th>
<th>Brief Description</th>
<th>Allowed Services (before authorization)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T2023</td>
<td>HE</td>
<td>Face-to-face contact between CM and client (child under 18)</td>
<td>1 month unit</td>
</tr>
<tr>
<td></td>
<td>HE</td>
<td>Face-to-face contact between CM and client (adult 18 and over)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HE U4</td>
<td>Telephone contact (adult 18 and over)</td>
<td></td>
</tr>
</tbody>
</table>
| T1017     | HE  | Face-to-face encounter (child under 18)  
*For IHS/631 and FQHC billing only* | 1 encounter |
|           | HE  | Face-to-face encounter (adult 18 and over)  
*For IHS/638 and FQHC billing only* | |

Generally, only one provider can bill for the same recipient in the same month of service. However, one county or tribe and one county-contracted provider may provide case management to the same recipient in the same month of service when the need for more than one source of case management is fully documented.

## Neuropsychological Services

<table>
<thead>
<tr>
<th>Proc Code</th>
<th>Mod</th>
<th>Brief Description</th>
<th>Allowed Services (before authorization)</th>
</tr>
</thead>
<tbody>
<tr>
<td>96117</td>
<td></td>
<td>Neuropsychological Assessment (testing) 1 hour unit</td>
<td>Does not require prior authorization. Authorization is required for neuropsychological testing and assessment 96117 to exceed 7 hours per CY. A maximum of 10 hours may be approved with authorization for a single assessment; and/or if multiple assessments (i.e., re-evaluation) are requested and determined to be medically necessary, a maximum of 15 hours of 96117 may be allowed with authorization for the CY. Effective 01/01/04, the unit length for this service is changed from 15 minutes to 1 hour.</td>
</tr>
<tr>
<td>H2012</td>
<td>HK</td>
<td>Cognitive Remediation Training <em>Behavioral Health Day Treatment</em> - 60 min unit</td>
<td>Authorization is required prior to initiation of service.</td>
</tr>
<tr>
<td>97535</td>
<td>HE</td>
<td>Neuropsychological Rehabilitation <em>Self-care-home management training</em> - 15 min unit</td>
<td></td>
</tr>
</tbody>
</table>

Only DHS-approved providers can bill for neuropsychology services. See Neuropsychological Services section of chapter for provider eligibility criteria.
<table>
<thead>
<tr>
<th>Proc Code</th>
<th>Brief Description</th>
<th>Allowed Services (before authorization)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90804</td>
<td>Individual Psychotherapy (20 - 30 min unit)</td>
<td>26 hours per CY, cumulative. (Individual Psychotherapy may not be provided concurrently with Individual Interactive Psychotherapy.)</td>
</tr>
<tr>
<td>90805</td>
<td>Individual Psychotherapy with Medical E/M (20 - 30 min unit) psychiatrist only</td>
<td>Authorization is required for more than 26 hours (52 visits/units of 90804, 90805) or 90875 (when billed in two-unit increments) or 26 hours of 90806 or 90807 or 40 units of 90875 (when billed in two-unit increments) per CY. Note: 90875 when billed as one unit and 90806 or 90807 combined decrements from the total 26 hours per CY. There is not a separate benefit level for each code. Likewise, 90875 when billed as two units and 90806 or 90807 combined decrement from the total 26 hours per CY. There is not a separate benefit level for each code. A child under age 21 eligible for FCSS is eligible to concurrently receive services in this package.</td>
</tr>
<tr>
<td>90806</td>
<td>Individual Psychotherapy (45 - 50 min unit) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90807</td>
<td>Individual Psychotherapy with Medical E/M (45 - 50 min unit) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90808</td>
<td>Individual Psychotherapy (75 - 80 min unit)</td>
<td></td>
</tr>
<tr>
<td>90809</td>
<td>Individual Psychotherapy with Medical E/M (75 - 80 min unit) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90810</td>
<td>Interactive Individual Psychotherapy (20 - 30 min unit)</td>
<td>A child under age 21 eligible for FCSS is eligible to concurrently receive services in this package.</td>
</tr>
<tr>
<td>90811</td>
<td>Interactive Individual Psychotherapy with Medical E/M (20 - 30 min unit) psychiatrist only</td>
<td>Authorization is required for 90810 - 90814 when the thresholds of 90806 or 90807 have been used. These codes are included in the thresholds of 90806 or 90807. (The provider cannot bill both a 90806 and 90807 and 90810 - 90814. Choose one or the other.)</td>
</tr>
<tr>
<td>90812</td>
<td>Interactive Individual Psychotherapy (40 - 45 min unit)</td>
<td></td>
</tr>
<tr>
<td>90813</td>
<td>Interactive Individual Psychotherapy with Medical E/M (45 - 50 min unit) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90814</td>
<td>Interactive Individual Psychotherapy (70 - 80 min unit)</td>
<td></td>
</tr>
<tr>
<td>90815</td>
<td>Interactive Individual Psychotherapy with Medical E/M (70 - 80 min unit) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90875</td>
<td>Individual psychophysiological therapy incorporating biofeedback, with psychotherapy (20 - 30 min unit)</td>
<td>Authorization is required for 90847 in excess of 26 hours per CY. 90846 must be used when the family member being treated is not present during the family therapy session. 90846 is subject to the same authorization requirements and limitations as those imposed on 90847. Use of this code does not result in an additional benefit level but counts against the benefit level available for 90847. A child under age 21 eligible for FCSS is eligible to concurrently receive services in this package.</td>
</tr>
<tr>
<td>90846</td>
<td>Family Psychotherapy (20 - 30 min unit) without patient present</td>
<td></td>
</tr>
<tr>
<td>90847</td>
<td>Family Psychotherapy (20 - 30 min unit) with patient present</td>
<td></td>
</tr>
<tr>
<td>90853</td>
<td>Group Psychotherapy (20 - 30 min unit)</td>
<td>Authorization is required when more than three hours of 90853 are provided in a five calendar day period or when more than 78 hours per CY have been reached.</td>
</tr>
<tr>
<td>90857</td>
<td>Interactive Group Psychotherapy (20 - 30 min unit)</td>
<td>Authorization is required for 90857 when the threshold of 90853 has been used. 90857 is included in the threshold 90853. A child under age 21 eligible for FCSS or HBMHS is eligible to concurrently receive these services.</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple Family Group Psychotherapy (20 - 30 min unit)</td>
<td>40 units per CY. 1 session (up to 4 units) per week. 10 week maximum.</td>
</tr>
<tr>
<td>Proc Code</td>
<td>Brief Description</td>
<td>Allowed Services (before authorization)</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>90816</td>
<td>Individual Psychotherapy (20 - 30 min unit)</td>
<td>26 hours per CY, cumulative (Psychotherapy may not be provided concurrently with Interactive Individual Psychotherapy).</td>
</tr>
<tr>
<td>90817</td>
<td>Individual Psychotherapy with Medical E/M (20 - 30 min unit) psychiatrist only</td>
<td>All of the inpatient and outpatient individual psychotherapy codes listed count toward the CY 26-hour maximum of individual psychotherapy services allowed before authorization.</td>
</tr>
<tr>
<td>90823</td>
<td>Interactive Individual Psychotherapy (20 - 30 min unit)</td>
<td>Codes 90816 through 90829 when provided in other than an inpatient POS are subject to the same practice parameters and service coverage limitations as other outpatient, individual psychotherapy codes (90804 through 90815) unless authorized.</td>
</tr>
<tr>
<td>90824</td>
<td>Interactive Individual Psychotherapy with Medical E/M (20 - 30 min unit) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90818</td>
<td>Individual Psychotherapy (40 - 50 min unit)</td>
<td></td>
</tr>
<tr>
<td>90819</td>
<td>Individual Psychotherapy with Medical E/M (45 - 50 min) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90821</td>
<td>Individual Psychotherapy (75 - 80 min unit)</td>
<td></td>
</tr>
<tr>
<td>90822</td>
<td>Individual Psychotherapy with Medical E/M (75 - 80 min unit) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90826</td>
<td>Interactive Individual Psychotherapy with Medical E/M (70 - 80 min unit) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90827</td>
<td>Interactive Individual Psychotherapy (45 - 50 min unit)</td>
<td></td>
</tr>
<tr>
<td>90828</td>
<td>Interactive Individual Psychotherapy with Medical E/M (45 - 50 min unit) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90829</td>
<td>Interactive Individual Psychotherapy (75 - 80 min unit)</td>
<td></td>
</tr>
</tbody>
</table>
# Adult Mental Health Rehabilitative Benefits

<table>
<thead>
<tr>
<th>Proc Code</th>
<th>Mod</th>
<th>Brief Description</th>
<th>Allowed Services (before authorization)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2017</td>
<td></td>
<td>Basic Living and Social Skills - 15 min unit</td>
<td>Authorization is required for more than 260 hours per 180 days or 300 hours per CY combined total of H2017, H2017 HM and H2017 HQ.</td>
</tr>
<tr>
<td></td>
<td>HM</td>
<td>Individual - provided by a mental health professional or mental health practitioner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HQ</td>
<td>HM Individual - provided by a mental health rehabilitation worker</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HQ Group - provided by a mental health professional, mental health practitioner, or a mental health rehabilitation worker</td>
<td></td>
</tr>
<tr>
<td>90882</td>
<td></td>
<td>Community Intervention - 15 min unit provided by a mental health professional or mental health practitioner</td>
<td>Authorization is required for more than 10 hours per month or 72 hours per CY.</td>
</tr>
<tr>
<td></td>
<td>HM</td>
<td>HM Provided by a mental health rehabilitation worker</td>
<td></td>
</tr>
<tr>
<td>H0034</td>
<td></td>
<td>Medication Education - 15 min unit (provided by a physician, registered nurse, physician’s assistant or a pharmacist)</td>
<td>Authorization is required for more than 26 hours per CY of H0034 and 26 hours per CY of H0034 HQ.</td>
</tr>
<tr>
<td></td>
<td>HQ</td>
<td>HQ Group</td>
<td></td>
</tr>
</tbody>
</table>

Use modifier HW with any of the above codes, or code and modifier combinations, when service is provided by state staff (Adult Mental Health Initiatives)
### Adult Mental Health Crisis Response Benefits

<table>
<thead>
<tr>
<th>Proc Code</th>
<th>Mod</th>
<th>Brief Description</th>
<th>Allowed Services (before authorization)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0031</td>
<td></td>
<td>Crisis Assessment, mobile - 15 min unit provided by a mental health professional POS is not 23</td>
<td>Maximum 2 hours (8 units) per day Authorization is required for more than 4 1/4 hours (19 units) per calendar month or 8 hours (32 units) per CY</td>
</tr>
<tr>
<td></td>
<td>HN</td>
<td>Provided by a mental health practitioner</td>
<td></td>
</tr>
<tr>
<td>H2011</td>
<td></td>
<td>Crisis Intervention, mobile - 15 min unit Provided by a mental health professional</td>
<td>Authorization is required for more than 10 hours in one day or more than 30 hours in 30 days or more than 60 hours in a CY.</td>
</tr>
<tr>
<td></td>
<td>HN</td>
<td>Provided by a mental health practitioner</td>
<td></td>
</tr>
<tr>
<td>S9484</td>
<td></td>
<td>Crisis Stabilization, non-residential - 60 min unit Individual - provided by a mental health professional or mental health practitioner</td>
<td>Authorization is required for more than 60 hours combined total of S9484 HQ, S9484, S9484 HM and H0018 in a 365-day period. One day of H0018 is counted as 8 hours. Authorization is required for more than 7 days of H0018 in a 365 day period</td>
</tr>
<tr>
<td></td>
<td>HM</td>
<td>Individual - provided by a mental health rehabilitation worker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HQ</td>
<td>Group - provided by a mental health professional, mental health practitioner, or mental health rehabilitation worker</td>
<td></td>
</tr>
<tr>
<td>H0018</td>
<td></td>
<td>Crisis Stabilization, Residential - per diem</td>
<td></td>
</tr>
</tbody>
</table>

Use modifier HW with any of the above codes, or code and modifier combinations, when service is provided by state staff (Adult Mental Health Initiatives)
### Children's Mental Health Rehabilitative - FCSS

<table>
<thead>
<tr>
<th>Proc Code</th>
<th>Mod</th>
<th>Brief Description</th>
<th>Allowed Services (before authorization)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2014</td>
<td>UA</td>
<td>Skills Training &amp; Development - 15 min Individual</td>
<td>68 hours per CY, and not to exceed 68 hours in a consecutive 6 month period</td>
</tr>
<tr>
<td></td>
<td>UA HR</td>
<td>Skills Training &amp; Development - 15 min Family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>UA HQ</td>
<td>Skills Training &amp; Development - 15 min Group</td>
<td></td>
</tr>
<tr>
<td>H2019</td>
<td>UA</td>
<td>Therapeutic Behavioral Services - 15 min (Level I Mental Health Behavioral Aide)</td>
<td>100 hours per CY, and not to exceed 100 hours in a consecutive 6 month period</td>
</tr>
<tr>
<td></td>
<td>UA HM</td>
<td>Therapeutic Behavioral Services - 15 min (Level II Mental Health Behavioral Aide)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>UA HE</td>
<td>Therapeutic Behavioral Services - 15 min (Direction of Mental Health Behavioral Aide)</td>
<td>See text in FCSS section for information</td>
</tr>
<tr>
<td>H2015</td>
<td>UA</td>
<td>Comp Community Support Services - 15 min (Crisis Assistance)</td>
<td>24 hours per CY, and not to exceed 24 hours in a consecutive 6 month period</td>
</tr>
<tr>
<td>S9484</td>
<td>UA</td>
<td>Crisis Intervention Mental Health Service (Mental Health Crisis Intervention and Stabilization) 60 min provided by MH professional</td>
<td>192 hours per CY</td>
</tr>
<tr>
<td></td>
<td>UA HN</td>
<td>Provided by MH practitioner</td>
<td></td>
</tr>
<tr>
<td>H2012</td>
<td>UA</td>
<td>Behavioral Health Day Treatment - 60 min (Therapeutic Components of Preschool Program)</td>
<td>72 hours per CY</td>
</tr>
<tr>
<td>H2032</td>
<td>UA</td>
<td>Activity Therapy - 15 min (Therapeutic Components of Camp Program)</td>
<td>See text in FCSS section for information</td>
</tr>
<tr>
<td>H0046</td>
<td>UA</td>
<td>Mental Health Services, nos - 1 min (FCSS Travel Time)</td>
<td>40 hours per CY, and not to exceed 40 hours in a consecutive 6-month period</td>
</tr>
</tbody>
</table>

MHCP recipients accessing FCSS may also access General Mental Health Services Benefits and Mental Health Psychotherapy Benefits for children under 21.

There are no spacing requirements between sessions.

FCSS may not be provided concurrently with HBMHS or TSFC.

No more than 60 hours of day treatment may be provided concurrently with FCSS.

When billing for components of FCSS, the procedure codes must be billed with modifier UA (previously YD).
<table>
<thead>
<tr>
<th>Proc Code</th>
<th>Mod</th>
<th>Brief Description</th>
<th>Allowed Services (before authorization)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90804</td>
<td>U8</td>
<td>Individual Psychotherapy (20 - 30 min)</td>
<td>48 hours per CY, and not to exceed 48 hours in a consecutive 6-month period.</td>
</tr>
<tr>
<td>90805</td>
<td>U8</td>
<td>Individual Psychotherapy with Medical E/M, (20 - 30 min) psychiatrist only</td>
<td>Individual Psychotherapy may not be provided concurrently with Interactive Psychotherapy</td>
</tr>
<tr>
<td>90806</td>
<td>U8</td>
<td>Individual Psychotherapy (45 - 50 min)</td>
<td></td>
</tr>
<tr>
<td>90807</td>
<td>U8</td>
<td>Individual Psychotherapy with Medical E/M, (45 - 50 min) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90808</td>
<td>U8</td>
<td>Individual Psychotherapy (75 - 80 min)</td>
<td></td>
</tr>
<tr>
<td>90809</td>
<td>U8</td>
<td>Individual Psychotherapy with Medical E/M, (75 - 80 min) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90875</td>
<td>U8</td>
<td>Biofeedback Training (20 - 30 min)</td>
<td></td>
</tr>
<tr>
<td>90846</td>
<td>U8</td>
<td>Family Psychotherapy, without patient present (20 - 30 min)</td>
<td></td>
</tr>
<tr>
<td>90847</td>
<td>U8</td>
<td>Family Psychotherapy, with patient present (20 - 30 min)</td>
<td></td>
</tr>
<tr>
<td>90849</td>
<td>U8</td>
<td>Multiple Family Group Psychotherapy (20 - 30 min)</td>
<td></td>
</tr>
<tr>
<td>90810</td>
<td>U8</td>
<td>Interactive Individual Psychotherapy (20 - 30 min)</td>
<td>48 hours per CY, and not to exceed 48 hours in a consecutive 6 month period</td>
</tr>
<tr>
<td>90811</td>
<td>U8</td>
<td>Interactive Individual Psychotherapy with Medical E/M, (20 - 30 min) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90812</td>
<td>U8</td>
<td>Interactive Individual Psychotherapy (45 - 50 min)</td>
<td></td>
</tr>
<tr>
<td>90813</td>
<td>U8</td>
<td>Interactive Individual Psychotherapy with Medical E/M, (45 - 50 min) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90814</td>
<td>U8</td>
<td>Interactive Individual Psychotherapy (75 - 80 min)</td>
<td></td>
</tr>
<tr>
<td>90815</td>
<td>U8</td>
<td>Interactive Individual Psychotherapy with Medical E/M, (75 - 80 min) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>H2014</td>
<td>U8</td>
<td>Skills Training &amp; Development - 15 min Individual</td>
<td>192 hours per CY, and not to exceed 192 hours in a consecutive 6 month period</td>
</tr>
<tr>
<td>H2014</td>
<td>U8 HR</td>
<td>Skills Training &amp; Development - 15 min Family</td>
<td></td>
</tr>
<tr>
<td>H2014</td>
<td>U8 HQ</td>
<td>Skills Training &amp; Development - 15 min Group</td>
<td></td>
</tr>
<tr>
<td>H0046</td>
<td>U8</td>
<td>Mental Health Services, nos - 1 min (HBMHS Travel Time)</td>
<td>128 hours per CY, and not to exceed 128 hours in a consecutive 6-month period</td>
</tr>
</tbody>
</table>

There are no spacing requirements between sessions, however, individual psychotherapy and interactive individual psychotherapy may not be provided concurrently.

HBMHS may not be provided concurrently with Basic Children’s Mental Health Benefits (except group psychotherapy), TSFC or FCSS.

No more than 60 hours of day treatment may be provided concurrently with HBMHS.

When billing for components of HBMHS, the procedure codes must be billed with modifier U8 (previously YA).
### Children’s Mental Health Rehabilitative - TSFC

<table>
<thead>
<tr>
<th>Proc Code</th>
<th>Mod</th>
<th>Brief Description</th>
<th>Allowed Services (before authorization)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90804</td>
<td>U9</td>
<td>Individual Psychotherapy (20 - 30 min)</td>
<td>48 hours per 6 months</td>
</tr>
<tr>
<td>90805</td>
<td>U9</td>
<td>Individual Psychotherapy with Medical E/M, (20 - 30 min) psychiatrist only</td>
<td>Individual Psychotherapy may not be provided concurrently with Interactive Psychotherapy</td>
</tr>
<tr>
<td>90806</td>
<td>U9</td>
<td>Individual Psychotherapy (45 - 50 min)</td>
<td></td>
</tr>
<tr>
<td>90807</td>
<td>U9</td>
<td>Individual Psychotherapy with Medical E/M, (45 - 50 min) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90808</td>
<td>U9</td>
<td>Individual Psychotherapy (75 - 80 min)</td>
<td></td>
</tr>
<tr>
<td>90809</td>
<td>U9</td>
<td>Individual Psychotherapy with Medical E/M, (75 - 80 min) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90846</td>
<td>U9</td>
<td>Family Psychotherapy, without patient present (20 - 30 min)</td>
<td></td>
</tr>
<tr>
<td>90847</td>
<td>U9</td>
<td>Family Psychotherapy, with patient present (20 - 30 min)</td>
<td></td>
</tr>
<tr>
<td>90849</td>
<td>U9</td>
<td>Multiple Family Group Psychotherapy (20 - 30 min)</td>
<td></td>
</tr>
<tr>
<td>90853</td>
<td>U9</td>
<td>Group Psychotherapy (20 - 30 min)</td>
<td></td>
</tr>
<tr>
<td>90875</td>
<td>U9</td>
<td>Biofeedback Training (20 - 30 min)</td>
<td></td>
</tr>
<tr>
<td>90810</td>
<td>U9</td>
<td>Interactive Individual Psychotherapy (20 - 30 min)</td>
<td>48 hours per 6 months</td>
</tr>
<tr>
<td>90811</td>
<td>U9</td>
<td>Interactive Individual Psychotherapy with Medical E/M, (20 - 30 min) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90812</td>
<td>U9</td>
<td>Interactive Individual Psychotherapy (45 - 50 min)</td>
<td></td>
</tr>
<tr>
<td>90813</td>
<td>U9</td>
<td>Interactive Individual Psychotherapy with Medical E/M, (45 - 50 min) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90814</td>
<td>U9</td>
<td>Interactive Individual Psychotherapy (75 - 80 min)</td>
<td></td>
</tr>
<tr>
<td>90815</td>
<td>U9</td>
<td>Interactive Individual Psychotherapy with Medical E/M, (75 - 80 min) psychiatrist only</td>
<td></td>
</tr>
<tr>
<td>90857</td>
<td>U9</td>
<td>Interactive Group Psychotherapy (20 - 30 min)</td>
<td></td>
</tr>
<tr>
<td>H2014</td>
<td>U9</td>
<td>Skills Training &amp; Development - 15 min - Individual</td>
<td>192 hours per CY, and not to exceed 192 hours in a consecutive 6 month period</td>
</tr>
<tr>
<td>H2014</td>
<td>U9 HR</td>
<td>Skills Training &amp; Development - 15 min - Family</td>
<td></td>
</tr>
<tr>
<td>H2014</td>
<td>U9 HQ</td>
<td>Skills Training &amp; Development - 15 min - Group</td>
<td></td>
</tr>
<tr>
<td>H0046</td>
<td>U9</td>
<td>Mental Health Services, nos 1 min (TSFC Travel Time)</td>
<td>128 hours per CY, Not to exceed 128 hours in a consecutive 6-month period</td>
</tr>
</tbody>
</table>

There are no spacing requirements between sessions, however, individual and group psychotherapy may not be provided concurrently with interactive individual and group psychotherapy.

TSFC may not be provided concurrently with Basic Children’s Mental Health Benefits, HBMHS or FCSS.

No more than 60 hours of day treatment may be provided concurrently with TSFC.

When billing for components of TSFC, the procedure codes must be billed with a modifier U9 (previously YB).
Sample Individual Treatment Plans (ITP)

Sample ITP #1

Sample ITP #2

Legal References

Minnesota Statutes, sections 245.461 to 245.486
Minnesota Statutes, sections 245.487 to 245.4887
Minnesota Statutes, sections 245.50 to 245.52; 245.61 to 245.63; 245.66; 245.697; 245.699; 245.70; 245.71; 245.715
Minnesota Statutes, section 256B.04
Minnesota Statutes, section 256B.0623, 256B.0624; 256B.0625; 256B.0945; 256B.761; 256B.81; 256B.82; 256B.83; 256B.84; 256D.03; 256L.03
Minnesota Statutes, sections 260 to 260.191
Minnesota Rules, parts 9505.0175 to 9505.0475
Minnesota Rules, parts 9505.0322 to 9505.0327 (Rule 47, MH services portion)
Minnesota Rules, part 9505.0540
Minnesota Rules, parts 9505.5000 to 9505.5105
Minnesota Rules, parts 9505.2175 to 9505.2180
Minnesota Rules, parts 9505.0500 to 9505.0670 (Rule 36)
Minnesota Rules, parts 9520.0750 to 9520.0870 (Rule 29)
Minnesota Rules, parts 9520.0900 to 9520.0926 (Rule 79)
Minnesota Rules, parts 9545.0905 to 9545.1090 (Child Caring Institutions)
42 CFR 435.1008-1009 (IMD)
42 CFR 440.60(a)
42 CFR 440.160 (inpatient psych, under 21)
42 CFR 440.170(e) (emergency hospital services)
42 CFR 440.230 (amount, scope and duration)
Title XIX, Section 1915(g) of the Social Security Act (MH-TCM)
Chapter 17

Rehabilitative Services: Physical Therapy, Occupational Therapy, Speech-Language Pathology and Audiology Services

This chapter provides policy and billing information for providers of physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), rehabilitation agency services (including therapy services provided by nursing home employees or contractors, physician clinics, outpatient hospitals, and community or public health clinics), audiology and hearing aids.

Individual education plan (IEP) services provided in schools are addressed in the Children's Services chapter (Ch. 9) and rehabilitative services provided by home health agencies are addressed in the Home Care Services chapter (Ch. 24).

Definitions

**Audiologist:** A person certified in clinical competence from the American Speech and Hearing Association.

**Audiologic Evaluation:** An assessment administered by an audiologist or otolaryngologist to evaluate communication problems caused by hearing loss.

**Comprehensive Outpatient Rehabilitation Facility (CORF):** A non-residential facility that is established and operated exclusively to provide diagnostic, therapeutic and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons, at a single fixed location, by or under the direction of a physician and that meets the conditions of participation. Additionally, a facility that qualifies as a CORF may be enrolled to provide mental health services.

**Direction:** The actions of a physical or occupational therapist who instructs the physical or occupational therapist assistant, monitors the assistant's provision of services, and provides on-site observation of the treatment and documentation of its appropriateness at least every sixth treatment session for each recipient when treatment is provided by an assistant and meets the other supervisory requirements of Minnesota Rules 5601.1500 and 5601.1600, and MS 148.6432.

**Functional Status:** The ability to carry out the tasks associated with daily living.

**Hearing Aid:** A monaural hearing aid, set of binaural hearing aids, or other device worn by the recipient to improve access to and use of auditory information.

**Hearing Aid Accessory:** Chest harnesses, tone and ear hooks, carrying cases, and other accessories necessary to use the hearing aid, but not included in the cost of the hearing aid.

**Hearing Aid Services:** Services to dispense hearing aids and provide hearing aid accessories and repairs.

**Hearing Aid Service Provider:** A person who has been certified by the Department of Health as a hearing instrument dispenser (or their trainee).

**Long Term Care Facility (LTC):** Nursing facility (NF), skilled nursing facility (SNF), or intermediate care facility for the mentally retarded (ICF-MR).

**Occupational Therapist (OT):** A person certified by the National Board for Certification of Occupational Therapy as an occupational therapist and, where applicable, licensed by the state in which he/she practices.
**Occupational Therapist Assistant (OTA):** A person who has successfully completed all academic and fieldwork requirements of an occupational therapy assistant program approved or accredited by the Accreditation Council for Occupational Therapy Education and is currently certified by the National Board for Certification of Occupational Therapy as an occupational therapy assistant, and where applicable, is licensed by the state in which he/she practices.

**Otolaryngologist:** A physician specializing in diseases of the ear and larynx who is certified by the American Board of Otolaryngology or eligible for board certification.

**Physical Therapist (PT):** A person who is a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent. Physical therapists must meet the state licensure requirements of MS 148 and Minnesota Rules 5601.

**Physical Therapist Assistant (PTA):** A person graduated from a physical therapy assistant educational program accredited by the American Physical Therapy Association or a comparable accrediting agency.

**Rehabilitative Agency:** A provider certified by Medicare to provide restorative, specialized maintenance therapy, and social or vocational adjustment services.

**Rehabilitative and Therapeutic Services:** Restorative therapy, specialized maintenance therapy, and rehabilitative nursing services.

**Rehabilitative Nursing Services:** Rehabilitation nursing care as specified in Minnesota Rules 4658.0525.

**Restorative Therapy:** A health service specified in the recipient's plan of care, ordered by a physician or other licensed practitioner of the healing arts within the practitioner’s scope of practice under state law, and that is designed to restore the recipient's functional status to a level consistent with the recipient's physical or mental limitations.

**Specialized Maintenance Therapy:** A health service specified in the recipient's plan of care by a physician, or other licensed practitioner of the healing arts within the practitioner’s scope of practice under state law, that is necessary for maintaining a recipient's functional status at a level consistent with the recipient's physical or mental limitations, and that may include treatments in addition to rehabilitative nursing services, as defined in Minnesota Rules 4658.0525.

**Speech-language Pathologist (SLP):** A person who has a certificate of clinical competence in speech-language pathology from the American Speech and Hearing Association and meets the state registration requirements. Speech language providers are required by MHCP to hold current registration with the Minnesota Department of Health.

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**Eligible Providers**

- Audiologist
- CORF
- Hearing aid service provider
- Long term care facility
- Occupational therapist
- Otolaryngologist
- Physical therapist;
- Rehabilitation agency
- Speech-language pathologist
Enrollment Requirements

An individual is eligible to enroll as a therapist in private practice if they are either a physical therapist or an occupational therapist as defined in this chapter and are not employees of a hospital, CAH, skilled nursing facility, HHA, hospice, CORF, CMHC, a rehabilitation agency or Public Health Agency. A therapist in private practice must maintain a private office even if services are furnished in a patient’s home. A private office is space that is leased, owned, or rented by the practice and used for the exclusive purpose of operating the practice. For example: A therapist in private practice may not furnish covered services in a skilled nursing facility. Therefore, if a therapist wished to locate their private office on site at a nursing facility, the private office space may not be part of the Medicare participating SNF’s space and the therapist’s services may only be furnished within the therapist’s private office space.

Speech-language pathologists, as defined in this chapter, are eligible to enroll as independent providers if they maintain an office at their own expense. An individual completing the clinical fellowship year required for certification is not eligible to enroll as an independent speech language pathologist.

Audiologists, as defined in this chapter, are eligible to enroll as independent providers if they maintain an office at their own expense.

Use of Physical and Occupational Therapist Assistants

MHCP reimburses providers for the services of a PTA or an OTA when services are provided under the direction (defined above) of a therapist. The therapist must provide on-site observation of the treatment and documentation of its appropriateness at least every sixth treatment session when the therapist assistant provides services. Therapists will not be reimbursed for assistants providing evaluations or reevaluations.

Supervision During Fellowship Year of Speech-Language Pathology and Audiology

- A person completing the clinical fellowship year required for certification may provide speech-language services under the supervision of an SLP but is not eligible to enroll as a provider.
- Services provided by another SLP employed by the SLP in private practice are not reimbursed by MHCP unless the employee is an SLP completing a clinical fellowship year.
- A person completing the clinical fellowship year required for certification as an audiologist may provide services under the supervision of an audiologist.
- Services performed by either a SLP or audiologist completing the clinical fellowship year required for certification are billed under the supervising SLP or audiologist and are paid the same rate as services delivered by the SLP or audiologist.
- See specific requirements regarding supervision of fellows in MS 148.515, subd. 5.
Eligible Recipients

- MA recipients and MinnesotaCare recipients.
- GAMC recipients may only receive rehabilitative services from outpatient hospitals/clinics, physician clinics, community and public health clinics, or rehabilitation agencies. (PT, OT, SLP or audiology providers in private practice are not reimbursed for services provided to GAMC recipients.)
- Recipients who are eligible for both MHCP and Medicare may not receive services from speech-language pathologists in private practice because these providers may not enroll as a provider with Medicare.

Plan of Care

Rehabilitative, therapeutic, specialized maintenance therapy, and audiology services must be provided under a written treatment plan that states with specificity the recipient’s condition, functional level, treatment objectives, the physician’s order, plans for continuing care, modifications to the plan, and the plans for discharge from treatment.

The plan of care must be reviewed, revised and signed as medically necessary by the recipient's physician, or other licensed practitioner of the healing arts within the practitioner’s scope of practice under state law at least once every 60 days. If the service is a Medicare covered service, and is provided to a recipient who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.

The following must be documented in the recipient's plan of care:

- The medical diagnosis and any contraindications to treatment;
- A description of the recipient's functional status;
- The objectives of the rehabilitative and therapeutic service;
- A description of the recipient's progress toward the objectives; and
- Additional documentation requirements as specified in the Health Care Programs and Services chapter (Ch.2).

Recipient's Record of Services

Providers must document all evaluations, services provided, client progress, attendance records, and discharge plans. Documentation must be kept in recipient's records. The record of services must contain the following:

- The date, type, length, and scope of each rehabilitative and therapeutic service provided to the recipient;
- The name or names and titles of the persons providing each rehabilitative and therapeutic service; and
- A statement, every 30 days by the therapist providing or supervising the services provided by a long term care recipient, that the therapy's nature, scope, duration and intensity are
appropriate to the medical condition of the recipient in accordance with Minnesota Statutes (not required for an initial evaluation).

- See documentation requirements as specified in the Health Care Programs and Services chapter (Ch. 2).

**Covered Services**

To be covered as a rehabilitative and therapeutic service:

- Physical therapy and occupational must be prescribed by a physician, or other licensed practitioner of the healing arts within the practitioner’s scope of practice under state law.
- Speech-language pathology and audiology services must be provided:
  - upon written referral by a physician or other licensed practitioner of the healing arts within the practitioner’s scope of practice under state law, or in the case of a long-term care facility resident on the written order of a physician; and
  - by an SLP, audiologist, or a person completing the clinical fellowship year required for certification as an SLP or audiologist under the supervision of an SLP or audiologist as specified in MS 148.515, subd. 4.
- Occupational therapy and physical therapy must require the skills of a PT, OT, or therapy assistant who is under the direction of a PT or an OT. The therapist must provide on-site observation of the treatment and documentation of its appropriateness at least every sixth treatment session when the therapy assistant provides services.
- Treatment must be specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician, or other licensed practitioner of the healing arts within the practitioner’s scope of practice under state law at least once every 60 days (see Plan of Care section in this chapter for additional requirements).
- The recipient’s functional status must be expected by the physician, or other licensed practitioner of the healing arts within the practitioner’s scope of practice under state law to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period.

To be a covered GAMC service, therapy must be provided in an outpatient hospital, physician clinic, community and public health clinic, rehabilitative agency or long term care facility that has been certified by Medicare to provide rehabilitative services.

Services provided by rehabilitation agencies must be provided at a site surveyed by the Minnesota Department of Health and certified according to Medicare standards, or at a site that meets State Fire Marshall standards, as documented in the providers' records, or at the recipient's residence. However, if services are provided to Medicare eligible recipients, providers must comply with Medicare’s site requirements.
Specialized Maintenance Therapy

Specialized maintenance therapy is covered only when it is provided by a PT, OT, therapy assistant, or speech-language pathologist, specified in a plan of care that meets the requirements of this chapter, and is provided to recipients whose condition cannot be maintained or treated only through rehabilitative nursing services, as defined in Minnesota Rules 4658.0525, or services of other care providers, or by the recipient because the recipient’s physical, cognitive or psychological deficits result in:

- Spasticity or severe contracture that interferes with the activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient’s previous level of function; or
- A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance movement patterns, activities of daily living, cardiovascular function, integumentary status, or positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient’s current environmental demands.

Specialized maintenance therapy must have expected outcomes that are:

- Functional,
- Realistic,
- Relevant,
- Transferable to the recipient’s current or anticipated environment, such as home, school, community, work,
- Consistent with community standards.

Specialized maintenance therapy must meet at least one of the following characteristics:

- prevent deterioration and sustain function
- provide interventions, in the case of a chronic or progressive disability, that enable the recipient to live at the recipient’s highest level of independence, or
- provide treatment interventions for recipients who are progressing but not at a rate comparable to the expectations of restorative care.

Work Hardening Programs

Work conditioning/hardening programs are intensive, highly structured, and job oriented. Individualized treatment plans are designed to restore an individual's physical, behavioral and vocational functions within an interdisciplinary model. The treatment plan must be based on an assessment of the recipient's work setting or job demands and must incorporate the goals of expeditious and physically appropriate tasks to return to employment.

If the recipient was injured at work, MHCP will not cover work conditioning/work hardening programs. All work conditioning/work hardening programs require authorization and must have been referred by a vocational rehabilitation counselor.
Include the following on the authorization form or on an attachment:

- Referral from vocational rehabilitation counselor;
- Personnel involved (who make up the multi-disciplinary team);
- If mental health services will be provided, state what is required, the basis for the need, and what type of mental health professional will provide the service;
- Assessment results (including work conditioning assessment, vocational rehabilitation assessment and appropriate documentation as to whether the recipient has ever been treated for chemical dependency, how long ago, etc.);
- Duration of program;
- Describe development of program goals in relation to specific job requirements;
- Define specific work goals and timetables; and
- Describe set frequency and hours of attendance.

Requested number of billings are to reflect the number of hours to be covered by the authorization request for each discipline that is to provide services. Authorizations not including this information will be returned.

When the recipient has been discharged or terminated from the work conditioning or work hardening program, the provider must notify DHS and the referral source and include the following documentation:

- Reasons for program termination;
- Clinical and functional status;
- Recommendations regarding return to work; and
- Recommendations for follow-up service.

**Standards for Augmentative Communication Devices**

**Augmentative Communication Device:** A device dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a recipient with severe expressive communication disorders (e.g., communication picture books, communication charts and boards, and mechanical/electronic devices).

- Augmentative communication devices are obtained from MHCP enrolled medical equipment and supply providers and manufacturers of augmentative communication devices.
- Technical services, such as repairs, are covered. Bill repairs with the augmentative communication device HCPCS code and the repair modifier (RP). Labor time (number of hours) for repairs is billed with the HCPCS labor code.
- Indirect time spent programming, upgrading, modifying or setting up an augmentative communication device or communication/picture book for a recipient is not billable. Only direct time spent with the recipient is billable and documentation in the patient’s records must support the need for face-to-face involvement.
Criteria for Authorization of Augmentative Communication Devices

- A description of the current medical status and history.
- An assessment of the verbal and physical capabilities in relation to need and use of an augmentative communication device (electronic and non-electronic).
- A detailed description of the therapeutic history in the areas of physical and occupational therapy and speech-language pathology. The nature, frequency, and duration of total therapeutic history provided to the recipient. Speech-language treatment approaches in relation to the need and use of an augmentative communication device must be detailed.
- An explicit evaluation of each augmentative communication device or method of communication tried by the recipient and information on the effectiveness of each device. All parameters of device selection must be addressed (e.g., interactive ability in all situational contexts; school, home, vocational, work, and social environments). A trial period of the device requested is not mandatory if objective data provides documentation for purchase.
- A detailed description of the recipient's ability to use the proposed device, including speed and accuracy. Situation references dependent upon the mobility level of the recipient must be addressed (e.g., How will the device be adapted to meet the needs of a recipient who uses a walker? Is the communication device less obtrusive than other methods when mobility levels are considered?). Empirical data regarding the trial period of use with the device is required (e.g., frequency of device use in various settings).
- A description of the level of communication initiation with the selected communication device. If the pattern of initiation is different from past history, provide an explanation and justification for the change.
- A detailed description and plan for the proposed nature, frequency, and duration of therapeutic intervention in relation to the augmentative communication device. Include all therapeutic intervention necessary.

For additional authorization policies and procedures, refer to the Authorization chapter (Ch. 5).

Non-covered Services Relating to Augmentative Communication Devices

- Environmental control devices such as switches, control boxes or battery interrupters;
- Modification, construction, programming, or adaptation of communication systems;
- Facilitated communication: a technique by which a "facilitator" provides physical and other supports in an attempt to assist a person with a significant communication disability to point to pictures, objects, and printed works or letters. (MHCP does not cover facilitated communication by any provider.);
- Personal computers and laptop computers that are not dedicated communication devices.

Augmentative Communication Device Billing Procedures

- 92597:* Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
- 92605:* Evaluation for prescription of non-speech generating augmentative and alternative communication device
• 92606:* Therapeutic service(s) for the use of non-speech generating device, including programming and modification
• 92607:* Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
• 92608:* Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)
• 92609:* Therapeutic services for the use of speech-generating device, including programming and modification

* Refer to the speech-language pathology thresholds in this chapter for information on the number of units available without authorization.

Rehabilitation Services Thresholds

The following instructions apply to rehabilitative, therapeutic, and audiology services provided to MHCP recipients living in the community or long term care facility.

• Service thresholds for OT, PT and SLP are one-time only. Medically necessary services needed beyond the one-service thresholds require authorization.
• Audiology service thresholds are by calendar year (see Rehabilitation Services Billing Threshold Chart in this chapter).
• Recipients may require a greater number of evaluations, modalities or procedures than the initial service threshold. Recipients may receive additional medically necessary services with authorization.
• Medicare crossover claims for the payment of recipient's coinsurance and/or deductible are not included or counted in the threshold limits; but
• Third-party liability claims sent to DHS for payment after other coverage paid will go toward the threshold limits.

Non-covered Services

• Physical or occupational therapy that is provided without a prescription from a physician, or other licensed practitioner of the healing arts within the practitioner’s scope of practice under state law;
• Speech-language or audiology services provided without a written referral from a physician, or other licensed practitioner of the healing arts within the practitioner’s scope of practice under state law;
• * Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the LTC facility;
• * Ambulation of a recipient who has an established functional gait pattern;
• * Services for conditions of chronic pain that do not interfere with the recipient's functional status and that can be treated by routine nursing measures;
• * Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide;
• * Bowel and bladder retraining programs;
• Art and craft activities for the purpose of recreation;
• Services not medically necessary;
• Services not documented in the recipient's health care record;
• Services not part of the recipient's plan of care;
• Services specified in a plan of care that is not reviewed and revised as medically necessary by the recipients attending physician;
• Services that are not designed to improve or maintain the functional status of a recipient with a physical impairment or a cognitive or psychological deficit;
• Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the recipient's IEP;
• A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements;
• Vocational or educational services, including functional evaluations, except as provided under IEP-related services;
• Services provided by a therapy aide or therapy student;
• Psychosocial services;
• Record keeping documentation and travel time (the transport and waiting time of a recipient to and from therapy sessions);
• Services provided by a rehabilitation agency that take place in a sheltered workshop, Day Training and Habilitation center (DT&H), Day Activity Center (DAC), or a residential or group home which is an affiliate of the rehabilitation agency;
• *Yearly assessments of LTC residents to meet OBRA regulations; and
• Training or consultation provided by an audiologist to an agency, facility, or other institution.

* These items are considered rehabilitative nursing and are part of the LTC facility per diem payment.

Authorization Criteria and Documentation

Submit the following with the authorization form:

• Readable, photocopied material;
• Arranged in chronological order;
• Documentation matching requested services; and
• Reasons why the skills of a physical therapist are required.

Send only requested documentation, not the entire file.

Initial Evaluation:

• Treatment diagnosis and date of onset, including any contraindications to treatment;
• Origin and rationale for referral, including a copy of physician's order or referral;
• Summary of previous therapy, including all evaluation or assessment reports or summary of initial findings signed by the therapist providing services;
• Current and prior functional status, including baseline evaluation and brief history indicating medical necessity;
• Documentation of when current function was lost;
• All tests performed and interpretation of results;
• Identified problems; and
• Corresponding short and long term goals that are functional, objective and measurable.

CDMI will retain copies of the initial evaluation for future authorization requests.

Care Plans

• Treatment plan, including procedure codes and modifiers used;
• Frequency of treatment and duration of each session: The record must show the date, type, length, and scope of each rehabilitative and therapeutic service provided to the recipient (the number of units requested must match the documentation - double check your calculations);
• The objective or rehabilitative and therapeutic services stated in short and long term goals which are functional, objective, and measurable;
• Functional status;
• Recipient's progress toward treatment goals for current treatment program (be specific - simply stating the recipient is making progress is not sufficient);
• Anticipated duration of future treatment including specific discharge plans; and
• Documentation supporting the need for the level of service/skill requested including the name(s) and title(s) of persons providing the service, and the name of title of the therapist supervising or directing the services.

Therapy Groups

• Description of the purpose of the group;
• Number of patient and staff members in group;
• Ratio of staff to patients;
• Duration of each session;
• Specifications regarding the medical necessity for PT or OT;
• Number of group sessions requested; and
• All items under "Initial Evaluation" and "Care Plans" (above).

Service/Supplies

• Brief history indicating medical necessity; and
• Itemized statement of supplies.
Authorization Termination

DHS will terminate reimbursement when services are discontinued by the referral source or when the recipient has:

- Met the goals of the program;
- Developed behavioral or vocational problems that are not being addressed and that interfere with return to work;
- Failed to comply with the requirements of participation;
- Developed medical contraindications; or
- Reached a plateau prior to meeting goals.

Billing

- See the Billing Policy chapter (Ch. 4) for specific CMS-1500 and UB-92 requirements.
- An independently enrolled SLP or an OT or PT in private practice may not bill for the service of another therapist.
- Services provided by PT or OT in private practice, or an independently enrolled SLP must be billed by the individual therapist, using his/her provider number.
- Services provided by therapists employed by a rehabilitation agency, LTC facility, physician clinic, CORF, CAH, Public Health Agency, hospice, or outpatient hospital, must be billed using the facility or agency's provider number.
- Services provided by a therapy assistant, when the therapist is not on the premises, must be billed using a WW modifier on the claim and are reimbursed at a reduced rate.
- Claims for services delivered to a recipient by two or more therapists in the same block of time (co-therapy session): Providers must split the time so that the total time billed does not exceed the actual length of the session.
- Use the "XC" modifier to signify that the therapy service provided was specialized maintenance therapy. The "XC" modifier is only intended to be used for specialized maintenance therapy claims and documentation in the patient’s record must support the service was specialized maintenance therapy. Any other use of the "XC" modifier is improper.
- Independent Speech Language Pathologists must advise dually eligible Medicare/Medicaid recipients to seek treatment from providers enrolled with both Medicare and MHCP.
- Independently enrolled audiologist may bill for services provided in his/ her own office, the recipient's home, LTC facility, or at Day Training and Habilitation Center(s).
- Use X5511 (OT Supplies) to bill occupational therapy supplies fabricated by the therapist, such as splints, casts, and adaptive aids. Do not use X5511 for ready made supplies or for pre-fabricated supplies that can be obtained from a medical supplier.
- The provider that bills for and receives payment for services is responsible for the accuracy of the claims and for maintaining patient records that fully disclose the extent of the benefits provided.
- Always follow Medicare guidelines for MHCP recipients who are dually eligible for Medicare and Medicaid when providing Medicare covered services.
Rehabilitative services provided in a LTC facility: Long-term care facilities may provide rehabilitative services to their residents and members of the community, utilizing either their own staff or by contracting with an outside service vendor (rehab agency). Services must be provided on the premises. MHCP will not make separate reimbursement for therapy services for residents of an LTC facility that includes therapy as part of the per diem rate. Use the following criteria to determine the correct billing method to use.

- **Employees of the LTC Facility**: PT, OT, or SLP services provided by employees of the LTC facility must be billed by the LTC facility on either the CMS-1500 or UB-92.

- **Rehabilitation Agency**: PT, OT, or SLP services provided by a rehab agency at an LTC facility can be billed by either party. However; the party designated to do the billing must bill for all rehabilitative services.

When services are billed by the rehab agency:

- Use either the UB-92 or CMS-1500;
- Enter the rehab agency's 9-digit MHCP provider number; and
- Enter the LTC facility's 9-digit provider number in FL 83, or in the physician ID field on ITS.

When services are billed by the LTC facility:

- Use either the CMS-1500 or UB-92; and
- Enter the LTC facility's 9-digit provider number.

- **Independent SLP and Private Practice PT and OT**: Services provided to MHCP recipients can be billed by either the LTC facility or the contracted independent SLPs, and PTs and OTs in private practice. However; the party designated to do the billing must bill for all rehabilitative services. The services can be billed one of two ways:

Independent SLPs or private practice PTs or OTs under contract with the LTC facility may:

- Use either the CMS-1500 or UB-92; and
- Enter the therapist's individual 9-digit MHCP provider number.

LTC facilities may:

* Use either the CMS-1500 or UB-92; and
* Enter the LTC facility's 9-digit MHCP provider number.

The provider that bills for and receives payment for services is responsible for the accuracy of the claims and for maintaining patient records that fully disclose the extent of the benefits provided. If Medicare requires the LTC facility to bill for Medicare covered rehabilitative services for dually eligible recipients, follow Medicare's requirements until Medicare benefits are exhausted.
Therapy Services Provided in Physician Clinics, Outpatient Hospitals, Community or Public Health Clinics

- Services provided by a PT, OT, SLP or audiologist employed by physicians, outpatient hospitals, community or public clinics must be billed by those organizations.
- Outpatient hospital services may only be provided in an outpatient hospital facility.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>One-Time Service Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>97003</td>
<td>Occupational therapy evaluation initial - 15 minutes</td>
<td>6 units, any combination of these codes</td>
</tr>
<tr>
<td>97004</td>
<td>Occupational therapy re-evaluation, periodic - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>X5511</td>
<td>Occupational therapy supplies, fabricated</td>
<td>Up to $32.00 per year</td>
</tr>
<tr>
<td>97703</td>
<td>Checkout for orthotic/prosthetic use, established patient - 15 minutes</td>
<td>Counts toward PT one-time service threshold</td>
</tr>
<tr>
<td>97150</td>
<td>Group session *</td>
<td>Always requires authorization</td>
</tr>
<tr>
<td>97750</td>
<td>Physical performance test - functional capacity *</td>
<td></td>
</tr>
<tr>
<td>X4511</td>
<td>Unlisted occupational therapy *</td>
<td>One-time Service threshold: 200 units (50 hours), any combination of these codes</td>
</tr>
<tr>
<td>X4515</td>
<td>Motor skills - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>X4524</td>
<td>Preventive skill - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>X4526</td>
<td>Therapeutic adaptations - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97532</td>
<td>Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct patient contact by provider, 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97533</td>
<td>Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct patient contact by provider, 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97535</td>
<td>Self care/home management (e.g., ADL’s compensatory training, meal preparation, safety procedures and instructions in use of adaptive equipment) - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97537</td>
<td>Community/work reintegration training (e.g., shopping, transportation, money management) – 15 minutes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>One-Time Service Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>97001</td>
<td>Physical therapy evaluation, initial - 15 minutes</td>
<td>8 units, any combination of these codes</td>
</tr>
<tr>
<td>97002</td>
<td>Physical therapy re-evaluation, periodic - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97032</td>
<td>Electrical stimulation - 15 minutes</td>
<td>Service threshold: 120 units (30 hours), any combination of these codes</td>
</tr>
<tr>
<td>97033</td>
<td>Iontophoresis – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97034</td>
<td>Contrast baths - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97035</td>
<td>Ultrasound - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97036</td>
<td>Hubbard tank – 15 minutes</td>
<td></td>
</tr>
</tbody>
</table>
## Physical Therapy Service Thresholds (cont.)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>One-Time Service Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>97110</td>
<td>Therapeutic procedure/exercises - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97112</td>
<td>Therapeutic procedure, neuromuscular - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97113</td>
<td>Therapeutic procedure, aquatic therapy - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97116</td>
<td>Therapeutic procedure, gait training - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97124</td>
<td>Massage – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97140</td>
<td>Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction) one or more regions - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97504</td>
<td>Orthotics fitting and training; upper and lower extremity – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97520</td>
<td>Prosthetics, initial - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic activities - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97542</td>
<td>Wheelchair management/propulsion training - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97703</td>
<td>Checkout for orthotic/prosthetic use - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>X5515</td>
<td>PT wound care - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>95831</td>
<td>Muscle testing, manual with report; extremity (excluding hand) or trunk*</td>
<td>2 treatment sessions, any combination</td>
</tr>
<tr>
<td>95832</td>
<td>Muscle testing, manual; hand, with or without comparison with normal side*</td>
<td></td>
</tr>
<tr>
<td>95833</td>
<td>Muscle testing, manual; total evaluation of body, excluding hands *</td>
<td></td>
</tr>
<tr>
<td>95834</td>
<td>Muscle testing, manual; total evaluation of body, including hands *</td>
<td>2 treatment sessions, any combination</td>
</tr>
<tr>
<td>90901</td>
<td>Biofeedback training - electromyography *</td>
<td>Service threshold: 30 treatment sessions, any combination of these codes</td>
</tr>
<tr>
<td>97010</td>
<td>Hot or cold packs *</td>
<td></td>
</tr>
<tr>
<td>97012</td>
<td>Traction *</td>
<td></td>
</tr>
<tr>
<td>97014</td>
<td>Electrical stimulation *</td>
<td></td>
</tr>
<tr>
<td>97016</td>
<td>Vasopneumatic devices *</td>
<td></td>
</tr>
<tr>
<td>97018</td>
<td>Paraffin bath *</td>
<td></td>
</tr>
<tr>
<td>97020</td>
<td>Microwave *</td>
<td></td>
</tr>
<tr>
<td>97022</td>
<td>Whirlpool *</td>
<td></td>
</tr>
<tr>
<td>97024</td>
<td>Diathermy *</td>
<td></td>
</tr>
<tr>
<td>97026</td>
<td>Infrared *</td>
<td></td>
</tr>
<tr>
<td>97028</td>
<td>Ultraviolet *</td>
<td></td>
</tr>
<tr>
<td>97039</td>
<td>Unlisted modality *</td>
<td>Always require authorization</td>
</tr>
<tr>
<td>97139</td>
<td>Unlisted therapeutic procedure - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97150</td>
<td>Therapeutic procedures, group (2 or more persons)</td>
<td></td>
</tr>
<tr>
<td>97545</td>
<td>Work hardening conditioning, initial 2 hours</td>
<td></td>
</tr>
</tbody>
</table>
### Physical Therapy Service Thresholds (cont.)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>One-Time Service Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>97546</td>
<td>Work hardening, each additional hour</td>
<td></td>
</tr>
<tr>
<td>97750</td>
<td>Physical performance test or measurement (functional capacity) – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97799</td>
<td>Unlisted physical med/rehab service *</td>
<td></td>
</tr>
<tr>
<td>X4511</td>
<td>Unlisted therapeutic procedure (for serial casting) *</td>
<td></td>
</tr>
<tr>
<td>95851</td>
<td>Range of motion measurements and report; each extremity (excluding hand) or each trunk section *</td>
<td>12 treatment sessions, any combination of these codes</td>
</tr>
<tr>
<td>95852</td>
<td>Range of motion measurements and report; hand, with or without comparison to normal side *</td>
<td></td>
</tr>
<tr>
<td>X5511</td>
<td>Fabricated casting/splinting supplies</td>
<td>Up to $32.00 per year. Additional supplies in excess of $32.00 per year, require authorization.</td>
</tr>
</tbody>
</table>

### Speech-Language Pathology Service Thresholds

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>One-Time Service Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>92506</td>
<td>Medical evaluation of speech - 15 minutes</td>
<td>1 evaluation</td>
</tr>
<tr>
<td>92610</td>
<td>Evaluation of oral and pharyngeal swallowing function</td>
<td>4 treatment sessions, any combination of these codes</td>
</tr>
<tr>
<td>92611</td>
<td>Motion fluoroscopic evaluation of swallowing function by cine or video recording</td>
<td></td>
</tr>
<tr>
<td>92612</td>
<td>Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording</td>
<td></td>
</tr>
<tr>
<td>92614</td>
<td>Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording</td>
<td></td>
</tr>
<tr>
<td>92616</td>
<td>Flexible fiberoptic endoscopic evaluation of swallowing</td>
<td></td>
</tr>
<tr>
<td>92597</td>
<td>Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech</td>
<td>2 treatment sessions, any combination of these codes</td>
</tr>
<tr>
<td>92605</td>
<td>Evaluation for prescription of non-speech generating augmentative and alternative communication device</td>
<td></td>
</tr>
<tr>
<td>92607</td>
<td>Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour</td>
<td></td>
</tr>
<tr>
<td>92608</td>
<td>Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)</td>
<td></td>
</tr>
<tr>
<td>92700</td>
<td>Unlisted otolaryngological service or procedure</td>
<td>Always require authorization</td>
</tr>
<tr>
<td>92606</td>
<td>Therapeutic service(s) for the use of non-speech generating device, including programming and modification</td>
<td></td>
</tr>
<tr>
<td>92609</td>
<td>Therapeutic services for the use of speech-generating device, including programming and modification</td>
<td></td>
</tr>
<tr>
<td>V5362</td>
<td>Speech screening (articulation) - 15 minutes</td>
<td>4 units, each code</td>
</tr>
<tr>
<td>V5363</td>
<td>Language screening (receptive or expressive) - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>V5364</td>
<td>Dysphagia screening - 15 minutes</td>
<td></td>
</tr>
</tbody>
</table>
### Speech-Language Pathology Service Thresholds (cont.)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>One-Time Service Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>92507</td>
<td>Individual speech, language or hearing treatment - 15 minutes</td>
<td>Service threshold: 200 units (50 hours), any combination of these codes</td>
</tr>
<tr>
<td>92508</td>
<td>Group speech language or hearing treatment</td>
<td></td>
</tr>
<tr>
<td>92510</td>
<td>Aural rehabilitation following cochlear implant - 15 minutes</td>
<td></td>
</tr>
<tr>
<td>92526</td>
<td>Treatment of swallowing dysfunction and/or oral function for feeding, 1 unit = 1 session</td>
<td></td>
</tr>
</tbody>
</table>

### Audiology Service Thresholds

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Annual Service Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>92506</td>
<td>Evaluation of speech - 15 minutes</td>
<td>2 evaluations per calendar year</td>
</tr>
<tr>
<td>92507</td>
<td>Treatment of speech - 15 minutes</td>
<td>5 units per calendar year</td>
</tr>
<tr>
<td>92531-92547, 92551-92557, 92560-92589</td>
<td>Audiologic function tests</td>
<td>No limit, bill 1 treatment session per test</td>
</tr>
<tr>
<td>92590</td>
<td>Monaural hearing aid exam and selection</td>
<td>1 treatment session per calendar year, any combination of codes</td>
</tr>
<tr>
<td>92591</td>
<td>Binaural hearing aid exam and selection</td>
<td></td>
</tr>
<tr>
<td>92594</td>
<td>Electroacoustic evaluation for monaural hearing aid</td>
<td></td>
</tr>
<tr>
<td>92595</td>
<td>Electroacoustic evaluation for binaural hearing aid</td>
<td></td>
</tr>
<tr>
<td>92596</td>
<td>Ear protector attenuation measurement</td>
<td></td>
</tr>
<tr>
<td>92592</td>
<td>Monaural hearing aid check</td>
<td>4 checks per calendar year, 1 unit maximum per check</td>
</tr>
<tr>
<td>92593</td>
<td>Binaural hearing aid check</td>
<td></td>
</tr>
<tr>
<td>92700</td>
<td>Unlisted otorhinolaryngological service or procedure</td>
<td>Always requires authorization</td>
</tr>
<tr>
<td>92510</td>
<td>Aural rehabilitation following cochlear implant - 15 minutes</td>
<td>Counts towards SLP 50 hour service threshold</td>
</tr>
</tbody>
</table>

* Each modality equals one treatment session.

### Hearing Aids

Hearing services are an MHCP covered service. Before providers are reimbursed for hearing aid assessments or dispensing, a physician, physician assistant or nurse practitioner must rule out medical or surgical indications contrary to fitting the recipient with a hearing aid. After ruling out contraindications, the physician then refers the recipient for an audiologic evaluation to determine if a hearing aid is necessary. An audiologist or otolaryngologist must provide the audiologic testing and if a hearing aid is indicated, prescribe a specific hearing aid offered under the hearing aid volume purchase contract. An individual who is enrolled as a hearing aid dispenser, but is not an audiologist or otolaryngologist, may not perform audiologic evaluations or prescribe hearing devices.

The hearing aid service provider must dispense the hearing aid according to the hearing aid exam, selection, and prescription of the otolaryngologist and audiologist. The recipient is to see an
In addition to reimbursement for dispensing hearing aids, hearing aid service providers may bill for:

- Hearing aid repairs;
- Accessories;
- Ear molds for hearing aids;
- Batteries; and
- Ear Impressions.

Hearing aid service providers are not separately reimbursed for audiologic evaluations, hearing aid exams and selection, hearing aid checks to determine the effectiveness of the hearing aid, or home visits.

**Enrolled Hearing Aid Dispensers**

- An individual may enroll as a hearing aid service provider if he/she is certified by the Minnesota Department of Health as a hearing instrument dispenser.
- Out-of-state hearing aid service providers who sell hearing aids/instruments in Minnesota must be certified by the Minnesota Department of Health.
- Out-of-state hearing aid service providers who do not sell hearing aids/instruments in Minnesota must comply with licensing or registration requirements of the other state, but are not required to be certified in Minnesota.

**Covered Services**

**Hearing Aid Volume Purchase Contract**

All hearing aids must be purchased directly from manufacturers that contract with DHS. Hearing aid service providers are paid the contract price plus a dispensing fee. Terms of the hearing aid contract are outlined below:

- Hearing aids must:
  - Be new, current production models.
  - Be complete instruments, including all necessary equipment to make it fully functional, carrying case and all items necessary for a proper fit.
  - Use standard commercial batteries and battery sizes.
  - Be accompanied by a live performance graph and invoice at the contracted price.
  - Have a minimum 24-month manufacturer warranty covering parts and labor. The warranty is exclusive of the ear piece, cord, and batteries.
  - Have a one-year loss and damage warranty.
• No extra charge may be made for
  - specially molded ear piece (ear molds)
  - casing color choice
  - hypo-allergenic or soft canal casing

• Hearing aids that do not prove satisfactory to a user are to be returned to the manufacturer within 90 days the date the hearing aid is provided to the recipient at no cost to DHS or the hearing aid dealer.
• The contract price for a hearing aid cannot be further reduced or altered.
  - Orders for DHS contracted hearing aids may not be used to obtain, or grant, additional commercial discounts.

• Manufacturers will not process hearing aid orders unless all authorization requirements are met.
• The manufacturer may not charge extra for packaging, postage, insurance, or handling while the aid is under warranty.

**Hearing Aids Not on Volume Purchase Contract List (Non-contract aids)**

Hearing aid service providers must provide hearing aids under the terms of the volume purchase contract. If the audiologist prescribes a non-contract hearing aid, the hearing aid service provider must obtain authorization by providing the information below:

• Reasons the contract aids will not meet the recipient's needs;
• Reasons the non-contract aid will meet the recipient's needs (describe extenuating circumstances that eliminate the possible use of a contract aid); and
• The hearing aid service provider who bills for the repair of a non-contract aid must obtain and include the purchase date and the purchase warranty expiration date of the hearing aid from the manufacturer. If the aid is under warranty, MHCP will not reimburse providers or manufacturers for repairs or the cost of returning the aid to the manufacturer.

**Dispensing Fee**

DHS will reimburse the hearing aid service provider one dispensing fee for fitting and dispensing a monaural or set of binaural hearing aids for a recipient. Claims are not eligible for payment until after the hearing aid has been dispensed. The dispensing fee includes:

• Adjusting the hearing aid to the wearer, including the necessary programming on digital and digitally programmable aids,
• Provision of at least three hearing aid batteries of the type necessary to operate the hearing aid,
• Informing the recipient of the trial period,
• Instructing and counseling the recipient on use and care of the hearing aid,
• A written copy of the manufacturer's warranty,
• Returning the hearing aid to the manufacturer for repair during the 24-month warranty period for parts and labor; and
• Replacing the aid during the 12-month replacement warranty period.

**Hearing Aid Trial Period**

Hearing aids obtained under the volume purchase contract that are not satisfactory to the user may be returned to the manufacturer within 90 days after the dispensing date, but no sooner than 30 days.

The trial period consists of consecutive days beginning the day the hearing aid is provided to the recipient and must extend at least 30 days, but no more than 90 days. The hearing aid service provider must inform the recipient of the beginning and ending dates of the trial period, and refer the recipient to the prescribing audiologist when the aid cannot be adjusted to the recipient’s satisfaction. If the audiologist prescribes a hearing aid to replace the unsatisfactory aid, the hearing aid service provider must order the prescribed replacement aid.

**Hearing Aid Replacement**

MHCP covers one hearing aid or set of binaural hearing aids within a period of five years for an eligible recipient. If hearing aids must be replaced more often due to change in hearing, or hearing aid loss, theft, or irreparable damage, the provider must request authorization for a new aid. MHCP considers the recipient's physical or mental impairment in determining whether circumstances were beyond the recipient's control if the aid is lost or broken and will only approve a replacement in those cases.

*Always* check the EVS system to determine the recipient’s eligibility and prior receipt of a hearing aid(s) before dispensing or requesting an authorization.

MHCP will not replace a lost or broken hearing aid for an adult 21 years of age or over when MHCP has replaced a hearing aid twice within the five-year period previous to the date of request. In such cases when MHCP does not provide a hearing aid, the hearing aid service provider may provide the eligible recipient with a contract hearing aid at the contract price. The hearing aid and dispensing fee shall be paid by the recipient.

**Hearing Aid Repairs**

MHCP does not cover repairs or the cost of returning the aid to the manufacturer if the aid is under warranty. All claims for hearing aid repairs must include the hearing aid expiration warranty date. To verify the hearing aid warranty has expired, hearing aid service providers must obtain the purchase date and purchase warranty expiration date from the manufacturer and submit with hearing aid repair claims. All hearing aid repairs are required to be warrantied for a minimum of six months, whether sent to the manufacturer or performed by the hearing aid service provider. Most manufacturers on the volume purchase contract are providing a one-year repair warranty. Specific repair warranty information can be found in [Provider Update #142](#).
The hearing aid repair rate is determined by the hearing aid volume purchase contract under which the aid was purchased. The hearing aid volume purchase contracts require manufacturers to honor the contracted repair rate for a period of three years following the expiration of the contract.

For non-contract hearing aids, those that were purchased outside the volume purchase contract, parts and labor, including manufacturer fees, constitute one repair charge.

**Ear Impressions**

Ear impressions needed for the purpose of custom making an in-the-ear (ITE) hearing aid and ear molds for behind-the-ear (BTE) hearing aids are reimbursed as a separate service from the dispensing fee.

**Ear Molds**

Replacement ear molds for BTE hearing aids are covered.

**Accessories**

Hearing aid accessories such as chest harnesses, telecoils, and tone and ear hooks are covered.

**Telecoils**

If not standard with recommended hearing aid, telecoils are covered:

- One aid per person;
- When the audiologist determines a recipient needs the telecoil to use the telephone; and
- After the audiologist determines that the recipient's telephone is compatible with the hearing aid's telecoil by report or direct examination.

**Batteries**

Hearing aid batteries may not, at one time, be dispensed in a quantity that exceeds a 90-day supply. Hearing aid batteries may not be dispensed unless the recipient is in need of the batteries and has requested them.

**Systems Other Than Personal Hearing Aids**

Authorization is required for all systems other than personal hearing aids. When such systems as FM systems, vibrotactile devices, or personal communicators (e.g., pocket talkers) are requested, justification is needed, just as for non-contract aids. The audiologist must also address the following points:

- Why the person cannot use personal hearing aids (e.g., person's unique inability to use auditory information provided via hearing aids); and
• Documentation of expectation of person's ability to recognize and use vibrotactile information, specific to vibrotactile instruments (e.g., response to environmental vibratory information or low frequency bone conducted vibratory information).

Non-covered Services

• Replacement batteries provided on a scheduled basis regardless of actual need.
• Services specified as part of the contract price when billed separately for payment, including charges for repair of hearing aids under warranty.
• Routine screening of individuals or groups for identification of hearing problems.
• Separate reimbursement for postage, handling, taxes, mileage, or pickup and delivery.
• Non-electronic hearing aids, telephone amplifiers, vibrating bed alarms, phone handsets, visual telephone ringers, swim molds, ear plugs, dry aid kits, and battery chargers.
• Regularly scheduled maintenance, cleaning, and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian or attending physician.
• Loaner hearing aid charges.
• Canal type hearing aids.
• Non-contract hearing aids obtained without authorization.
• Services included with the dispensing fee when billed separately.
• Hearing aid services to a resident of an LTC facility if the services did not result from a request by the resident, a referral by a registered nurse or licensed practical nurse who is employed by the LTC facility, or a referral by the resident's family, guardian or attending physician.
• Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the "safe harbor" exceptions listed in Code of Federal Regulations, title 42, part 1001, section 952.

Hearing Services Documentation Requirements and Approval Criteria

The following documentation requirements for medical records apply regardless of whether or not the hearing aid requires authorization. This information must also be attached to authorization forms, if authorization is required.

• Physician's medical clearance stating no contraindication for hearing aid use. This may include general support for amplification, if needed, to determine medical necessity. Hearing services for a resident of an LTC facility must result from a request by the recipient, or a referral by facility nursing staff or the recipient's family, guardian, or attending physician, and be part of the recipient's plan of care or ordered in writing by the attending physician.
• Audiologic recommendations including:
  • Written recommendation for hearing aid(s) including manufacturer specifications; and
  • Follow-up plan for determining effectiveness of hearing aid use.
• Documentation supporting audiologic recommendations:
  - Audiogram – air and bone thresholds, speech thresholds, word recognition scores for each ear or reason why this data was not obtained and report of substitute data, e.g., sound field, informal tests – Internal consistency of data needed;
  - History of previous appliance use and status of current aid(s), if applicable;
  - When evidence of middle ear dysfunction exists (e.g., abnormal tympanometry or audiometric conductive loss), audiologist must give rationale for recommending hearing aid use prior to documentation of normal middle ear function (e.g., previous diagnosis of inoperable otosclerosis); and
  - Audiologist's documentation of need for amplification, this may include interpretation of audiometric data relative to recipient's communication needs, formal hearing aid evaluation, real ear measurements, sound field, etc.

• An adult's pure-tone average (PTA) must be 25 dB HL and a child's PTA must be 20 dB HL or greater in the fitted ear to qualify for a hearing aid under this program, or authorization is required. The PTA is the average air-conduction threshold for 1000 and 2000 Hz, and 3000 Hz measured with an earphone.

Billing

All hearing aid providers must bill services on the Pharmacy/Supply Invoice (DHS-3065 or ITS software). For further billing instructions, please refer to the Billing Policy chapter (Ch. 4).

• Claims for hearing aid purchases must include;
  - Correct model number
  - Correct modifiers – NU, LT, RT
  - ICD-9 diagnosis code(s)
  - Monaural aid = 1 unit
  - Binaural aids = 2 units

• Bill the usual and customary charge.
  - Claims may not be submitted before the hearing aid(s) is dispensed.
  - Do not bill accessories included with the initial hearing aid purchase.

• Use the appropriate HCPCS code.

• Bill dispensing fee procedure code for the type of hearing aid dispensed, monaural, or binaural.
  - Monaural = 1 unit
  - Binaural = 2 units
  - Dispensing fees require authorization whenever the hearing aid requires authorization.
• If the provider has billed for an unsatisfactory hearing aid, the provider must submit a replacement claim for both the replacement hearing aid and all but one-half of the dispensing fee. Both the replacement hearing aid and dispensing fee require authorization.

  ▪ If the provider has not billed for the unsatisfactory aid and dispensing fee and it is the first hearing aid claim in five years, the new aid may be provided immediately without requesting authorization.

• Claims for hearing aid repairs must include the:
  ▪ Correct model number.
  ▪ Correct modifiers – RP, 22, LT, RT.
  ▪ The hearing aid purchase warranty expiration date entered in the comment section of the claim form using \texttt{mm/dd/yy} format.
  ▪ Hearing aid volume purchase contract number in the comment section of the claim form for all contract hearing aids.
  ▪ Repair invoice for repairs of non-contract hearing aids.

• Repairs do not constitute replacement of minor parts or cleaning of a hearing aid.
  ▪ Use the appropriate HCPCS codes to bill these services.

• Bill hearing aid batteries in quantities of one unit per battery.
• Hearing aid dispensing services cannot be billed under a hospital, clinic, or agency provider number. DHS only reimburses individuals enrolled as hearing aid service providers for hearing aid services.

For the current listing of manufacturers and hearing aid models available through the Minnesota Hearing Aid Volume Purchase Contract, refer to Provider Update \textit{#142}. Copies of Provider Update \textit{#142} can be obtained on-line or by contacting the Provider Call Center at (651) 282-5545 or 1-800-366-5411.

**Hearing Aid Services Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Service Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5070</td>
<td>Hearing aid in glasses, air conductive</td>
<td>Always require authorization</td>
</tr>
<tr>
<td>V5080</td>
<td>Hearing aid in glasses, bone conductive</td>
<td></td>
</tr>
<tr>
<td>V5150</td>
<td>Hearing aid in glasses, binaural</td>
<td></td>
</tr>
<tr>
<td>V5190</td>
<td>CROS, in glasses</td>
<td></td>
</tr>
<tr>
<td>V5230</td>
<td>BiCROS, in glasses</td>
<td></td>
</tr>
<tr>
<td>V5274</td>
<td>Assistive listening device, not otherwise specified (for use for FM systems and vibrotactile devices)</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Limit</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>V5090</td>
<td>Dispensing fee, unspecified hearing aid – use when dispensing FM system and vibrotactile device</td>
<td>1 monaural or binaural hearing aid per 5 calendar years</td>
</tr>
<tr>
<td>V5100</td>
<td>Pocket Talker</td>
<td></td>
</tr>
<tr>
<td>V5110</td>
<td>Pocket Talker dispensing fee</td>
<td></td>
</tr>
<tr>
<td>V5273</td>
<td>Assistive listening device, for use with cochlear implant</td>
<td></td>
</tr>
<tr>
<td>V5030</td>
<td>Monaural, body worn, air conductive</td>
<td></td>
</tr>
<tr>
<td>V5040</td>
<td>Monaural, body worn, bone conductive</td>
<td></td>
</tr>
<tr>
<td>V5050</td>
<td>Monaural, ITE</td>
<td></td>
</tr>
<tr>
<td>V5060</td>
<td>Monaural, BTE</td>
<td></td>
</tr>
<tr>
<td>V5120</td>
<td>Binaural, on-the-body</td>
<td></td>
</tr>
<tr>
<td>V5130</td>
<td>Binaural, ITE</td>
<td></td>
</tr>
<tr>
<td>V5140</td>
<td>Binaural, BTE</td>
<td></td>
</tr>
<tr>
<td>V5170</td>
<td>CROS, ITE</td>
<td></td>
</tr>
<tr>
<td>V5180</td>
<td>CROS, BTE</td>
<td></td>
</tr>
<tr>
<td>V5210</td>
<td>BiCROS, ITE</td>
<td></td>
</tr>
<tr>
<td>V5220</td>
<td>BiCROS, BTE</td>
<td></td>
</tr>
<tr>
<td>V5246</td>
<td>Monaural ITE, digitally programmable analog</td>
<td></td>
</tr>
<tr>
<td>V5247</td>
<td>Monaural BTE, digitally programmable analog</td>
<td></td>
</tr>
<tr>
<td>V5252</td>
<td>Binaural ITE, digitally programmable</td>
<td></td>
</tr>
<tr>
<td>V5253</td>
<td>Binaural BTE, digitally programmable</td>
<td></td>
</tr>
<tr>
<td>V5256</td>
<td>Monaural ITE, digital</td>
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</tr>
<tr>
<td>V5257</td>
<td>Monaural BTE, digital</td>
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<tr>
<td>V5260</td>
<td>Binaural ITE, digital</td>
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</tr>
<tr>
<td>V5261</td>
<td>Binaural BTE, digital</td>
<td></td>
</tr>
<tr>
<td>V5160</td>
<td>Dispensing fee, binaural</td>
<td>1 dispensing fee per 5 calendar years</td>
</tr>
<tr>
<td>V5200</td>
<td>Dispensing fee, CROS</td>
<td></td>
</tr>
<tr>
<td>V5240</td>
<td>Dispensing fee, BiCROS</td>
<td></td>
</tr>
<tr>
<td>V5241</td>
<td>Dispensing fee, monaural hearing aid, any type</td>
<td></td>
</tr>
<tr>
<td>V5266</td>
<td>Battery for use in hearing device</td>
<td>Limit, 90 day supply</td>
</tr>
<tr>
<td>V5267</td>
<td>Hearing aid supplies and accessories (e.g. chest harness, telecoils)</td>
<td>If recommended hearing aid requires authorization, parts and accessories also require authorization.</td>
</tr>
<tr>
<td>V5264</td>
<td>Ear mold/insert, not disposable, any type</td>
<td></td>
</tr>
<tr>
<td>V5275</td>
<td>Ear impressions, each</td>
<td></td>
</tr>
<tr>
<td>V5299</td>
<td>Miscellaneous hearing aid servicing (e.g. removal of ear wax, cleaning)</td>
<td></td>
</tr>
</tbody>
</table>
Legal References

MS 256B.0625, subd. 8; subd. 8a; subd. 8c; subd. 31a
MS 256D.03, subd. 4
Minnesota Rules 4658.0525
Minnesota Rules 9505.0175
Minnesota Rules 9505.0210
Minnesota Rules 9505.0220
Minnesota Rules 9505.0385
Minnesota Rules 9505.0386
Minnesota Rules 9505.0390
Minnesota Rules 9505.0391
Minnesota Rules 9505.0392
Minnesota Rules 9505.0410
Minnesota Rules 9505.0411
Minnesota Rules 9505.0287 (Hearing Aid Services)
MS 256B.0625, subd. 311 (Aug. Communication Devices)
42 CFR 440.110
42 CFR 483.45
42 CFR sub. H, 485.701 to 485.729
42 CFR sub. D, 486.150 to 486.163
Chapter 18

Chiropractic Services

Definition

A medically necessary chiropractic service provided by a licensed doctor of chiropractic.

Eligible Providers

Chiropractors who are licensed under Minnesota law.

Eligible Recipients

All MHCP recipients.

Covered Services

- Manual manipulation of the spine for treatment of subluxation (incomplete or partial dislocation) and determined to be medically necessary by generally accepted chiropractic standards of care; and
- X-rays that are needed to support a diagnosis of subluxation.

Non-covered Services

The following list of non-covered services is not all inclusive. There may also be other services that are not covered.

- Examinations and consultations;
- Office visits that do not include manual spinal manipulation;
- Laboratory services;
- Vitamins or nutritional counseling;
- Acupressure or acupuncture (see Physician and Professional Services chapter [Ch. 6] for acupuncture);
- Treatment for a neurogenic or congenital condition that is not related to a diagnosis of subluxation;
- Medical supplies or equipment supplied or prescribed by a chiropractor;
- X-rays, other than those needed to support a diagnosis of subluxation;
- Exercise counseling, activities of daily living counseling; and
- Physiotherapy modalities including, but not limited to:
  - Ultrasound
  - Diathermy
  - Electrical muscle stimulation
- Interferential current
- Russian stimulation
- Application of hot/cold packs
- Massage
- Manual muscle stimulation
- Activator

**Payment Limitations**

- Payment for manual manipulation of the spine is limited to six per month or a total of 24 per calendar year unless authorization is obtained. An office visit for manual manipulation of the spine is considered part of the service and cannot be billed separately to MHCP or recipients.
- Payment for x-rays is limited to radiological examinations of the full spine; the cervical, thoracic, lumbar, and lumbosacral areas of the spine; the pelvis; and the sacroiliac joints.

**Authorization Standards**

When you submit a request for authorization (DHS-3066), the [Chiropractic Information Form](#) must also be completed and attached.

**Billing**

Use the CMS-1500 claim format.

**Chiropractic Information Form**

[PDF version](#)

**Legal References**

Minnesota Rules 9505.0245
MS 148.01 to 148.106 (licensing requirements)
42 CFR 440.60(b)
Chapter 19: Dental Services

The purpose of the dental program is to provide for the medically necessary oral health needs of the recipient/enrollee and to maintain an appropriate level of dental health according to dental community standards.

Definitions

**Crown:** A restoration covering or replacing the major part of the whole portion of the tooth not covered by supporting tissues.

**Dental Service:** A diagnostic, preventive, or corrective procedure furnished by or under the supervision of a dentist.

**Emergency services:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- The recipient must be seen by the dentist on the same day that the recipient contacted the dentist in order for the situation to be considered an emergency.
- The situation is not considered an emergency if the recipient contacts the dentist and is not given an appointment for the same day of the call.
- Prescheduled services are not considered an emergency.
- Follow-up care, to initial emergency services, is considered part of the annual $500 cap. The recipient’s medical record must contain supporting documentation of the nature of the emergency.

When emergency criteria are met, the following services are considered emergency and paid outside the annual $500 cap:

- D0140 problem-focused evaluation
- D0160 Problem focused evaluation
- D0220 - D0230 X-ray
- D0270 - D0272 X-ray
- D0330 X-ray
- D2140 - D2430 Fillings
- D2940 Sedative filling
- D2951 Pin retention
- D2955 Post removal
- D2957 Post removal
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- D2970 - D2980  Temporary crown/crown repair
- D3220 - D3221  Pulpal debridement
- D3310 - D3348  Root canals
- D4320 - D4321  Splinting
- D7111  Coronal remnants-deciduous tooth
- D7140  Extraction
- D7210  Surgical removal of erupted tooth
- D7250  Surgical removal of residual tooth roots (cutting procedure)
- D7270  Tooth reimplantation and/or stabilization
- D7510 - D7520  Incision/drain abscess-intraoral soft tissue
- D9110  Palliative (emergency) tx of dental pain – minor procedure
- D9220 - D9248  Anesthesia
- D9420 - D9440  Professional visits
- D9610 - D9630  Drug injection
- D9910  Desensitizing medication
- D9911  Application of desensitizing resin, per tooth
- D9920  Behavior management
- D9930  Treatment of complication, post surgical/unusual circumstances
- D9951  Occlusal adjustment

**Fixed Partial Denture or Fixed Cast Metal Restoration or Fixed Bridge:** A prosthetic replacement of one or more missing teeth that is cemented or attached to the abutment adjacent to the space filled by the prosthetic replacement and that cannot be removed by the patient.

**Implant:** Material inserted or grafted into tissue or bone; or a device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement.

**Oral Hygiene Instruction:** An organized education program by or under the supervision of a dentist to instruct a patient about the care of the patient’s teeth.

**Rebase:** The process of refitting a denture by replacing the base material.

**Reline:** The process of resurfacing the tissue side of the denture with a new base material.

**Removable Prosthesis or Removable Dental Prosthesis:** Includes dentures and removable partial dentures. Any dental device or appliance replacing one or more missing teeth, including associated structures, if required, that is designed to be removed and reinserted by the patient.

**Medical and Surgical Services:** Medical and surgical services furnished by a doctor of dental medicine or dental surgery if the services:

- If furnished by a physician, would be considered physician's services;
- Under the law of the state where they are furnished, may be furnished either by a physician or doctor of dental medicine or dental surgery; and
• Are furnished by a doctor of dental medicine or dental surgery who is authorized to furnish those services in the state in which he or she furnished the services.

Eligible Providers

General dentists, endodontists, oral & maxillofacial surgeons, orthodontists, pedodontists, periodontists, and prosthodontists.

Eligible Recipients

All MHCP recipients.

Dental Copay for GAMC

GAMC recipients are required to pay a 50% copay for each restorative dental service provided on or after October 1, 2003. The copay provision limiting one copay per treating provider does not apply to the 50% restorative dental service copay. The services requiring a copay are the same as those in the MinnesotaCare Program. The 50% GAMC copays are listed in Provider Update #172 and available at http://www.dhs.state.mn.us/Provider/upd/update172.htm.

MinnesotaCare Dental Coverage Changes

Restorative dental benefits are added to the MinnesotaCare Basic and MinnesotaCare Basic Plus benefit sets. Previously, enrollees in these benefit sets had only preventive dental coverage. The restorative benefit that has been added is subject to the $500 annual cap as described later in this chapter. The services described under emergency services will be exempt from the $500 annual cap (emergencies, dentures, etc.).

The 50% restorative dental copay will not apply to enrollees in the MinnesotaCare Basic and MinnesotaCare Basic Plus benefit set. The 50% restorative dental copays will continue to apply to MinnesotaCare enrollees in the Basic Plus Two and Basic Plus One benefit set, and are listed in Provider Update #152 and available at http://www.dhs.state.mn.us/Provider/upd/update152.htm.

For FFS only, services meeting the emergency criteria defined in this chapter and provided to FFS MinnesotaCare Basic Plus Two and Basic Plus One enrollees are excluded from copay requirements. Prepaid health plan enrollees in these benefit sets will not be excluded from copays for emergency services. Contact the enrollee’s health plan if you have questions about the enrollee’s copay requirements.

Dental Services Benefit Annual $500 Cap

Effective for dates of service on or after October 1, 2003, adult dental coverage is limited to an annual $500 calendar year cap for MA, GAMC, and MinnesotaCare programs with dental benefits.
The annual $500 cap applies to:

- Dental services provided October 1, 2003 through December 31, 2003. The annual $500 cap starts again each January 1 of every calendar year. The annual $500 cap applies to authorized services that are not in progress prior to October 1, 2003.
- Enrollees of health plans.

**Individuals exempt** from the annual $500 cap are:

- Recipients under age 21
- Pregnant women whose pregnancy has been coded in the DHS system

**Services exempt** from the annual $500 cap are:

- Services authorized and in progress prior to October 1, 2003
- Emergency services
- Dentures and related extractions
- Medical/surgical services performed by a dentist and billed on the CMS-1500 claim form
- Facility fees submitted by a hospital or a free-standing Ambulatory Surgical Center (ASC)
- Ancillary services, such as anesthesia

Providers are not required to submit claims to DHS after the recipient has met the annual $500 cap.

**Fee-for-Service Recipient Responsibility**

- If the annual $500 cap is met within a specific service, the recipient is responsible for the remaining amount that MHCP would have paid. The recipient is not responsible for more than the MHCP allowable for that specific service.
- After the annual $500 cap is met, the recipient is responsible for the provider’s usual and customary charge.

**Example:** A recipient has met $425 of the $500 annual cap. The recipient receives additional dental services. The MHCP dental provider submits an ADA claim with three lines of service.

1. **Line 1:** Provider’s submitted charge = $50.00, DHS allowed amount = $35.00
   - DHS approves the service. Because the annual $500 cap is not yet met, the DHS paid amount is applied toward the annual $500 cap. After line one has processed, $460.00 of the cap has been met, and $40.00 remains of the $500 annual cap.

2. **Line 2:** Provider submitted charge = $100.00, DHS allowed amount = $60.00
   - DHS approves the service. Because the annual $500 cap is not yet met, $40.00 of the DHS allowed amount is applied toward the annual $500 cap. The provider may bill the recipient the balance of the DHS allowed amount; in this case, $20.00.

3. **Line 3:** Provider submitted charge = $200.00, DHS allowed amount = $150.00
   - DHS denies the service. Because the annual $500 cap has been met, the provider may bill the recipient the provider’s usual and customary charge for the service; in this case, $200.
Covered Services (Not all inclusive)

- Oral hygiene instruction;
- Fluoride treatment;
- Panoramic film;
- Dental x-rays;
- Dental prophylaxis;
- Sealants;
- Oral evaluation;
- Full mouth debridement;
- Behavior management, which in dental terminology, is a documented service that is necessary to ensure that a covered dental procedure is performed correctly and safely;
- Space maintainer;
- Oral surgery and extractions;
- Fillings;
- Endodontic therapy and periodontal therapy;
- Removable partial dentures;
- Removable dentures;
- Crowns that meet the specifications of utilization criteria (see guideline below);
- Orthodontic treatment that meets the specifications of utilization criteria (see guidelines below);
- Reline or rebase of a removable denture;
- Dental implants that meet the specifications of utilization criteria (See guideline below).

Coverage Guidelines and Authorization

Removable Prosthesis

Initial placement or replacement of a removable prosthesis is limited to once every three years per patient unless a condition applies:

- Replacement of a removable prosthesis in excess of this limit is eligible for payment if the replacement is necessary because the removable prosthesis was misplaced, stolen, or damaged due to circumstances beyond the patient’s control. When applicable, the patient’s degree of physical and mental impairment must be considered in determining whether the circumstances were beyond a patient’s control.

- Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient’s dental needs.

- Service for a removable prosthesis must include instruction in the use and care of the prosthesis and any adjustment necessary to achieve a proper fit during the six months immediately following the provision of the prosthesis. The dentist shall document the instruction and the necessary adjustments, if any, in the patient’s dental record.
Authorization Criteria for Partial Dentures

Requests for authorization for partial dentures must be submitted with the following dental history, case information, and documentation:

- History regarding all previous prosthesis.
- Dental history pertinent to request.
- Periapical of the involved arch for all partial denture requests.
- Indicate on the ADA claim form all missing teeth and teeth to be replaced by the partial denture.
  - "X" all missing teeth
  - "O" all teeth to be replaced by partial dentures
- Periodontal charting and periodontal prognosis of remaining teeth when requesting metal framework partial dentures;
- If requesting replacement of existing prosthesis:
  - Specific reason for request; and
  - Specify why existing full or partial denture cannot be relined, rebased, or repaired.

Removable Denture Payment Criteria

All of the following criteria must be met for a provider to receive payment for a removable denture:

- The crown to root ratio must be better than 1:1;
- The surrounding abutment teeth and the remaining teeth must not have extensive tooth decay; and
- The abutment teeth must not have large restorations or stainless steel crowns.

Fixed Partial Denture, Fixed Bridge

Authorization is required for fixed dentures (which are cost-effective) for persons who are unable to use removable dentures because of their medical condition.

Replacement of damaged fixed denture for individuals who are unable to use a removable denture due to a medical condition, requires authorization.

Requests for authorization for fixed denture must be submitted with the following documentation:

- The recipient's mental and/or physical condition including ICD-9-CM and DSM III-R diagnoses that cause the recipient's inability to use a removable denture.
- An explanation of the reason the recipient is unable to use a removable denture.
- The specific treatment plan, and the long-range prognosis for the remaining dentition.

Dentures and Related Extractions
Denture procedure codes D5110 - D5899, D6053 - D6054, D6078 - D6079, D6090, D6210 - D6999, including complete, partial, removable, and fixed dentures, as well as denture relining and repairs, are excluded from the annual $500 cap.

Extraction procedure codes D7140 - D7250, when extraction is performed in preparation for dentures, are excluded from the annual $500 cap. When only third molars/wisdom teeth are extracted, payment will be applied to the annual $500 cap.

**Orthodontic Treatment Criteria**

At least one of the following criteria must be met:

1. There is a disfigurement of the patient’s facial appearance including protrusion of upper or lower jaws or teeth;
2. There is spacing between adjacent teeth which interferes with the biting function;
3. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when the person bites;
4. Positioning of jaws or teeth impairs chewing or biting function; or
5. Based on a comparable assessment of the above (1) to (4) criteria, there is an overall orthodontic problem that interferes with the biting function.

**Orthodontic Authorization Documentation**

The dentist must submit the following documentation when considering orthodontic care:

- Description of classification of occlusion (e.g., angle class, arch crowding or spacing, etc.).
- Functional problems (e.g., overbite, overjet, cross bites, etc.).
- Disfiguring characteristics (e.g., facial asymmetry, etc.).
- Contributing factors (e.g., missing teeth, impacted teeth, etc.).
- Specific treatment plan and appliances (enter the appropriate treatment code in the area labeled procedure number).
- Five intraoral photographs; upper and lower occlusal. Prints or mounted slides are acceptable. Include profile photos.
- Appropriate radiographs (panorex or full mouth and cephalometric).

A separate letter may be included with additional information if desired. If the above information is not adequate, DHS may request study models. **Do not send models unless requested.**

**MHCP does not cover treatment deemed to be cosmetic or for aesthetic reasons.**

Orthodontic care usually requires lengthy treatment. It is recommended that the provider discuss the expected eligibility period with the family and the county human services agency before initiating treatment. This will clarify the eligibility policies and help reduce denial of payment, due to subsequent ineligibility.
Crowns

An individual crown must be made of prefabricated stainless steel, prefabricated resin, or laboratory resin to be covered, except as medically necessary in conjunction with a fixed bridge cover by MHCP or an implant covered by MHCP.

**Dental Implant Criteria**

The following criteria (1) to (3) must be met to receive payment for dental implants and related services:

1. There must be bone and tooth loss that compromises chewing or breathing;
2. The implants must be medically necessary and cost-effective; and
3. A complete treatment plan, including prosthesis and all related services, must be approved prior to the start of treatment.

The Authorization Request for Dental Implants form must be completed and included with the necessary documentation requirements sent to CDMI. The Authorization Request for Dental Implants form is available through DHS Forms Supply and on the DHS Web site at http://www.dhs.state.mn.us/provider/pdf/dhs-3538.pdf.

**Peridontal Scaling and Root Planing**

The following criteria must be met to receive payment for periodontal scaling and root planing:

- Evidence of bone loss must be present on the current radiographs-panoramic, full mouth series or bitewing-to support the diagnosis of periodontitis;
- There must be current periodontal charting with six point and mobility noted, including presence of pathology and periodontal prognosis;
- The pocket depths must be greater than four millimeters; and
- Classification of the periodontology case type must be in accordance with documentation established by the American Academy of Periodontology.

For consideration of periodontal recall, include:

- Date of original periodontal scaling and root planning;
- Documentation showing response to treatment/benefit from treatment (e.g., initial and current periodontal charting); and
- Current radiographs.

**General Authorization Standards and Criteria**

When requesting authorization for a procedure, adequate and detailed documentation must be attached to the authorization request. Use the American Dental Association (ADA) form when requesting, Current Dental Terminology (CDT-3) procedure codes, and the Medical Authorization form (DHS 3066) when requesting Physician's Current Procedural Terminology (CPT) procedure.
codes. All authorization requests must be submitted to Care Delivery Management, Incorporated (CDMI). See Authorization chapter (Ch. 5) for authorization requirements. Reminder: CDT-4 codes required effective January 1, 2003.

Non-covered Services

The following dental services are not eligible for payment under the medical assistance program:

- Pulp caps;
- A local anesthetic that is used in conjunction with an operative or surgical procedure and billed as a separate procedure;
- Hygiene aids, including toothbrushes;
- Medication dispensed by a dentist that a patient is able to obtain from a pharmacy;
- Acid etch for a restoration that is billed as a separate procedure;
- Prosthesis cleaning;
- Removable unilateral partial denture that is a one-piece cast metal including clasps and teeth;
- Dental service for cosmetic or aesthetic purposes;
- Fixed partial denture or fixed bridge, unless it has been determined to be medically necessary and cost-effective for a patient who cannot use a removable prosthesis due to a mental or physical medical condition;
- Replacement of a denture when a reline or rebase would correct the problem;
- Gold restoration or inlay, including cast nonprecious and semiprecious metals;
- Implants and related services when the conditions and criteria are not met.

Oral Surgery

Oral Surgery Eligible Providers

Board eligible and board certified oral and maxillofacial surgeons must use the Physician's Current Procedural Terminology (CPT) procedure codes when billing MHCP. To receive reimbursement for CPT procedure codes, the provider must be enrolled individually with DHS.

Billing

Refer to the Billing Policy chapter (Ch.4) for billing. Consult the CPT manual for oral and maxillofacial surgery procedure codes. Authorization requirements may be different for CPT procedure codes. Do not bill using HCPCS or CDT-3 dental codes.

Hospitalization

Inpatient

Authorization is required for services performed in the inpatient hospital setting for medical or dental services provided by a dentist. The treating dentist must obtain authorizations for inpatient
hospitalization and the services provided in the hospital. Inpatient hospitalization for dental services are subject to utilization review procedures.

**Outpatient**

Authorization is required only if the procedure to be performed requires authorization. Routine services do not require authorization.

**Medical/Surgical Services of a Dentist**

Dentists who perform medical procedures must follow the practitioner and general authorization guidelines for exams, consultations, radiology, surgery, anesthesia, and laboratory services.

**Coverage Criteria**

**Dental Services:** Any service rendered in connection with care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth. "Structures directly supporting the teeth" means the periodontium, gums, dento-gingival junction, periodontal membrane, cementum of teeth and alveolar process, or the alignment or occlusion of teeth.

For example, the reconstruction of a ridge performed primarily to prepare the mouth for dentures cannot be reimbursed as a medical procedure. This is considered a dental procedure. However, when the reconstruction of a ridge is performed at the same time as the surgical removal of a tumor, the procedure would then be considered a medical service.

**Medical Services:** Services performed by a dentist are defined as surgery when related to the jaw or any structure contiguous to the jaw. "Structures contiguous to the jaw" include structures of the facial area and below the eyes (e.g., mandible, teeth, gums, tongue, palate, salivary glands, or sinuses). This includes reduction of any fracture of the jaw or any facial bone, including dental splints or other applications used for this purpose.

For ancillary services to be covered, the primary services/procedures must be covered services under MHCP. If the primary procedure is not a covered service, regardless of the complexity or difficulty, coverage of services such as the administration of anesthesia, diagnostic x-rays, and other related procedures will not be covered.

**Anesthesia**

Anesthesia provided in the dental office should be billed on the ADA claim form with CDT-3 procedure codes. Any anesthesia service performed in an ASC/hospital setting must be billed on the CMS-1500 by the anesthesia group. If the procedure requires the services of a CRNA/anesthesiologist, bill on the CMS-1500 with CPT procedure codes or ASA anesthesia codes with the appropriate modifiers. When the CRNA/anesthesiologist is a hospital employee, the hospital bills the anesthesia services.
A/an CRNA/anesthesiologist who is enrolled as a MHCP provider must bill separately for their anesthesia services.

**Combined Medical and Dental Treatments**

For procedures that need authorization for both medical and dental services, the authorizations are to be coordinated. The written authorization for medical services must also include the information about the dental services to be performed along with the medical services. Request medical services on the Medical Authorization Form (DHS-3066) and dental services on the ADA claim form.

**Temporomandibular Joint (TMJ) Disorder**

Whether TMJ treatment is a medical service or dental service is determined by the underlying cause. If the underlying cause is dental in nature, the dentist must bill CDT-3 procedure codes. If the underlying cause is medical in nature, bill CPT procedure codes.

Examples of conditions that are not medical services, and must be billed as dental services on the ADA claim form using CDT-3 dental procedure codes include:

- Malocclusion of the teeth; or
- Grinding of the teeth.

If the underlying cause is systemic, a medical disease, or a significant injury, the treatment of TMJ is billed by the dentist as a medical service. Some examples of covered medical conditions are:

- Rheumatoid arthritis;
- Damage associated with seizure activity; or
- Status post facial trauma.

Osteoarthritis or degenerative arthritis of the TMJ is not a systemic disease, but a local problem usually related to a dental cause. Therefore, these diagnoses cannot be billed as a medical service.

All TMJ splints require authorization.

**CPT Coding**

Dentists using CPT procedure codes and coding must select the code for the procedure or service which most accurately identifies the service performed. Any additional procedures performed, or pertinent special services, must also be listed. When necessary, list any modifying or extenuating circumstances. Any service or procedure must be adequately documented in the recipient's/enrollee's medical record. Medical services provided by a dentist must be billed on the CMS-1500 using CPT procedure codes.
Modifiers

Modifying medical procedure codes indicates that a service or procedure has been altered by some specific circumstance, but has not changed in its definition or code. The use of modifiers eliminates the need for separate procedure billings. Modifiers **must** be used when applicable. Please refer to the CPT manual for specific information on modifiers.

Assisting at Surgery

Assisting at surgery is allowed for some complex procedures. If a medical procedure requires authorization and an assistant will be used, include this information with the authorization. A separate entry for the assistant surgeon is not required on the authorization requests. When billing for the assistant surgeon, use the authorization number given to the primary surgeon.

Billing

- Use the ADA claim when billing CDT-4 codes for professional dental services. CDT-4 codes are required effective January 1, 2003.
- Use the CMS-1500 when billing CPT procedure codes for medical/technical services.
- Enter the valid tooth surface and tooth number when applicable.
- Submit usual and customary charges. DHS will automatically calculate and apply the DHS allowable to the $500 annual cap.
- Collect copays at the time of the visit or bill the recipient, according to office policy.
- A principal diagnosis (ICD-9-CM code) is required when using CPT codes.
- D8660 pre-orthodontic treatment visit (D0350-photographs, and x-rays billed separately) replaces deleted local code X0515-orthodontic full case study.
- Outpatient facilities must use CPT codes on the CMS-1500 claim form.
- Authorization requirements are unchanged. Services that required authorization prior to October 1, 2003, continue to require authorization after October 1, 2003.

Prorated Payment for Prosthesis

Payment for removable prosthesis for which fabrication has begun, but has yet to be completed when the recipient’s eligibility terminates, will be prorated. Include **percent of total work completed** in the remarks section of the claims form.

Separate Billing Prohibited

Separate billing, either to MHCP or the recipient/enrollee, for sterilization of instruments, infection control procedures, or surgical supplies is prohibited. This prohibition includes, but is not limited to:

- Gauze/sterile packing
- Suture material
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- Needles
- Syringes
- Sterilization solutions/equipment
- Barriers
- Drapes
- Eye protection
- Gloves
- Disposable equipment/supplies
- MinnesotaCare tax

Legal References

MS 256B.0625, subd. 9
MS 256D.03, subd. 4
MS 256L.03, subds. 1 & 5
Minnesota Rules 9505.0270 & 9505.0445
42 CFR 100
Chapter 20

Eyeglass and Vision Care Services

Minnesota Health Care Programs (MHCP) no longer uses volume purchase to obtain eyeglasses (frames and lenses) for recipients.

Vision care providers enrolled with MHCP are not required to deal with any specific state-contracted laboratory in order to serve MHCP clients. Vision care providers must bill MHCP directly, using standard billing forms, and CPT and HCPCS procedure codes. Providers must bill MHCP their usual and customary charge for their services. MHCP will pay the amount billed, or the maximum allowable, whichever is lower.

Definitions

Comprehensive Vision Examination: A complete evaluation of the visual system. The services includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields, basic sensorimotor examination, biomicroscopy, examination with cycloplegia or mydriasis, and tonometry.

Date of Service: The actual date the service is performed or the supplies are dispensed.

Dispensing Services: The technical services (fitting of spectacles) necessary for the design, fitting, and maintenance of glasses (frames and lenses) as prescribed by an optometrist or ophthalmologist.

Eyeglass/Vision Service: A comprehensive or intermediate vision exam provided by an optometrist or ophthalmologist and/or eyeglasses dispensed by an optician, optometrist or ophthalmologist.

Eyeglasses/Spectacles: A pair of lenses mounted in a frame to aid vision, as prescribed by an optometrist or ophthalmologist.

Intermediate Vision Examination: An evaluation of a new or existing specific visual problem complicated with a new diagnosis or management problem not necessarily relating to the primary diagnosis.

Ophthalmologist: A physician who has academic training in ophthalmology beyond the state requirements for licensure and experience in the treatment and diagnosis of the diseases of the eye.

Optician: A supplier of eyeglasses to a patient as prescribed by the patient's optometrist or ophthalmologist.

Optometrist: A person licensed as an optometrist under Minnesota law.
Eligible Providers

Ophthalmologists, opticians, and optometrists are allowed to enroll with MHCP, and provide and bill for services within their scope of practice.

Eligible Recipients

MHCP residents are eligible to receive a new pair of glasses every 24 months or more frequently if they meet medical necessity criteria identified below.

Vision care providers must call the Eligibility Verification System (EVS) at 1-800-657-3613 or 651-282-5354 to find out when the recipient’s last pair of MHCP eyeglasses were dispensed.

Covered Services

- Comprehensive vision examinations.
- Intermediate vision examinations.
- Plastic or polycarbonate changeable photochromatic (transition) lenses for certain childhood illnesses, developmental disability, or a seizure condition where clear glass/plastic lenses may pose a safety risk.
- Tinted or polarized lenses when medically necessary.
- Aspherical hand held magnifiers (3.7 X 11.0 diopter), when medically necessary.
- Double segs (FT25, FT28), plastic or glass, when medically necessary.
- Fresnel prism, Slab off prism, when medically necessary.
- Repairs to frames and lenses purchased through MHCP.

Medical Necessity Criteria for Receiving Eyeglasses More Frequently Than Every Two Years

Vision providers may dispense eyeglasses even though two years have not passed since a recipient’s last pair was dispensed, if one of the following medical necessity criteria is met.

- There is a change in correction of 0.5 diopters or greater in either sphere or cylinder power in either eye;
- There is a shift in axis of greater than 10 degrees in either eye;
- A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary;
- There is a change in the recipient’s head size which warrants a new pair of eyeglasses; or
- The recipient has had an allergic reaction to the previous pair of eyeglasses.
Quality of Covered Eyeglasses

- Lenses covered by MHCP must be first quality impact resistant glass, plastic or polycarbonate single vision, bifocal or trifocal lenses.
- Lenses must conform to the American National Standards Institute Recommendation for Prescription Ophthalmic Lenses, ANSI’s most current standards, and the FDA requirements for impact resistance.
- All lenses must be finished (hardened and edged) and assembled in the frame.
- Children ages 18 and younger must receive polycarbonate lenses.
- A new eyeglass case must be included with each pair of eyeglasses.
- Eyeglasses found by the recipient to be unsatisfactory due to defective workmanship and/or materials must be replaced or repaired by the provider without cost to the recipient or MHCP.
- Errors made in prescribing or dispensing are the responsibility of the prescribing and/or dispensing provider and are not to be billed to MHCP or the recipient.

Repairs

Repairs made to frames and lenses not under warranty may be billed to the MHCP using the appropriate CPT repair code. Only frames and lenses purchased through the MHCP program are covered for repair. Lenses replaced, frame parts replaced or repaired are billed to MHCP along with the CPT repair and refitting code. Do not use the dispensing code for repairs or refitting of frames or lenses.

Recipients with Private Health Insurance Coverage

Recipients with private insurance coverage that have an eyeglass benefit must obtain their eyeglasses, eye examination, and vision services through their primary insurance. Recipients whose private insurance plan does not cover eyeglasses as a benefit must receive eyeglasses from an enrolled MHCP optical provider.

Contact Lenses

Contact lenses are covered without authorization if prescribed for aphakia, keratoconus, aniseikonia and bandage lenses. All other diagnosis/conditions require authorization. When an authorization is necessary, the provider must submit the following information to document medical necessity:

- Diagnosis;
- Prescription; and
- Detailed explanation of why eyeglasses do not meet the medical needs of the recipient.
Non-covered Services

- Replacement of lenses or frames to change the style or color
- Cosmetic services
- Tints or polarized lenses for fashion purposes
- Protective coating for plastic lenses
- Edge and anti-reflective coating of lenses
- Industrial, sport eyeglasses or glasses for computer screen usage, unless they are the recipient’s only pair and are necessary for vision correction.
- Invisible bifocals or progressive bifocals
- Contact lenses which required authorization which was not obtained
- Replacement of lenses or frames due to provider error in prescribing, frame selection, or measurement
- High index plastic lenses
- Eyeglasses or lenses for occupational or educational needs, unless it is the recipient’s only pair and it is necessary for vision correction
- Services or materials that are considered experimental or not clinically proven by prevailing community standards or customary practice
- Backup eyeglasses or split prescription into two pairs of eyeglasses.

Billing, Coding, Copay and Documentation

- Bill all claims for vision care items and services to MHCP using the CMS-1500 form (paper or electronic).
- Each line item submitted charge must reflect the provider’s usual and customary charge.
- Bill frames, lenses, dispensing fee, repairs, and other covered items and services using HCPCS (level I, II and III) codes and guidelines. You may purchase a HCPCS manual from Minnesota’s Bookstore, 660 Olive St., St. Paul, MN 55155, (651) 297-3000 (metro), or 1-800-657-3757, or online at www.MinnesotasBookstore.com.
- Include the appropriate ICD-9 diagnosis code on the claim in the following situations:
  - A medical condition that requires either a tint or photochromatic lenses
  - Aphakia, keratoconus or anisekonia that requires contact lenses
  - Allergic reaction to previous frame that requires new frames
  - Certain childhood illnesses, developmental disability, or a seizure condition where clear glass/plastic lenses may pose a safety risk and which therefore require plastic or polycarbonate changeable polychromatic (Transition) lenses
  - Medical condition that requires an aspherical hand held magnifier (3.7 X 11.0 diopter)
  - Medical condition which requires Fresnel prism, Slab off prism

Vision ICD-9 diagnosis code list (PDF)
Effective October 1, 2003, eyeglasses (complete frames and lenses) are subject to a copay. A copay does not apply if only the frames are dispensed or only the lenses are dispensed, or to eyeglass repairs. The MA recipient eyeglass copay is $3.00. The GAMC recipient eyeglass copay is $25.00.

Document the following situations in the recipient’s medical record:

- a change in the recipient’s head size which requires eyeglasses before the 24 month period is up
- a change in the recipient’s vision which meets the medical necessity criteria above and which requires eyeglasses before the 24 month period is up
- the recipient’s eyeglasses have been lost, stolen, or irreparably damaged and therefore require replacement with an identical pair before the 24 month period is up
- eyeglasses are dispensed for occupational, educational, industrial or sports needs but these eyeglasses are the recipient’s only pair and they are needed for vision correction

Billing the Recipient

The recipient may purchase non-covered add-ons and non-covered items. Add-ons are lens treatments that can be added to pair of covered lenses and frames. Examples are: lenses coating, special edge treatments, scratch resistant coating, anti-reflective lens coating, etc. Recipients may pay for the cost of the add-on products. The provider must inform the recipient before providing the item that it is not covered by MHCP and that the recipient is responsible for the payment of the add-on item.

Recipients may be billed for non-covered items. If a recipient chooses to purchase upgraded lenses that are not medically necessary (such as high-index plastic, transition lenses, no-line bifocals) or an upgraded frame that is not medically necessary (such as a more fashionable frame, back-up glasses), the recipient is responsible for payment of the entire cost of the lenses and/or frame. The provider cannot bill the recipient for the difference between covered lenses and/or frame and the upgraded lenses and/or frame. MHCP will not pay for the dispensing fee, repairs or adjustments made to upgraded products or non-covered items.

*DHS does not have prior authorization requirements for eyeglass benefits. Services not listed are not available through the eyeglasses program.*

Maximum Allowable Rates

Providers must bill DHS at their usual and customary charge. MHCP will pay the lower of the submitted charge, or the maximum allowable rate. Examples of maximum allowable rates for services provided after January 1, 2002, are:
### HCPCS Code (Modifier) & Description

<table>
<thead>
<tr>
<th>HCPCS Code (Modifier) &amp; Description</th>
<th>MHCP Maximum Allowable Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2020 Frames, purchases</td>
<td>29.15</td>
</tr>
<tr>
<td>V2020 (RP) Frames, purchases (repair and replacement)</td>
<td>13.81</td>
</tr>
<tr>
<td>V2103 Spherocylinder, single vision, piano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens</td>
<td>15.17</td>
</tr>
<tr>
<td>V2203 Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens</td>
<td>20.89</td>
</tr>
</tbody>
</table>

### CPT Code & Description

<table>
<thead>
<tr>
<th>CPT Code &amp; Description</th>
<th>MHCP Maximum Allowable Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>92340 Fitting of spectacles, except for aphakia; monofocal</td>
<td>28.84</td>
</tr>
<tr>
<td>92341 Fitting of spectacles, except for aphakia; bifocal</td>
<td>33.99</td>
</tr>
<tr>
<td>92342 Fitting of spectacles, except for aphakia; multifocal, other than bifocal</td>
<td>34.76</td>
</tr>
</tbody>
</table>

### Vision Therapy/Orthoptics and Pleoptics

All vision therapy requires authorization. When submitting a request for a medical authorization (DHS-3066), attach and complete the DHS [Vision Therapy Form](#).

### Visual Therapy/Orthoptics/Pleoptics Coverage Criteria

- Diagnosis and treatment of amblyopia, sensory or motor strabismus, and accommodative disorders causing subjective visual complaints which are not relieved by wearing prescription eyewear;
- Home visual therapy is to be used, including home treatment with patching, lens fogging, red/green/polaroid filters, and other lenses/devices; and
- Visual therapy for amblyopia is limited to children under age 10. If improvement is not noted after four sessions, the recipient must be referred to an appropriate professional (e.g., neurologist or ophthalmologist) for further evaluation.

Billing for Verteporfin (HCPCS code Q3013) and Ocular Photodynamic Therapy (CDT code 67221) is covered only for ICD-9-CM 362.52. For Hospital Outpatient Services, CPT code 67221 and Verteporfin injection (HCPCS code C1203) is covered only for ICD-9-CM 362.52. No separate payment for the intravenous infusion service is allowed. Payment for the infusion is packaged into CPT code 67221.
Payment Limitations

The physician monitoring progress may bill for a limited examination in addition to the orthoptic/pleoptics training. Document in the medical record that the physician has seen the recipient and performed the necessary procedures for a limited examination. Limited examinations to evaluate visual therapy is limited to one per week.

Vision Therapy Form

Vision Therapy Form (PDF)

Legal References

Minnesota Rules 9505.0277
Minnesota Rules 9505.0445
42 CFR 410
42 CFR 411
42 CFR 440.120(d)
Chapter 21

Transportation Services

Transportation is a covered service if provided to or from the site of an MHCP covered medical service. An MHCP covered service is a payable service if provided by an enrolled health care provider and billed using the recipient's 8-digit MHCP identification number.

ALS: Advanced Life Support.

Advanced Life Support, Level 1 (ALS1): Transportation by ground ambulance vehicle, medically necessary supplies and services and an ALS assessment by ALS personnel or the provision of at least one ALS intervention.

Advanced Life Support, Level 2 (ALS2):
- Three or more different administrations of medications by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer’s Lactate), or transportation, medically necessary supplies and services, and
- The provision of at least one of the following ALS procedures: manual defibrillation/cardioversion; endotracheal intubation; central venous line; cardiac pacing; chest decompression; surgical airway; introsseous line.

Ambulance Service: The transport of a recipient whose medical condition or diagnosis requires medically necessary services before and during transport.

Ancillary Services: Health services, incident to ambulance transportation services, that may be medically necessary on an individual basis, but are not routinely used and are not included in the base rate for ambulance.

Basic Life Support (BLS): Transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services.

BLS Emergency: When medically necessary, the provision of BLS services as specified above, in the context of an emergency response.

Common Carrier Transportation: The transport of a recipient by bus, taxicab, other commercial carrier, or by private automobile.

Day Training and Habilitation (DT&H) Services: Refer to the DT&H chapter (Ch. 25).

Medical Transportation: The transport of a recipient for the purpose of obtaining a covered service or transporting the recipient after the service is provided. The types of medical transportation are common carrier, special transportation, and life support.
Minnesota Department of Transportation (Mn/DOT): The principal Minnesota state agency to develop, implement, administer, consolidate and coordinate state transportation policies, plans and programs (MS Ch. 174).

No Load Transportation: A response to a request for ambulance service that does not result in the transport of a recipient.

Special Transportation: The transport of a recipient who, because of physical or mental impairment, is unable to safely use a common carrier and does not require ambulance service. "Physical or mental impairment" means a physiological disorder, physical condition, or mental disorder that prohibits access to, or safe use of, common carrier transportation.

Specialty Care Transport (SCT): Specialty care transport means interfacility transportation of a critically injured or ill recipient by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic.

Covered Services

- Ambulance services.
- Special transportation to and from covered medical services.
- Common carrier. (See the Access Services section in Requirements for Providers chapter (Ch.1).

Multiple Riders

If a provider transports two or more MHCP recipients simultaneously in one vehicle from the same point of pick up, to the same destination, the payment will be prorated. See the Rates section of the Billing Policy chapter (Ch. 4) for more information on payment rates. Failure to note the number of riders on the claim will result in a denial of the claim.

Multiple Segments

Billing for separate segments of a trip are no longer allowed. A one-way trip shall be billed and reimbursed as one (1) base rate unit of service regardless of the number of segments that may be included in the trip. Multiple segments are defined as those services rendered when a passenger requires pickup and transportation between several different destinations as part of a continuum while the transportation provider waits, prior to a return to the point of origin. Each segment is considered one part of the complete round trip. Example: Client is picked up at point A, there is a stop at point B, client travels to point C, final destination. Only one base rate is allowed from point A through point C. No separate base rate may be billed for the continuation of a trip.

Transportation Between Hospitals or Long Term Care Facilities

Transportation is covered between two LTC facilities or between two hospitals if the provider obtains a statement signed by the physician or a member of the nursing staff at the originating
facility stating the medically necessary health service is part of the recipient's plan of care and is not available at the originating facility. The documentation must be attached to the claim.

**Ambulance Transportation**

**Eligible Recipients**

- **Non-emergency Ambulance Transportation:** MA and GAMC recipients, and MinnesotaCare recipients under the age of 21 and pregnant women.
- **Emergency Ambulance Transportation:** All MHCP recipients and recipients.

**Eligible Providers**

Providers must be licensed under MS 144E.10 and 144E.16, as an advanced life support, basic life support, or scheduled life support transportation service.

**Payment Limitations**

- If a recipient is pronounced dead by a legally authorized person after transportation is called, but before it arrives, service to the point of pickup is covered.
- If transportation is provided to a recipient who is pronounced dead en route, or dead on arrival, by a legally authorized person, the transportation is covered.
- If a recipient is pronounced dead by a legally authorized person before transportation is called, transportation is not covered.
- Infants may be transferred from a NICU level II or III nursery to a hospital within the family's local trade area if the distance from the family home to the facility caring for the infant is greater than 40 miles.
- Transport between two hospitals is only covered when the first hospital must discharge the recipient to another hospital because they could not care for the recipient.
- The medical necessity of the ambulance transportation service for a recipient must be documented by the state report (Ambulance Run Report) required under MS 144E.17.
- The recipient's transportation must be in response to a 911 emergency call, a police or fire department call, or an emergency call received by the provider.
- Ambulance transportation that responds to a medical emergency is covered by MHCP for "no load transportation" only if the ambulance transportation provided medically necessary treatment to the recipient at the pickup point. The payment is limited to charges for transportation to the point of pickup and for ancillary services. Use the ET modifier for this service.
- The recipient should be transported to the nearest facility with the appropriate level and type of care for treatment.
Air Ambulance Coverage Guidelines

Transportation by air ambulance is covered by MHCP if the recipient has a potentially life-threatening condition that does not permit the use of another form of transportation. Air ambulance transportation for a recipient not having a potentially life-threatening condition may be paid at the ALS ground transportation rate.

In order to be eligible for payment under air ambulance, the referring facility must not have adequate facilities to provide the medical services needed by the client. Transport must be to the nearest appropriate facility.

All air ambulance transportation originating outside of Minnesota or going to a destination outside of Minnesota must receive authorization from the DHS medical review agent (CDMI).

Providers must submit documentation with all claims for hospital-to-hospital air ambulance trips. Air ambulance documentation must be completed by the referring hospital, submitted with the claim, and must include:

- The reason the physician at the referring hospital ordered air ambulance transportation;
- Why air ambulance transportation, rather than ground ambulance, was medically necessary;
- The patient's diagnosis (use ICD-9-CM diagnosis codes); and
- The name of the referring physician or agency.

The above noted documentation is not required if any of the following conditions necessitated the need for air ambulance transportation (use ICD-9-CM diagnosis codes):

- Abdominal aortic aneurysm
- Acute myocardial infarction
- Acute renal failure
- Amputation (traumatic above the wrist or ankle)
- Anoxia
- Asphyxia (severe birth asphyxia with one minute APGAR score 0-3)
- Bleeding (uncontrolled or internal)
- Burns (major, 3rd degree)
- Cardiac arrest
- Cerebral edema (brain swelling due to injury or illness)
- Diaphragmatic hernia of newborn
- Drowning, near drowning
- Eclampsia of pregnancy
- Encephalitis
- Extremity fracture with absent pulses or cold and cyanotic
- Flail chest injury (ribs broken off at sternum)
- Major trauma or "polytrauma"
- Meningitis
• Neonatal respiratory distress
• Placenta previa causing hemorrhage
• Premature separation of placenta
• Premature delivery (threatened or actual)
• Respiratory/pulmonary insufficiency
• Respiratory arrest
• Spinal cord injury
• Status seizures
• Status asthmaticus
• Traumatic perforation or rupture of esophagus or trachea

**Authorization for Non-Emergency Ambulance Trips**

Authorization is required for non-emergency ambulance transports for recipients who will be transported more than six one-way trips (three round trips) during a calendar month.

**Special Transportation**

**Eligible Recipients**

All criteria must be met to be eligible for special transportation:

- The recipient must be eligible for MA; a GAMC recipient eligible for MA benefits and residing in an Institute for Mental Disease; a MinnesotaCare enrollee under the age of 21 or a MinnesotaCare pregnant woman; and
- The recipient must have a physical or mental impairment that keeps him or her from safely accessing and using a bus, taxicab, private automobile, or other common carrier.

**Eligible Providers**

Special transportation providers must be certified by the Minnesota Department of Transportation under MS 174.29 to 174.30. The special transportation provider's driver must provide driver-assisted services. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle.

**Physician's Certification of Need for Special Transportation Form**

The Physician's Certification of Need for Special Transportation form (DHS-2910) must be completed and signed by the attending physician, nurse practitioner, clinical nurse specialist or physician assistant working under the delegation of the attending physician. For nursing facility residents, the form may be completed by the medical director, if an M.D.
• Send the completed forms to DHS prior to the service, unless EVS indicates the recipient has already been approved for special transportation services.
• Forms must be completed within one calendar month from the day a recipient is first transported.
• A copy of the form is included at the end of this chapter.

For recipients enrolled in prepaid health plans, the appropriate health plan must be contacted for approval and/or special transportation requirements.

**Multiple Attendants**

BLS and ALS base rates include two attendants. An attendant is an employee of the special transportation provider and meets all Mn/DOT driver certification requirements. Special transportation payment will allow an extra attendant only in conjunction with stretcher services. Document medical necessity and submitted with the claim. Document the name of the extra attendant in the driver log. Bill extra attendant code (T2001) and stretcher code (T2005) on the same claim. For service dates on or after 06/01/04, use procedure code T2049 for non-emergency stretcher mileage instead of S0209 with the 22 modifier. Payment for an attendant, who is a person other than the driver, and non-emergency stretcher, will be made at a maximum rate established by DHS. Ambulance supply codes and the night surcharge code are not covered under special transportation.

**Payment Limitations for Stretcher Services**

The use of a stretcher is a covered service for special transportation when the medical need of the patient does not require a higher level of special medical services (e.g., when the patient’s condition does not require medical supervision, medical equipment, the administration of drugs or the administration of oxygen, etc.). The stretcher vehicle must be capable of loading a stretcher (gurney) into the vehicle and must be inspected and approved by Mn/DOT. Documentation of the need for stretcher services must be kept by the transportation provider.

**Payment Limitations for Day Training and Habilitation (DT&H) Programs and Day Programs**

MHCP will not separately reimburse special transportation providers for transporting DT&H clients to and from the DT&H. (This service is already paid to the DT&H provider in their daily rate.)

Special transportation services to and from service sites are covered only if the special transportation provider has a contract with the DT&H provider, and accepts the transportation rate of that provider under the service agreement.

Special transportation services for DT&H recipients are covered by MHCP when transporting eligible recipients of special transportation to and from authorized medical appointments. Refer to the DT&H chapter (Ch. 25) for more information.
Payment Limitations for Transportation to Waivered Services

Transportation to or from waivered services for a recipient on a waivered services program is not a separately billable special transportation service. Transportation to and from waivered services must be entered on a service agreement. Contact the Community Supports for Minnesotans with Disabilities (CSMD) Resource Center at (651) 282-2086 or 1-800-383-7888 for claim form completion instructions. Only transportation to or from MA covered services are billable for recipients in a waiver program.

Payment Limitations for Local Trade Area and Transport to the Nearest Appropriate Provider

One-way mileage for special transportation within the recipient's local trade area must not exceed 20 miles for a trip originating inside the seven county metropolitan area or 40 miles for a trip originating outside of the seven county metropolitan area, if appropriate health services are available within the local trade area. Special transportation to reach a health service destination outside of the recipient's local trade area, must be ordered by the recipient's attending physician and be on file with the transportation provider. If a recipient travels outside his or her locality when necessary medical services are available locally, transportation costs incurred may not be reimbursable. Transports generally must be to the nearest appropriate Medicaid provider. Bill only for the most direct point to point mileage. Use commercially available software or Internet-based applications to determine the most direct mileage. Record origin and destination address.

Payment Limitations for Wheelchair Codes

The reimbursement rate for persons who need a wheelchair-accessible van are higher than for those who do not need a wheelchair-accessible van. A person who needs a wheelchair-accessible vehicle is defined as a Medicaid recipient with severe permanent or temporary mobility impairments who is unable to ambulate without a wheelchair, and whose condition requires the use of a vehicle lift or ramp as in a wheelchair-accessible van. A wheelchair-accessible van must operate under the authority and in compliance with promulgated regulations of Mn/DOT, and registered as such by Mn/DOT. Billing under the wheelchair van codes will not be paid unless the client is documented as a wheelchair user on the Certification of Need for Special Transportation form (reviewed and approved by DHS), and the van providing the service is wheelchair-accessible and certified by Mn/DOT.

Common Carrier Transportation

Recipients who are not eligible for special transportation may use buses, taxicabs, private automobiles, commercial carrier, or volunteer drivers for transportation to and from medical appointments. The recipient must contact their local county agency for policies regarding common carrier transportation. See Access Services section of Requirements for Providers chapter (Ch.1).
Out-of-State Transportation Limitation

All medical transportation originating outside of Minnesota, or going to a destination outside of Minnesota, must be authorized by the DHS medical review agent (CDMI) with the following exceptions:

- Transportation within local trade areas that include portions of other states bordering Minnesota;
- Emergency transportation; and
- Services provided to a recipient for whom the state makes adoption assistance or foster care maintenance payments.

Out-of-state medical services requiring common carrier transportation must be authorized by the county. County agencies considering requests for out-of-state common carrier transportation must contact the Provider Call Center to verify that the medical service has been authorized. Refer to the Authorization chapter (Ch. 5) for more information.

Billing

- Use the CMS-1500.
- Bill exact direct mileage, rounded only to the nearest mile. Do not use zone or region mileage calculations. Use commercially available software or Internet-based applications to determine the most direct mileage. Bill loaded miles only. Enter pickup point and destination in box 19 or the Transport Origin field on ITS.
- Use appropriate HCPCS codes, if available, for:
  - Ambulance; use the HCPCS code that best describes the services rendered. The codes must be used to reflect the type of service provided, not the type of vehicle used.
  - Emergency and non-emergency transportation.
  - Disposable supplies; if HCPCS codes are not available, use routine disposable supply codes, with a lump sum charge on one line for all disposable supplies and attach documentation to the claim, itemizing the supplies and charges.
  - Ambulance oxygen and oxygen supplies; do not itemize.
  - Injections, drugs, and solutions; do not itemize unless using J3490; do not use modifiers.
  - Miles traveled beyond the nearest appropriate facility to meet the medical needs of the recipient.
- Use HCPCS modifiers to:
  - Indicate both point of origin and destination for both pick up and return trips;
  - Clarify two trips on the same date. If the modifiers are the same, combine the HCPCS codes; and
• Report a maximum of one round trip per mileage claim line.
• HCPCS modifiers are not required on mileage codes.
• Submit separate claims for air and ground transport on the same date of service for the same recipient.

Non-covered Services

The services listed below are not covered by MHCP as medical transportation services:

• Transportation of a recipient to a hospital or other site of health services for detention that is ordered by a court or law enforcement agency except when life support transportation is medically necessary;
• Transportation of a recipient to a facility for alcohol detoxification that is not medically necessary;
• "No Load" transportation except as described in the ambulance transportation section of this chapter;
• Additional charges for luggage, stair carry of the recipient, and other airport, bus, or railroad terminal services;
• Airport surcharge;
• Federal or state excise or sales taxes on air ambulance service;
• Transportation of a recipient to a non-covered MHCP service (e.g., grocery store, health club, church, synagogue) and those services excluded from transportation payment;
• Special transportation services for transporting recipients from their residence to a Day Training and Habilitation or Adult Day Program site and back again;
• Extra attendant charges for PCA's accompanying recipients for whom they are providing services; and
• Oral drugs such as nitroglycerine tablets or spray, oral glucose, Procardia tablets, Ventolin or Proventil inhalers, and syrup of ipecac are not covered.

Documentation Requirements

Transportation providers must keep trip documentation as specified in Requirements for Providers chapter (Ch.1), including the date/time of pickup or return, name and address of the recipient’s Medicaid provider destination, and vehicle and driver identification. Transportation providers must also obtain written documentation from the health care provider serving the recipient, by having the health care provider complete the Documentation of Medical Appointment. Records must be kept for 5 years from the date of service.

Minnesota Health Care Programs Certification of Need for Special Transportation Form

PDF version
Legal References

MS 174.29-174.30; 256B.0625, subd. 17, 17a & 18
Minnesota Rules 9505.0315 and 9505.0445
42 CFR 431.53
42 CFR 440.170(a)
Chapter 22

Pharmacy Services

Information in this chapter applies to all of Minnesota's Health Care Programs. Providers must contact the appropriate health plan for pharmacy information related to recipients in prepaid health plans.

The Medical Assistance program is funded with approximately one-half federal and one-half state funds. Most decisions regarding drug coverage are made at the federal level in accordance with Federal OBRA Laws of 1990. Those areas left to Minnesota's discretion are described in this chapter in the Limitations on Pharmacy Services section.

Drug Formulary Committee

The Drug Formulary Committee (DFC) is charged with reviewing and recommending which drugs require authorization. The DFC also reviews drugs for which coverage is optional under federal and state law. (For possible inclusion in the Medicaid fee-for-service formulary). The DFC is comprised of four physicians, three pharmacists, a consumer representative, and a nursing home representative. DFC meetings are open to the public and public comments are taken for an additional 30 days following a DFC recommendation to require prior authorization for a drug. The Department of Human Services (DHS) provides the DFC with information regarding the impact that placing a drug on authorization will have on the quality and cost of patient care.

Drug Utilization Review Board

The Drug Utilization Review (DUR) board selects specific drug entities or therapeutic classes to be targeted for provider and recipient educational interventions, and provides guidelines for their use. The DUR board is comprised of four licensed physicians, at least three licensed pharmacists and one consumer representative, with the remaining members being licensed health care professionals with clinically appropriate knowledge in prescribing, dispensing, and monitoring outpatient drugs. DUR Board meetings are open to the public.

Prescription Drug Program

See the Requirements for Providers chapter (Ch. 1) for information on the Prescription Drug Program.
Definitions

**Actual Acquisition Cost:** The net cost of a drug to the dispenser; this includes quantity, volume, and special discounts but does not include cash or time discounts.

**Quantity discount:** A price reduction that is dependent on the size or number of items ordered (e.g., a discount to the purchaser for buying drugs packaged in thousands rather than hundreds, or a discount for buying "x" units when either no discount or a lesser discount will apply if fewer than "x" units are ordered).

**Volume discount:** Sometimes synonymous with quantity discount but it may also be a reduction in price based on the monetary volume of an invoice (e.g., 10% reduction for an order of $500 or more).

**Cash discount:** A reduction in price that occurs when cash accompanies the order for merchandise.

**Time discount:** A reduction in price that occurs when payment is made within a short period of time (not to exceed 10 days) after receipt of the merchandise; this definition will not apply to large volumes or quantities of drugs that are ordered and then received in small increments over a specified time period with payment made for each increment after it is needed.

**Compounded Prescription:** A prescription prepared in accordance with Minnesota Rules, part 6800.3100.

**Drug Efficacy Study Implementation (DESI) Drugs:** Federal Food and Drug Administration (FDA) designations related to "substantial evidence" of effectiveness. DESI drugs were introduced to the market between 1937 and 1962, during which time manufacturers did not have to show that their products were effective. Federal Medicaid statutes prohibit state Medicaid agencies from paying for these drugs. Examples include Midrin and Anusol HC suppositories.

**Dispensing Fee:** The amount allowed for the pharmacy service in dispensing the prescribed drug.

**Generically Equivalent Drug:** A drug product that, in the pharmacist’s professional judgement, is safely interchangeable with the prescribed drug.

**Estimated Actual Acquisition Cost (EAAC):** DHS estimate of a pharmacy's actual acquisition cost of a drug. EAAC is set at average wholesale price (AWP) minus 9 percent.

**Federal Drug Rebate Program:** Established by the federal statute referred to as OBRA 90, requires manufacturers to sign a rebate agreement with the federal Center for Medicare and Medicaid Services (CMS) in order to have their products covered for Medicaid recipients. State Medicaid agencies administer the program and collect rebates from the manufacturers.

**Maintenance Drug:** A prescribed drug that is used by a recipient for a period greater than two consecutive months.
Maximum Allowable Cost (MAC): The highest drug ingredient reimbursement that will be allowed for certain drugs designated by CMS or by DHS. Federally designated values are referred to as federal upper limits (FUL).

Pharmacist: An individual with a currently valid license issued by the Minnesota Board of Pharmacy to practice pharmacy.

Pharmacy: An established place of business in which prescriptions, drugs, medicines, chemicals, and poisons are prepared, compounded, dispensed, vended, or sold to or for the use of patients and from which related clinical pharmacy services are delivered.

Pharmacy Service: The dispensing of drugs, counseling, concurrent DUR and other activities as described in Minnesota statutes § 151.01, subd. 27, or as performed by a dispensing physician.

Prescribed Drug: A drug as defined in Minnesota Statutes, section 151.01, subdivision 5, and ordered by a practitioner.

Shelf Price: The price charged by a provider for a product when that product is sold to the public in the original, unopened manufacturer’s container. Temporary sale prices or advertised markdowns with time limitations do not apply to shelf price.

Usual and Customary: "Usual and customary charge" refers to the meaning in part Minnesota Rules 9505.0175, subpart 49, whether the drug is purchased by prescription or over the counter, in bulk, or unit dose packaging. However, if a provider's pharmacy is not accessible to, or frequented by, the general public, or if the over the counter drug is not on display for sale to the general public, then the usual and customary charge for the over the counter drug shall be the actual acquisition cost of the product plus a 50 percent markup based on the actual acquisition cost. In this event, this calculated amount must be used in billing DHS for an over the counter drug. Amounts paid in full or in part by third-party payers shall be included in the calculation of the usual and customary charge only if a third-party payer constitutes 51 percent or more of the pharmacy's business based on the number of prescriptions filled by the pharmacy on a quarterly basis.

Eligible Providers, Prescribers, Recipients

Eligible Dispensing Providers

- A pharmacy that is licensed by the Minnesota Board of Pharmacy;
- An out-of-state pharmacy that applies for retroactive enrollment;
- A physician located in a local trade area where there is no MHCP enrolled pharmacy. The physician, to be eligible for payment, must personally dispense the prescribed drug according to applicable Minnesota statutes, and must adhere to the labeling requirements of the Minnesota Board of Pharmacy; and
- A physician or nurse practitioner employed by or under contract with a community health board for communicable disease control.
Eligible Prescribers

A physician, osteopath, dentist, podiatrist, nurse practitioner, mental health certified nurse specialist, optometrist, physician assistant or other health care professional licensed to prescribe drugs under Minnesota statutes, the laws of another state or Canada may prescribe drugs within the scope of their profession. Pharmacists may prescribe over-the-counter (OTC) medications to FFS MA, GAMC and PDP recipients. Managed care plans under contract to DHS may allow this but are not required to do so.

Eligible Recipients

All MHCP recipients.

How to Determine Drug Coverage

An Interactive Voice Response (IVR) system is available to providers to verify drug coverage using National Drug Codes (NDC). The telephone numbers are:

IVR (651) 282-2599 or 1-800-657-3985

Once connected to the IVR, a voice will guide you through the process of accessing drug coverage information. The system also offers an option allowing providers to leave a message if they wish to add a drug to the covered list. In the event that the Minnesota Medicaid point-of-service billing system is unavailable, pharmacists are required to use the IVR to verify drug coverage.

Labeler Codes

A labeler code is the first five digits of an NDC. The Labeler Code List includes manufacturers that participate in the Federal Drug Rebate Program. The list is no longer included in this manual. If a manufacturer is not a participant in the Federal Drug Rebate Program, its products will not be covered by MHCP. Questions regarding manufacturer participation can usually be answered by making an inquiry about specific drug coverage through the IVR system.

Non-covered Services

The following are not covered by MHCP:

- Drugs determined to be less-than-effective (DESI) by the FDA and drugs identified as identical, related or similar to DESI drugs;
- Drugs which are made by manufacturers that do not have a rebate agreement with CMS;
- Drugs which are limited or excluded by the state as allowed by federal law (OBRA 90);
- Drugs dispensed after their expiration date;
• The cost of shipping or delivering a drug;
• Drugs, both legend and OTC, that are not prescribed by practitioners licensed to prescribe or that are not prescribed within their scope of practice;
• Herbal or homeopathic products;
• Nutritional supplements except as specifically allowed in this Provider Manual or in DHS Provider Updates;
• Compounded drugs, except as allowed in this chapter;
• Drugs which require prior authorization and for which prior authorization criteria have not been met; and
• Drugs prescribed by a physician who has been excluded by the Office of Inspector General (OIG). Pharmacies may be required to return MHCP payment for dispensed drugs written by an excluded physician.

**Drug Categories with Limited Coverage**

<table>
<thead>
<tr>
<th>Category</th>
<th>Covered/Non-covered Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agents used to promote smoking cessation</td>
<td><strong>Covered:</strong> All smoking cessation products are covered.</td>
</tr>
<tr>
<td>Agents when used for cosmetic purpose or hair growth</td>
<td><strong>Not covered</strong></td>
</tr>
</tbody>
</table>
| Agents when used for acne, warts, pathological skin conditions | **Covered:**
- Anti-acne drugs
- Anti-wart drugs
- Legend topical drugs for pathological skin conditions, but not if used for cosmetic purposes or hair growth
- Tretinoin products (acne only – not for wrinkles or other cosmetic purposes) |
| Agents when used for symptomatic relief of cough and colds | Only the legend and OTC drugs listed in this chapter or in DHS Provider Updates are covered for cough and cold indications. |
| Antihistamines (OTC)                           | **Covered:**
- Chlorpheniramine
- Clemastine
- Cyproheptadine
- Diphenhydramine
- Hydroxyzine
- Meclizine
- Promethazine plain |
| Antihistamine and decongestant combinations    | **Covered:**
- Pseudoephedrine/brompheniramine
- Pseudoephedrine/chlorpheniramine |
| Antitussives and expectorants                  | **Covered:**
- Benzonatate 100 mg capsules
- Guaifenesin & dextromethorphan
- Guaifenesin tablets
- Guaifenesin and codeine
- Guaifenesin syrup
- Guaifenesin with hydrocodone syrup |
| Appetite Suppressants                          | **Not covered**                                                                           |
| Decongestants                                  | **Covered:**
- Pseudoephedrine                            |
<table>
<thead>
<tr>
<th>Category</th>
<th>Covered/Non-covered Drug</th>
</tr>
</thead>
</table>
| **Eye - Ear – Nose – Mouth**   | **Covered:**  
- 0.65% saline nose spray  
- Artificial tears: liquid and ointment  
- Carbamide peroxide otic drops  
- Chlorhexidine gluconate  
- Cromolyn sodium  
- Hypertonic sodium chloride  
- Naphazoline/antazoline  
- Naphazoline/pheniramine maleate  
- Oxymetazoline HCL nasal spray  
- Refresh Plus & Celluvisc  
- Sodium chloride for inhalation therapy |
| (continued)                    |                                                                                                                                                        |
| **Eye - Ear – Nose – Mouth**   | **Covered:**  
- Bisacodyl  
- Casanthranol and docusate sodium  
- Docusate sodium  
- Evac-Q-Kwik  
- Glycerin suppository and enemas  
- Lactulose  
- Magnesium citrate  
- Milk of Magnesia  
- Mineral oil  
- Natural vegetable laxative (psyllium)  
- Phosphate enemas  
- Senna  
- Senokot-S  
- Sorbitol 70% (may be repackaged from gallons to pints)  
- Theravac  
- Unifiber |
| **Laxatives**                  | **Covered:**  
- Butoconazole nitrate  
- Clotrimazole  
- Ketoconazole shampoo 2% (OTC 1% ketoconazole is not covered)  
- Miconazole  
- Tolnaftate |
| **Pediculocides**              | **Covered:**  
- Dimethicone & dimethicone/ZnO (Proshield Plus, Baza Pro)  
- Calamine  
- Coal tar shampoo  
- Hydrocortisone 1% cream and ointment  
- Salicylic acid/coal tar/sulfur shampoo (Sebutone) |
| **Topical and vaginal**        | **Covered:**  
- Beta carotene/vitamins C and E/minerals (generics for Ocuvite): for prevention/treatment of macular degeneration  
- Calcium carbonate: for the prevention or treatment of osteoporosis  
- Calcium acetate  
- Ferrous gluconate and sulfate |

Some specific brands may not be covered | **Covered:**  
- Many single component products and combinations given the restrictions listed below. Use the NDC verification line to determine coverage of specific products.  
- Beta carotene/vitamins C and E/minerals (generics for Ocuvite): for prevention/treatment of macular degeneration  
- Calcium carbonate: for the prevention or treatment of osteoporosis  
- Calcium acetate  
- Ferrous gluconate and sulfate |
<table>
<thead>
<tr>
<th>Category</th>
<th>Covered/Non-covered Drug</th>
</tr>
</thead>
</table>
| Vitamins, minerals and electrolytes (continued) | - Iron polysaccharides complex  
- Levocarnitine: (L-carnitine)  
- Magnesium oxide  
- Niacin (vitamin B3): for the treatment of hyperlipidemia  
- Oral electrolytes: Pedialyte and Ricelyte  
- Fluoride: all legend preparations  
- Calcium with vitamin D preparations: for the prevention or treatment of osteoporosis  
- Sodium bicarbonate: tablet  
* General coverage rules  
- Except for certain conditions, vitamins are only covered for recipients with documented vitamin deficiencies. The vitamin deficiency must be recorded in the recipient's medical record. Products must be FDA approved and not just simply marketed as a health food or nutritional product. All other requirements for drug coverage must be met.  
- All vitamins are covered for children under seven years old  
- All prescription strength prenatal vitamin products for use during pregnancy and the breast-feeding period are covered. Prenatal vitamins are not covered for non-pregnancy use. |
| Analgesics – OTC                  | **Covered:**  
- Acetaminophen  
- Aspirin  
- Aspirin with buffers  
- Capsaicin cream: 0.025% and 0.075%  
- Ibuprofen  
- Naproxen  
* Antacids and antigas – OTC  
- Activated attapulgite  
- Bismuth subsalicylate: regular & extra strength tablets & liquid  
- Loperamide  
* Antidiarrheal – OTC  
- Activated charcoal  
- Activated charcoal/sorbitol solution  
- Ipecac syrup  
- Insulin: all types  
- Lactase: for lactose intolerance  
* Desi and IRS drugs  
- DESI and IRS drugs are FDA designations related to "substantial evidence" of effectiveness. No coverage for designation values 5 and 6. |
| Antiseptics                       | **Covered:**  
- Bacitracin  
- Chlorhexidine gluconate 3% or 4%  
- Hydrogen peroxide 3%  
- Povidone-iodine  
- Triple antibiotic ointment: polymyxin, neomycin and bacitracin  
* Miscellaneous – OTC  
- Activated charcoal  
- Activated charcoal/sorbitol solution  
- Ipecac syrup  
- Insulin: all types  
- Lactase: for lactose intolerance  
* Barbbiturates                          | **Covered:**                                                                 |
### Covered/Non-covered Drug

<table>
<thead>
<tr>
<th>Category</th>
<th>Covered/Non-covered Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>All legend</td>
<td>All legend</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Covered: All legend</td>
</tr>
</tbody>
</table>

**Pharmacist Prescribing - OTC Medications**

The following policies apply to pharmacists prescribing OTC medications:

- OTC medication must be medically necessary and the recipient must not need a referral to another health care professional.
- Drug therapy must be reviewed for potential adverse interactions.
- Drug counseling must be consistent with Minnesota Rules 6800.0910.
- Keep on file a prescription as defined in Minnesota Statutes 151.01, subd. 16. As with all other MA, GAMC and PDP prescriptions, the prescription must be kept on file for five years. For the purposes of providing OTC drugs to recipients, the pharmacist is the prescriber who must sign the prescription. Prescriptions may be refilled for up to 12 months as specified in Minnesota Rules 6800.3510.
- Prescription must be dispensed in accordance with all relevant sections of Minnesota Statutes chapter 151 and Minnesota Rules chapter 6800.
- The pharmacy’s provider number should be used as the *prescriber* number. Individual pharmacists will not be enrolled as providers.
- For the original fill, document on the prescription information regarding medical necessity, drug therapy reviews and drug counseling. For refills document in the patient’s profile any updated information regarding medical necessity, drug therapy reviews and drug counseling.
- As with all MA, GAMC and PDP prescriptions the pharmacist is strongly encouraged to have the recipient sign for receipt of the prescription whenever possible.
- OTC medications must be dispensed in the manufacturer's unopened container. Any OTC drug available in packaging designed for OTC sale to the public must be dispensed in the original packaging. Exception: Sorbitol may be re-packaged.
- OTC drug products must be billed at the shelf price of the pharmacy. If a pharmacy is not accessible to, or frequented by the general public, or if the OTC drug is not on display for sale to the general public, then the usual and customary charge for the OTC drug will be the actual acquisition cost of the product plus a 50% mark-up based on the actual acquisition cost.

**Limitations on Pharmacy Services**

- A prescribed drug must be dispensed in the quantity specified on the prescription unless the pharmacy is using unit dose dispensing or the specified quantity is not available in the pharmacy when the prescription is dispensed. Only one dispensing fee is allowed for dispensing the quantity specified on the prescription.
- The dispensed quantity of a prescribed drug must not exceed a three-month (90-day) supply.
• An initial or refill prescription for a maintenance drug must be dispensed in not less than a 30-day supply, but not more than a 34-day supply, unless the pharmacy is using unit dose dispensing or the drug is clozapine. No additional dispensing fee will be paid until that quantity is used by the recipient.
• Contraceptive drugs may be dispensed in quantities not exceeding a 90-day supply.
• Except as described below, or unless the drug is clozapine, the dispensing fee billed by or paid to a particular pharmacy or dispensing physician for a maintenance drug is limited to one fee per 30-day supply.
• More than one dispensing fee per calendar month for a maintenance drug for a recipient is allowed if the record kept by the pharmacist or dispensing physician documents that there is a significant chance of overdosage by the recipient if a larger quantity of drug is dispensed, and if the pharmacist or dispensing physician writes of this reason on the prescription.
• Refill prescriptions must be authorized and approved by the prescriber as consistent with accepted pharmacy practice. Refills must be documented in the prescription file and initialed by the pharmacist who refills the prescription.
• OTC medications must be dispensed in the manufacturer's unopened container. Any OTC drug available in packaging designed for OTC sale to the public must be dispensed in that original packaging. Exception: Sorbitol may be re-packaged.

Long Term Care (LTC) Facilities

Medically Necessary Drugs Not Covered by Outpatient Pharmacy Program

Federal law requires that LTC facilities provide residents with medically necessary drugs that are not covered by the outpatient pharmacy program. These drugs are part of a LTC facility's per diem and are reported in a cost report to DHS.

Lost Drugs

DHS should not be billed again if medication sent to a long-term care facility is lost or damaged. If the pharmacy lost the medication before delivering it to the facility, the pharmacy must send a replacement supply to the facility without billing DHS or the recipient. If the facility lost the medication after it was delivered, the pharmacy must send a replacement supply that should be billed to the facility not to DHS or the recipient.
Emergency Kit Medication Replacement

If a long-term care facility uses a dose of medication from an emergency kit, that dose may be billed separately to DHS only if certain conditions are met:

- If the dose is the only one that is given, the pharmacy replacing the dose may bill DHS for the dose;
- If the dose is the first of a series of doses, it must be billed to DHS together with subsequent doses. For example, if the order is for Rocephin 1gm IM once and the dose is taken from the emergency kit, the pharmacy may replace that dose and bill DHS. If the order is for Rocephin 1gm IM once daily for 7 days and the first dose is taken from the emergency kit, the pharmacy should not bill DHS for 1 dose to replace what was taken from the kit and 6 doses for the remainder of the supply. All 7 doses must be billed as one prescription.

Solutions, Irrigations and Supplies for LTC Facilities

DHS does not pay for solutions, irrigations or supplies used in LTC facilities for respiratory or wound care. This includes, but is not limited to, normal saline for irrigation, sterile water for irrigation, compounded antibiotic irrigation solutions, saline for inhalation or trach care, etc. These are all part of the per diem paid to the long-term care facility. Pharmacies should not bill DHS for these products when the recipient is in the facility.

Pass Meds, School or Job Med Supplies

If a Medical Assistance recipient, especially a resident of a nursing facility or group home, needs a small quantity of medication for passes, school, a job, or day programs, the pharmacy cannot bill DHS separately. For example, if a recipient receives carbamazepine 200mg TID, the pharmacy cannot separately bill for 70 tablets for use in a group home and 20 tablets for use at school. The total 90 tablets must be billed at one time to DHS. Of course, the pharmacist can then package the medication in any manner consistent with state and federal pharmacy laws and regulations. In this example, that might mean packaging 70 tablets in a unit dose container and 20 in a vial. However, packaging the prescription in two containers does not entitle the pharmacy to two dispensing fees.

“Catch-up” Supplies of Medication

Current Minnesota Statutes and Rules prohibit billing for “catch-up” supplies. Some pharmacies that service nursing facilities dispense small "catch-up" supplies of medications if the home runs out before the end of a billing cycle. For example, the pharmacy dispensed a 30-day supply only to have the facility call 25 days later indicating that it is out of the drug. The pharmacy then dispenses a 5-day supply and bills DHS. Several days later, the pharmacy bills DHS for another 30-day supply in order to get back on schedule.
Unit Dose Dispensing

- Providers specially enrolled with MHCP as a unit dose dispenser can receive a unit dose dispensing fee. To obtain a Provider Agreement Addendum, contact:

  Provider Enrollment Unit
  444 Lafayette Road
  St. Paul, MN 55155-3856
  1-800-657-3991 or (651) 282-5330

- Unit dose packaging procedures and fees apply only to legend drugs.
- Dispensing fees for legend drugs dispensed in unit dose packaging may not be billed or paid for more often than once per calendar month or when a minimum of 30 dosage units has been dispensed, whichever results in the lesser number of dispensing fees regardless of the type of unit dose system used by the pharmacy or the number of times during the month that the pharmacist dispenses the drug. If the recipient's drug supply is dispensed in small increments during the calendar month, the pharmacy must keep a written record of each dispensing act showing the date, NDC, and quantity of the drug dispensed. The pharmacy may only bill one dispensing fee.
- Only one dispensing fee per calendar month must be billed or paid for each maintenance legend drug, regardless of the type of unit dose system used by the pharmacy or the number of times during the month that the pharmacist dispenses the drug.
- The date of dispensing must be reported as the date of service on the claim to DHS, except when the recipient's drug supply is dispensed in small increments during the month. For this exception, the last dispensing date of the calendar month must be reported on the claim to DHS as the date of service. In the case of an exception, the quantity of drug dispensed must be reported as the cumulative total dispensed during the month or a minimum amount as required in the item above, whichever results in the lesser number of dispensing fees.
- DHS will pay an additional per prescription dispensing fee to pharmacies for the return of legend drugs to MHCP recipients in an LTC facility if:
  - The drug is dispensed using an in-pharmacy packaged unit dose system (approved by the Board of Pharmacy);
  - A minimum 30-day supply of the drug is dispensed, it is allowable to dispense a lesser supply for an acute course of medication therapy for a specified time period;
  - The NDC from the stock container is identified on the claim to DHS;
  - The unit dose package containing the drug meets the packaging standards in Minnesota Statutes, chapter 151 that govern the return of unused drugs to the pharmacy for reuse, and meets permeability standards of the State Board of Pharmacy;
  - The pharmacy provider repays DHS the amount reimbursed for the drug cost prorated to the quantity of unused drugs eligible for return and reuse; and
  - The provider indicates on the pharmacy claim that unit dose packaging was utilized by placing "06" or "08" in the DAW/UD code box:
06 - The patient resides in an LTC facility and this claim is eligible for the unit dose blister card dispensing fee.

08 - The prescriber's handwritten "DAW-brand necessary" is on the prescription, the patient resides in an LTC facility and this claim is eligible for unit dose blister card dispensing fee.

Returning Unused Unit Dose Package Drugs

Drugs dispensed in unit dose packaging must be returned to a pharmacy as specified below when the recipient no longer uses the drug. **This section applies even if the pharmacy does not receive the unit dose dispensing fee described in the previous section.**

- A provider of pharmacy services using a unit dose system must comply with Minnesota Rules, part 6800.2700.
- An LTC facility must return unused drugs dispensed in unit dose packaging to the provider that dispensed the drugs.
- The provider that receives the returned drugs must repay DHS the amount reimbursed for drug cost from which the prescription was billed, prorated to the quantity of the drug returned. The pharmacy must maintain a log containing the prescription number, date of return, number of remaining units, actual acquisition cost per unit, and total cost of the remaining units.

The pharmacy must send a check for the amount specified above for drugs returned no more than once a month but not less than once every three months. The refunded amount should not include dispensing fees. Checks must be made payable to "Department of Human Services" and be mailed to:

Minnesota Department of Human Services  
DHS Drug Returns  
P.O. Box 64836  
St. Paul, MN 55164-0836

Generic Equivalents

A generically equivalent drug, as defined in Minnesota Statutes, section 151.21, subdivision 2, must be dispensed in place of a prescribed brand name drug if the following conditions are met:

- The generically equivalent drug is, in the pharmacist’s professional judgement, safely interchangeable with the prescribed drug; and
- The charge for the substituted generically equivalent drug does not exceed the charge for the drug originally prescribed.
However, a substitution must not be made if the prescriber has determined that it is *medically necessary* for the brand product to be dispensed. See below for requirements for DAW prescribing.

A list of drug products which are excluded from generic substitution is established by the Drug Formulary Committee and communicated to the Minnesota State Board of Pharmacy for dissemination to pharmacists.

**Dispense as Written - Brand Necessary**

Effective for services provided on or after January 5, 2004. The Drug Formulary Committee reviewed and accepted the following prior authorization criteria for brand name medications:

- Prescribers must obtain authorization for any brand name multiple source drug that has an FDA “AB” rated generic equivalent.
- Providers must continue to write, in their own handwriting, "DAW – brand medically necessary" on the prescription (a checked DAW box or a typed DAW is not acceptable) and obtain authorization from Care Delivery Management Incorporated (CDMI).
- List the specific drug being requested, including dosage form, strength, and directions.
- Document when the generic was tried and the length of the trial period. If no trial period existed, provide the medical justification for brand name use.
- Specify the medical problem caused by the generic product. Describe the problem in detail. Examples: allergic reaction and/or attributable adverse events.
- Provide chart documentation of generic failure.
- Include physician, NDC number, and pharmacy MHCP provider number.

The following drugs, which are on the list of drugs exempt from Minnesota’s mandatory generic substitution law, do not require prior authorization:

- Dilantin 100 mg extended release capsules
- Synthroid and other brand name levothyroxine products

The pharmacy must notify the recipient and DHS when a generically equivalent drug is dispensed. The notice to the recipient may be given orally or by appropriate labeling on container dispensed. Notice to DHS is by use of appropriate billing codes.

Claims for prescriptions filled with a brand name medication when a generic is available must show "DAW - brand necessary" certification in the DAW/UD box on the Pharmacy/Supply Invoice or the corresponding field for electronic billing. There are two codes for legitimate billing:

06 - Patient resides in an LTC facility and this claim is eligible for the unit dose blister card dispensing fee.
08 - Prescriber's handwritten "DAW - brand necessary" is on the prescription, patient resides in an LTC facility and this claim is eligible for the unit dose blister card dispensing fee.

MAC price limitations do not apply if the prescriber has certified that a particular brand is medically necessary. If a prescription is "DAW - brand necessary," but the prescribed drug manufacturer is not a participant in the Federal Drug Rebate Program, the drug is not covered.

Billing

Pharmacy charges are submitted to DHS using the paper Pharmacy/Supply Invoice (DHS-3065), Point of Sale (POS), or ITS software.

Reversal of Claims

Pharmacy providers who have submitted claims on POS for recipients who have had a change in their spenddown amount or program of eligibility, should not reverse claims on POS. DHS will adjust the claims automatically. If a replacement claim does not appear on your RA within two weeks of the spenddown or eligibility change, contact the Provider Relations Help Desk at (651) 282-5545 or 1-800-366-5411.

Usual and Customary

The term usual and customary refers to an amount billed by a provider, meaning provider's charge to the type of payer that constitutes the largest share of their business. For this definition, payer means a third party or persons who pay for health services by cash, check or charge account.

- Providers must bill their usual and customary charge. This applies whether the drug is purchased by prescription or OTC, in bulk or unit-dose packaging.
- OTC drug products must be billed at the shelf price of the pharmacy.
- If a pharmacy is not accessible to, or frequented by the general public, or if the OTC drug is not on display for sale to the general public, then the usual and customary charge for the OTC drug will be the actual acquisition cost of the product plus a 50% mark-up based on the actual acquisition cost.
- Amounts paid in full or in part by third party payers must be included in the calculation of the usual and customary charge only if a third party payer constitutes 51% or more of the pharmacy's business, based on the number of prescriptions filled by the pharmacy on a quarterly basis.
- For recipients with private health insurance, the provider may not bill MHCP more than the client-liable amount (e.g., co-payment). An example of correct billing is as follows:
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- Submitted charge: Amount allowed by the third party payer;
- Prior payments: Amount paid by the third party payer; and
- Co-payment: The difference between the submitted charge and the prior payment.

Providers may need to manually override their system's usual and customary charge to prevent overbilling.

National Drug Codes (NDC)

All pharmacy claims submitted to DHS must identify the 11-digit NDC printed on the stock container in which the drug was purchased. For example, if a drug is purchased in a 5000-count bottle and repackaged in 100 count bottles prior to dispensing, the NDC for a 5000-count bottle must be used. In this case, using the NDC for a 100-count bottle is not permitted. Most drugs distributed by repackagers are not covered by Medicaid because the repackager has not signed a rebate agreement with CMS. A pharmacy may not dispense a repacker’s drug and then bill DHS using the original manufacturer’s NDC. NDC's for compounded drugs are discussed later in this chapter.

Dispensing Date

The dispensing date reported on the claim must be the actual date the entire quantity was dispensed. For drugs dispensed in unit dose containers, the last dispensing date of the calendar month must be used as the dispensing date on the claim form.

Prescribing Provider Numbers

All pharmacy claims must include the prescriber’s nine-digit MHCP provider number.

- Use the prescribing provider's 9-digit MHCP provider number in box 30 on the Pharmacy/Supply Invoice, or in corresponding POS or ITS field.
- Nurse practitioners and physician assistants enrolled with MHCP have their own 9-digit provider number. This number must be reported on the claim in box 30 on the Pharmacy/Supply Invoice, or corresponding POS or ITS field.
- Prescriptions written by unenrolled residents, physician assistants and nurse practitioners must use the 9-digit MHCP provider number of the supervising physician in box 30 on the Pharmacy/Supply Invoice, or corresponding POS or ITS field.
- The pharmacy’s provider ID number may be used as the prescriber ID number in box 30 on the Pharmacy/Supply Invoice or in the corresponding POS or ITS field if neither the physician nor the clinic at which the physician practices are enrolled as providers. This most commonly occurs if the physician is located outside of the state of Minnesota.
Payment for Prescribed Drugs

The maximum payment for a prescribed drug or compounded prescription is the lowest of the following:

- The maximum allowable cost for a drug established by CMS or DHS, plus a dispensing fee;
- The estimated actual acquisition cost for a drug plus a dispensing fee; or
- The pharmacy's usual and customary charge.

Maximum Allowable Cost (MAC) Drugs

CMS establishes federal upper limits (FUL) for reimbursement for multiple source drugs. In addition to the CMS established FUL, DHS has established a MAC list for additional drugs. These reimbursement levels are updated on an intermittent basis and are available on the DHS website at the following address: www.dhs.state.mn.us/provider/pharm/.

Enteral/Nutritional Products

See the Equipment & Supplies chapter (Ch. 23) for billing instructions and the Physician and Professional Services chapter (Ch. 6) for coverage information.

Billing for Drugs with Coverage Limits Based on Diagnosis

An ICD-9-CM diagnosis code must be included on all claims for certain drugs (see table below). The pharmacist must verify the diagnosis with the prescriber before submitting a claim.

- **For paper claims:** Enter the ICD-9-CM diagnosis code in box 37 on the Pharmacy/Supply Invoice.
- **For online Point of Sale:** Enter the ICD-9-CM diagnosis code in the diagnosis field. If an applicable field does not exist in your software, bill the prescription using a paper claim.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Covered Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>dexamfetamine</td>
<td>attention deficit hyperactivity disorder (ADHD)</td>
</tr>
<tr>
<td>dextroamphetamine</td>
<td>fatigue due to multiple sclerosis</td>
</tr>
<tr>
<td>methamphetamine</td>
<td>narcolepsy</td>
</tr>
<tr>
<td>methylphenidate</td>
<td>major depressive disorder, single or recurrent episodes.</td>
</tr>
<tr>
<td>(Adderall) mixed amphetamines</td>
<td></td>
</tr>
<tr>
<td>modafinil and pemoline.</td>
<td></td>
</tr>
<tr>
<td>Straterra (atomoxetine)</td>
<td>attention deficit hyperactivity disorder (ADHD)</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Medication</th>
<th>Covered Diagnoses</th>
</tr>
</thead>
</table>
| Cipro XR                 | **Cipro XR 500 mg**  
Covered only for treatment of uncomplicated UTI (acute cystitis) at a dosage of one tablet daily for three days  
Maximum allowable quantity is 3.  
**Cipro XR 100 mg**  
• Covered only for the treatment of complicated UTI or acute uncomplicated pyleonephritis at a dosage of one tablet daily for up to 14 days.  
• Maximum allowable quantity is 14. |
| Klonopin Wafers          | Covered only if the patient has difficulty swallowing or if there is a history of non-compliance                                                      |
| Remeron Soltabs,        |                                                                                                                                                   |
| Zyprexa Zydis, Risperdal-M |                                                                                                                                                   |
| Xanax XR                 | Covered only if the approved indication of panic disorder with or without agoraphobia                                                            |
| Actiq (oral transmucosal fentanyl) | Covered only for patients who have breakthrough cancer pain                                                                                     |
| Viagra                   | Covered only for males =18 years of age who have a diagnosis of impotence of organic origin                                                       |
| Cialis                   |                                                                                                                                                   |
| Levitra                  |                                                                                                                                                   |

**Online Pharmacy Claims Screening (ProDUR)**

Point of Sale (POS) claims are screened by DHS online edits that check recipient data and alert pharmacists to potential drug conflicts. This screening process occurs at the time of POS transmission and is referred to as ProDUR. Claims in conflict with ProDUR edits are identified by a series of DUR conflict codes and may be overridden by the pharmacist. The only POS edits that a pharmacist can override are those relating to DUR. A pharmacist may override a ProDUR edit only if there is a valid reason for doing so. Refer to the Policies for Handling “Refill-Too-Soon” Override and Authorization Requests section of this chapter.

**Paid Claims:** Some DUR conflict codes are posted for informational purposes only and allow the claim to be paid.

**Denied Claims:** If a claim is denied for payment based on a DUR conflict code, pharmacist’s professional judgment will need to be used to decide whether or not to fill the prescription. If it is in the recipient's best medical interest to fill the prescription, the denial may be overridden. Enter the appropriate intervention and outcome codes (from the following tables) in the corresponding field and resubmit the claim using POS. To override a denial code:

- Select a corrective action and enter the related intervention code in the corresponding field.
- Record the result of the corrective action using the appropriate outcome code in the corresponding field, and then resubmit the claim via POS.
Pro-DUR Conflict Codes

<table>
<thead>
<tr>
<th>Valid Value</th>
<th>DUR Conflict</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>Low Dose Alert</td>
<td>Prescribed doses are less than the standard dosing range</td>
</tr>
<tr>
<td>HD</td>
<td>High Dose Alert</td>
<td>Prescribed doses are greater than the standard dosing range</td>
</tr>
<tr>
<td>ER</td>
<td>Overuse Precaution</td>
<td>Refills that occur before the previous Rx supply should have been exhausted</td>
</tr>
<tr>
<td>LR</td>
<td>Underuse Precaution</td>
<td>Refills for maintenance drugs that occur after the previous Rx supply should have been exhausted</td>
</tr>
<tr>
<td>DD</td>
<td>Drug-Drug Interaction</td>
<td>Pharmacologic response of drugs in combination is different and not wanted compared to result expected when each drug is given individually</td>
</tr>
<tr>
<td>MC</td>
<td>Drug-Disease Interaction</td>
<td>Contraindication and warning concerning the use of certain drugs with patient's specific medical condition(s)</td>
</tr>
</tbody>
</table>

Pro-DUR Intervention Codes

<table>
<thead>
<tr>
<th>Valid Value</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No intervention</td>
</tr>
<tr>
<td>M0</td>
<td>Prescriber consulted</td>
</tr>
<tr>
<td>P0</td>
<td>Patient consulted</td>
</tr>
<tr>
<td>R0</td>
<td>Other source consulted</td>
</tr>
</tbody>
</table>

Pro-DUR Outcome Codes

<table>
<thead>
<tr>
<th>Valid Value</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Not specified</td>
</tr>
<tr>
<td>1A</td>
<td>Filled as is, false positive</td>
</tr>
<tr>
<td>1B</td>
<td>Filled as is</td>
</tr>
<tr>
<td>1C</td>
<td>Filled with different dose</td>
</tr>
<tr>
<td>1D</td>
<td>Filled with different drug</td>
</tr>
<tr>
<td>1E</td>
<td>Filled with different directions</td>
</tr>
<tr>
<td>1F</td>
<td>Filled with different quantity</td>
</tr>
</tbody>
</table>

Policies for Handling “Refill-Too-Soon” Override and Authorization Requests

Override of “refill-too-soon” is granted only for approved reasons by calling the Provider Call Center, at 1-800-366-5411 or (651) 282-5545. Upon approval, Call Center staff will issue an authorization number to be transmitted with the claim. Do not call CDMI to request an override.

Non-Controlled Substances: Override/authorization is granted in the following circumstances:
### Chapter 22: Pharmacy Services

<table>
<thead>
<tr>
<th>Circumstances (Non-Controlled Substances)</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication was lost, stolen, damaged or destroyed and recipient does not reside in a LTC facility such as a nursing home or ICF/MR.</td>
<td>Authorization is granted twice every six months.</td>
</tr>
<tr>
<td>Prescriber increased the dose of the medication.</td>
<td>Verify with the prescriber and document that the dose was increased.</td>
</tr>
<tr>
<td>Pharmacy entered the wrong days supply on the first fill.</td>
<td>Reverse the claim and rebill.</td>
</tr>
<tr>
<td>Change in living arrangement (for example, the recipient was admitted to or discharged from a nursing home).</td>
<td>Verify and document the change in living arrangement.</td>
</tr>
<tr>
<td>Recipient was discharged from a hospital and the hospital kept the medications that were taken from the patient at admission.</td>
<td>Verify and document the hospitalization and discharge.</td>
</tr>
<tr>
<td>Recipient was released from a correctional facility or detoxification center and the facility kept the medications that were taken from the recipient.</td>
<td>Verify and document release from correctional facility or detoxification center.</td>
</tr>
<tr>
<td>Recipient must travel out-of-state and will not return before the supply of a medication runs out.</td>
<td>Authorization is granted once every 6 months.</td>
</tr>
</tbody>
</table>

Override/authorization is NOT granted in the following circumstances:

<table>
<thead>
<tr>
<th>Circumstances (Non-Controlled Substances)</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication was lost, stolen, damaged or destroyed and recipient resides in a LTC facility such as a nursing home or ICF/MR.</td>
<td>The facility must replace the medication at its own cost.</td>
</tr>
<tr>
<td>Recipient increased the dose of the medication.</td>
<td>Authorization will not be granted.</td>
</tr>
<tr>
<td>Recipient received authorization because of a lost, stolen, damaged or destroyed medication twice within the last six months.</td>
<td>Additional authorization will not be granted.</td>
</tr>
<tr>
<td>Recipient received authorization due to travel out-of-state once during the last six months.</td>
<td>Additional authorization will not be granted.</td>
</tr>
<tr>
<td>Pharmacy is trying to be reimbursed for “pass meds,” “school supplies,” “work supplies,” etc.</td>
<td>Authorization will not be granted.</td>
</tr>
</tbody>
</table>
Controlled Substances: Override/authorization is granted for the following reasons:

<table>
<thead>
<tr>
<th>Circumstances (Controlled Substances)</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriber increased the dose of the medication.</td>
<td>Verify with the prescriber and document that the dose was increased.</td>
</tr>
<tr>
<td>Pharmacy entered the wrong days supply on the first fill.</td>
<td>Reverse the claim and rebill.</td>
</tr>
<tr>
<td>Change in living arrangement (for example, the recipient was admitted to or discharged from a nursing home).</td>
<td>Verify and document the change in living arrangement.</td>
</tr>
<tr>
<td>Recipient was discharged from a hospital and the hospital kept the medications that were taken from the patient at admission.</td>
<td>Verify and document the hospitalization and discharge.</td>
</tr>
</tbody>
</table>

Override/authorization is NOT granted in the following circumstances:

<table>
<thead>
<tr>
<th>Circumstances (Controlled Substances)</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication was lost, stolen, damaged or destroyed and recipient resides in a LTC facility such as a nursing home or ICF/MR.</td>
<td>The facility must replace the medication at its own cost.</td>
</tr>
<tr>
<td>Medication was lost, stolen, damaged or destroyed and recipient does not reside in a LTC facility such as a nursing home or ICF/MR.</td>
<td>Additional authorization will not be granted.</td>
</tr>
<tr>
<td>Recipient was released from a correctional facility or detoxification center and the facility kept the medication.</td>
<td>Additional authorization will not be granted.</td>
</tr>
<tr>
<td>Pharmacy is trying to be reimbursed for “pass meds,” “school supplies,” “work supplies,” etc.</td>
<td>Authorization will not be granted.</td>
</tr>
<tr>
<td>Recipient must travel out-of-state and will not return before the supply of a medication runs out.</td>
<td>Authorization will not be granted.</td>
</tr>
</tbody>
</table>

Compounded Products, Preparations, and Oral Drugs

Compounded Topical Products

Compounded topical products are covered when prescribed and dispensed as listed below. The following chart includes a description of the compounded topical product and the NDC code to use for billing. If a compounded topical product is not listed in the following chart, it is not covered. Never bill a compounded product using the NDC of one of the active ingredients.

- Bill using usual and customary charge for these products.
• Only the compounded topical products identified will be paid.

• Pharmacies cannot bill for a compound topical product by using the NDC of one of the active ingredients (e.g., a prescription for nystatin cream 30gm 1% hydrocortisone cream 30gm is not covered and cannot be billed by using the NDC for either nystatin cream or hydrocortisone cream). (This applies to POS and paper claims).

• Unless specified otherwise, listed ingredients can be prescribed and dispensed in any strength and can be put into any inert base.

• In all cases, the final concentration of ingredients is unrestricted if there is no strength or percentage listed. The final concentration is restricted if a strength or percentage is listed (e.g., the final concentration of hydrocortisone is limited to 1%).

• Enter the assigned 11-digit compounded drug code in the NDC code in box 26 on the Pharmacy/Supply Invoice, or in the NDC field in POS, or in the NDC/VPC field on ITS.

<table>
<thead>
<tr>
<th>Digits 1 - 5</th>
<th>Digits 6 - 9</th>
<th>Digits 10 - 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>compound prescriptions</td>
<td>formulation/finished product</td>
<td>volume/finished product*</td>
</tr>
<tr>
<td>use five zeros</td>
<td>use codes below</td>
<td>ml or gm</td>
</tr>
<tr>
<td>00000</td>
<td>XXXX</td>
<td>XX</td>
</tr>
</tbody>
</table>

*Volume (ml or mg) of product for the last two digits:

0-120 = 12
122-960 = 96
other = 99

Billing example below:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HC 0.3Gm</td>
<td>Billing code: 00000-1015-12</td>
</tr>
<tr>
<td>Menthol 0.5%</td>
<td></td>
</tr>
<tr>
<td>Phenol 0</td>
<td></td>
</tr>
<tr>
<td>qs ad 30Gm</td>
<td></td>
</tr>
</tbody>
</table>
Billing Codes for Compounded Topical Products

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1015</td>
<td>Hydrocortisone 1% (HC)</td>
</tr>
<tr>
<td>1018</td>
<td>HC + M + P</td>
</tr>
<tr>
<td>1017</td>
<td>HC + P + C</td>
</tr>
<tr>
<td>1016</td>
<td>HC + M + C</td>
</tr>
<tr>
<td>6022</td>
<td>Tar Preparations</td>
</tr>
<tr>
<td>6021</td>
<td>Liquor Carbonis Detergens LCD</td>
</tr>
<tr>
<td>6003</td>
<td>Crude Coal Tar (CCT)</td>
</tr>
<tr>
<td>6023</td>
<td>Michaelson’s Colloidal Tar (MCT)</td>
</tr>
<tr>
<td>6024</td>
<td>LCD + Tincture of Green Soap</td>
</tr>
<tr>
<td>4003</td>
<td>LCD + SA</td>
</tr>
<tr>
<td>4004</td>
<td>CCT + SA</td>
</tr>
<tr>
<td>4007</td>
<td>MCT + SA</td>
</tr>
<tr>
<td>6023</td>
<td>Triamcinolone Acetonide 0.025 to 0.1% (TRA)</td>
</tr>
<tr>
<td>2000</td>
<td>TRA + SA</td>
</tr>
<tr>
<td>2004</td>
<td>TRA + SA + LCD</td>
</tr>
<tr>
<td>2005</td>
<td>TRA + SA + MCT</td>
</tr>
<tr>
<td>2006</td>
<td>TRA + SA + CCT</td>
</tr>
<tr>
<td>2001</td>
<td>TRA + LCD</td>
</tr>
<tr>
<td>2002</td>
<td>TRA + MCT</td>
</tr>
<tr>
<td>2003</td>
<td>TRA + CCT</td>
</tr>
<tr>
<td>4000</td>
<td>Salicyclic Acid</td>
</tr>
<tr>
<td>4002</td>
<td>Salicyclic Acid (SA)</td>
</tr>
<tr>
<td>4005</td>
<td>SA 1% + Sulfur 3%</td>
</tr>
<tr>
<td>4003</td>
<td>SA 3% + Sulfur 6%</td>
</tr>
<tr>
<td>4004</td>
<td>SA + LCD</td>
</tr>
<tr>
<td>4007</td>
<td>SA + CCT</td>
</tr>
<tr>
<td>4016</td>
<td>SA 40% Plaster</td>
</tr>
<tr>
<td>6007</td>
<td>Miscellaneous</td>
</tr>
<tr>
<td>6007</td>
<td>Formaldehyde 40%</td>
</tr>
<tr>
<td>6011</td>
<td>Acetic Acid 1/4%</td>
</tr>
<tr>
<td>8000</td>
<td>Testosterone Cream up to 2%</td>
</tr>
<tr>
<td>8000</td>
<td>Trichloroacetic acid 50% sol.</td>
</tr>
</tbody>
</table>

Billing Codes for Compounded Ophthalmic Products

The following compounded ophthalmic products are covered. Use the corresponding code in box 26 on the Pharmacy/Supply Invoice or the corresponding fields on POS or ITS.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00000-7000-12</td>
<td>Prednisolone Acetate 0.25% in Cellulose Gum 2.5%</td>
</tr>
<tr>
<td>00000-7001-12</td>
<td>Healon 0.001% in Cellulose Gum 2%</td>
</tr>
<tr>
<td>00000-7005-12</td>
<td>Healon 0.001% in Cellulose Gum 2.5%</td>
</tr>
<tr>
<td>00000-7002-12</td>
<td>Healon 0.001% &amp; Prednisolone Acetate 0.25% in Cellulose Gum 2%</td>
</tr>
</tbody>
</table>
Compounded Intravenous (IV), & Total Parenteral Nutritional (TPN) Drugs

Compounded Coverage

Compounded IV and TPN drugs are covered according to Food and Drug Administration (FDA) guidelines regarding approved indications and preparation.

- The main ingredients of the compound must be manufactured by a rebating company; and
- Must conform to other DHS policy standards (e.g., drugs with limited coverage by category, drugs requiring authorization).

Commercially Available Products

If room stable commercially available products are compounded, reimbursement is limited to the rate of the commercially available product (AWP - 9% + dispensing fee).

Billing

Compounded IV and TPN drugs are billed on the paper Pharmacy Supply Invoice (DHS-3065).

- Enter 99999-9999-99 in box 26 on the Pharmacy/supply Invoice;
- In box 44, or on an attachment, list the active ingredients and their respective NDC's, inert ingredients, strengths, and quantities.
- Non-traditional IV containers (cassettes, intermates, etc.) when required for drug compounding (reconstitution of drug), must be billed on a paper Pharmacy/Supply Invoice. The submitted charge includes both the drug and container. Provide an explanation in the box 44 or use an attachment. A drug is ineligible for a compounding fee if it is put in a non-traditional IV container when not required for reconstitution (e.g. morphine solution). In this case, bill the drug and the non-traditional IV container on a separate line item.

Note: Refer to the Equipment and Supplies chapter (Ch. 23) for billing instructions for enteral nutrition products.
Compounded Oral Drugs

Compounded oral drugs for children and aphagic recipients are covered only when they are not commercially available:

- These compounds must contain only one active ingredient which is manufactured by a rebating company and must be compounded with an inert diluent; and
- They must conform to other DHS policy standards (e.g., drugs with limited coverage by category, drugs requiring authorization).
- Compound oral drugs must not be billed on the POS using the NDC for the active ingredient. All compound oral drugs must be submitted on a paper Pharmacy/Supply Invoice. **Compounded oral drugs cannot be billed point-of-sale. Do not bill for compounded oral drugs using the NDC of the active ingredient.**

Drug Authorizations

The following drugs require authorization, which can be obtained by calling CDMI at: (651) 662-5275 or toll-free at 1-888-878-0139, extension 25275. PA requests may also be faxed to (651) 662-7459.

**Drugs Subject to Prior Authorization (current as of 11/24/03)**

**ACE Inhibitors**
Accupril (quinapril)
Accuretic (quinapril/hydrochlorothiazide)
Mavik (trandolapril)

**Antiemetics**
Anzemet (dolasetron)
Emend (aprepitant)
Kytril (granisetron)
Zofran (ondansetron)

**Antihistamines**
Allegra (fexofenadine)
Allegra-D (fexofenadine/pseudoephedrine)
Zyrtec (cetirizine)
Zyrtec-D (cetirizine/pseudoephedrine)

**Botulinum Toxin**
Botox (botulinum toxin type A)
Myobloc (botulinum toxin type B)
Calcium Channel Blockers
Adalat, Adalat CC, Procardia, and Procardia XL (nifedipine)
Calan, Calan SR, Covera HS, Verelan and Verelan HS (verapamil)
Cardene, Cardene SR (nicardipine)
Cartia XT, Cardizem, Cardizem CD, Cardizem SR, Dilacor XR, Diltia XT, and Tiazac (diltiazem)
Plendil (felodipine)
Vascor (bepridil)

COX II Inhibitors
Bextra (valdecoxib)
Celebrex (celecoxib)
Vioxx (rofecoxib)

Erectile Dysfunction (as of 2/04)
Cialis (tadalafil)
Levitra (vardenafil)
Viagra (sildenafil)

Interferons
Actimmune (interferon Gamma-1B)
Alferon N (interferon Alfa N-3)

Lipase inhibitors
Xenical (orlistat)

Non narcotic stimulants (as of 2/04)
Provigil (modafinil) 100 mg tablets

Proton pump inhibitors
Nexium (esomeprazole)
Prilosec (omeprazole)

SSRIs
Celexa (citalopram) 10 mg & 20 mg tablets
Lexapro (escitalopram) 10 mg tablets
Paxil (paroxetine) 10 mg tablets
Prozac (fluoxetine) 40 mg capsules
Zoloft (sertraline) 25 mg and 50 mg tablets

Other
Ceredase (alglucerase)
Xolair (omalizumab)
If a drug is not on this list, do not call CDMI to obtain authorization. Pharmacies frequently call CDMI trying to obtain PA for a drug that DHS simply does not cover. CDMI cannot grant authorization for drugs that are not on the list.

**Brand name medications that have an AB rated generic equivalent**

Effective January 5, 2004 all brand name medications that have an FDA AB rated generic equivalent, except Dilantin 100 mg extended release capsules, Synthroid, and other brand name levothyroxine products, will be subject to prior authorization. For authorization of payment, chart documentation of generic failure is required and will include a description of the problem caused by the generic product, documentation of when the generic product was tried and length of the trial period, or will include a medical justification for brand name use. The prescriber is responsible for obtaining authorization of payment for a brand name medication. A written statement on the actual prescription “DAW – brand medically necessary” is still required by federal law.

The use of any medication for erectile dysfunction will require prior authorization beginning February 2004. Until this time, the diagnosis code for erectile dysfunction of organic origin must be transmitted with the pharmacy claim. Their use is limited to males, 18 years of age and older. Pharmacists should indicate on the prescription that they have contacted the prescriber to confirm the diagnosis. A recipient may not receive more than 6 tablets per month.

**For drugs dispensed and billed by a pharmacy, the pharmacist is responsible for obtaining the prior authorization number from CDMI.** The pharmacist may have to obtain some information from the prescriber, such as diagnosis, but this is consistent with Minnesota Rules 6800.3110, subp. 2a, which reads:

“Minimum information required; Medicaid patients.” For Medicaid patients, a reasonable effort must be made by the pharmacy to obtain, record, and maintain at least the following information regarding individuals obtaining prescription services at the pharmacy:

A. Name, address, telephone number, date of birth or age, and gender;

B. Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices being used, showing the prescription number, the name and strength of the drug or device, the quantity and date received by the patient, and the name of the prescriber; if this information is obtained by someone other than the pharmacist, the pharmacist must review the information with the patient; and

C. Pharmacist comments relevant to the individual's drug therapy, including, where appropriate, documentation of the following for each prescription:

(1) the pharmaceutical care needs of the patient;
(2) the services rendered by the pharmacist; and
(3) the pharmacist's impression of the patient's drug therapy.
This documentation is not required for residents of a licensed nursing home where a consultant pharmacist is performing regular drug regimen reviews”.

Prior authorization criteria and forms for proton-pump inhibitors and COX-2 inhibitors can be downloaded from the Pharmacy Program page of the DHS Web site: www.dhs.state.mn.us/provider/pharm/.

Discounts, Coupons and Other Promotions

Pharmacies cannot use coupons, discounts or similar promotions in order to attract business from Medical Assistance recipients. Federal anti-fraud and abuse provisions prohibit certain types of business transactions or arrangements. (Section 231(h) of HIPAA and the Office of Inspector General Special Fraud Alert, 59 Fed. Reg. 242;1994). See Requirements for Providers chapter (Ch.1) for details.

Legal References

Minnesota Statutes, section 256B.0625, subd. 13a-13g
Minnesota Rules, part 9505.0340
Minnesota Rules, parts 9505.5000 to 9505.5105
42 CFR 440.120(a)
Title XIX, Section 1927 of the Social Security Act
Chapter 23

Equipment and Supplies

Eligible Providers

Medical suppliers (including oxygen contract vendors), pharmacies, and home health agencies.

Hospital outpatient facilities, physicians, nurse practitioners, clinical nurse specialists, physician assistants, and clinics are eligible providers for medical equipment and supplies only when provided as a necessary adjunct to the direct treatment of a patient’s condition (e.g., crutches, splints) and not incident to the service provided.

Eligible Recipients

All MHCP recipients.

Volume Purchase Advisory Committee

DHS and Department of Administration representatives meet with volume purchase vendors, as needed, to discuss contract implementation and issues. Concerns about the volume purchase contracts should be directed, in writing, to:

Minnesota Department of Administration
Materials Management Division
112 Administration Building
50 Sherburne Avenue
St. Paul, MN 55155

Reimbursement

Payment is based on pricing methodology in Minnesota Rules 9505.0445, section S, which states: “For medical supplies and equipment, the rates shall be the lowest of the provider’s submitted charge, the Medicare fee schedule amount for medical supplies and equipment, or the amount determined as appropriate by use of the methodology set forth in this item.” If Medicare has not established a reimbursement amount for an item, then the MHCP payment will be based upon the 50th percentile of the usual and customary charges submitted to DHS for the items for the previous calendar year minus 20%. For an item for which no information about the usual and customary charges exists for the previous calendar year, payment shall be based upon the manufacturer’s suggested retail price minus 20%.
Covered Services

MHCP covers medical supplies and equipment, subject to limitations, authorization, and other requirements. Additional restrictions apply to supply and equipment coverage for recipients residing in long term care (LTC) facilities.

When the medical equipment or supply is purchased for a recipient, the item is the recipient’s property. Rent for durable medical equipment is covered up to 10 months, or to the purchase price of the equipment. MHCP covered repairs to medically necessary recipient-owned equipment and maintenance on equipment that requires frequent cleaning and/or routine calibration to ensure proper working order.

Non-covered Services

This is not an all-inclusive list.

Air conditioners
Beds – oscillating and lounge beds, bed baths and lifters, bedboards, tables, and other bed accessories.
Blood glucose analyzer – reflectance colorimeter
Control units and battery device adapters
Cervical roll or pillow
Dehumidifiers – room or central
Diathermy machines
Disposable wipes – including Attends wash cloths
Elevators and stair lifts
Enuresis or bed-wetting alarms
Environmental products (e.g., air filters, purifiers, conditioners, hypoallergenic bedding, and linens)
Exercise equipment
Food blenders
Grab bars
Heat and massage foam cushion pads
Home security systems
Household equipment and supplies such as ramps, switches, tableware, and feeding instruments
Humidifiers – room type or central
Hygiene supplies and equipment, including hand-held shower units and shower trays, and dental care supplies and equipment
Ice packs (disposable)
Incontinence undergarments (includes pants to wear with pads)
Instructional materials (e.g., pamphlets and books)
Isolation gowns, surgical gowns, and masks
Magnifying glasses
Massage devices
Medical alert bracelets and response systems
Medical supplies defined as drugs
Menses products (e.g., sanitary pads)
Motorized lifts for a vehicle
Orthopedic mattresses
Personal computers and printers, tape recorders, or video recorders,
Pulse tachometers
Ramps
Reachers
Reading glasses
Table foods
Telephones, telephone alert systems, telephone arms, or answering machines
Tennis/gym shoes
Thermometer covers
Toothbrushes and toothettes
Toys
Waterbeds
White cane for the blind

Documentation of Orders

Definitions

Dispensing Order: A limited DME order that is either written, fax, or verbal.

Detailed Written Order: An order that contains the dispensing order and follows Medicare guidelines.

Order Requirements

Dispensing Orders

For any DME item to be covered by MHCP, the supplier must have an order from the treating physician before dispensing the item.

MHCP requires that providers dispense one month of supplies at a time. Providers may not ship items on a regular, monthly basis without an indication from the recipient, family member, or authorized representative that the supply is needed.

Except for items requiring a written order prior to delivery, the “dispensing” order may be a written order (original or fax) or a verbal order. The order must contain:

- Description of item
- Name of recipient
- Name of physician
- Date of order
The supplier must maintain written documentation of the dispensing order. (This documentation must be available to DHS upon request.)

Authorization is required prior to delivery for:

- Pressure reducing pads
- Mattress overlays, mattresses
- Semi and total electric, and extra-wide/heavy duty hospital beds
- Seat lift mechanisms
- Power operated vehicles

**Detailed Written Orders**

Detailed written orders must be signed and dated by the treating physician before submitting the claim to DHS. Detailed written orders are **in addition** to the dispensing order, as described above. MHCP will **not** cover a DME item if the supplier only has a verbal order when the claim is submitted.

Detailed written order must contain:

- The patient’s name and address;
- A detailed description of the item;
- The signature of the treating physician;
- The date the order is signed (the **signature** and **date** must be personally entered by the physician and **may not be a stamp or other substitute**);
- If the item has been dispensed prior to the date the detailed written order is signed, the order must specify the start date; and
- All options or additional features which will be separately billed or which will require an upgraded code:
  - The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number.
  - Rented item orders must include the length of need.
  - Accessories or supplies provided on a periodic basis must include the quantity used, frequency of change or use, and length of need.

The detailed description of the item may be completed by someone other than the physician. The treating physician must review, sign, and date the order.

A faxed order is acceptable but the supplier must be able to provide the original order to DHS upon request.

**New Order**

A new order is needed when:
• An order changes for accessory, supply, drug, etc.;
• Regularly (even if there is no change in the order) for specific items only;
• The item is replaced; or
• The supplier changes.

Re-order

• Requests must come from the patient or an authorized representative each time additional supplies are needed.
• It is acceptable for medical supply providers to call the patient to verify a re-order.
• Automatically shipping supplies without the patient’s confirmation is not acceptable.

Medical Records

Medical records must contain the following information:

• The medical condition to substantiate the necessity of the type and quantity of items ordered and for the frequency of use or replacement (if applicable).
• The diagnosis and other pertinent information including duration of the condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitation, other therapeutic interventions and results, past experience with related item, etc.
• The clinical information supports the medical necessity for the item and substantiates the information on a supplier prepared statement or physician attestation (if applicable).
  ▪ Not limited to the physician’s office records.
  ▪ May include hospital, nursing home, or home health agency records.

• Records from other professionals including nurses, physical or occupational therapists, prosthetists, and orthotists.

DHS may request this information in selected cases. The supplier is liable for dollar amount involved if the information is not received, or does not substantiate medical necessity.

Neither a physician’s order, a supplier prepared statement, nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician.

Supplier Documentation

The medical supplier must have the following information on file:

• The original detailed written order.
• Patient’s diagnosis from the testing physician.
• Any information required for use of specific modifiers or attestation statements.
• Adequate information to assure that coverage criteria for an item has been met.
• Information in the medical record must adequately support the medical necessity for the item, or the supplier is liable for the dollar amount involved.

• Proof of delivery documentation.
  
  • Methods of delivery are: (1) supplier delivering directly to the patient or authorized representative; (2) supplier utilizing a delivery/shipping service to deliver the item; and (3) delivery of items to a Long Term Care (LTC) facility on behalf of the patient.

All services that do not have appropriate proof of delivery from the supplier will be denied, and all overpayments must be returned to DHS. Suppliers who consistently do not provide documentation to support their services will be referred to the DHS Surveillance and Integrity Review Systems (SIRS) Unit and the Office of the Attorney General.

Delivery of DME Supplies

Method 1. Supplier delivering items directly to the patient or authorized representative:

• The delivery slip must be signed and dated by the patient or authorized representative to verify the DME item was received.

• The date of the signature on the delivery slip must be the date DME was received by the patient or authorized representative.

• The delivery slip must include the patient’s name, quantity, a detailed description of the item(s) delivered, brand name, and serial number (if applicable).

• The date of service on the claim must be the date the DME item was received by the patient or authorized representative. An exception to this would be when an item must be billed using a date span and the quantity dispensed crosses over into next month.

Method 2. Supplier utilizing a delivery/shipping service to deliver items:

• Acceptable proof of delivery includes the delivery service’s tracking slip and the supplier’s shipping invoice.

• The supplier’s shipping invoice must include the patient’s name, quantity, detailed description of the item(s) delivered, brand name, serial number (if applicable), and delivery service’s package identification number associated with patient’s package(s).

• The delivery service’s tracking slip must reference the patient’s package(s), delivery address, and the corresponding package identification number given by the delivery service:
  
  ▪ Without the delivery service’s tracking log that identifies each individual package with a unique identification number and delivery address, the item will be denied and any overpayment will be recouped.
  
  ▪ When the recipient denies receipt of an item, the item will be denied and an overpayment will be recouped, unless the supplier maintains a detailed shipping invoice and the delivery service’s tracking log.

• Mail order DME items: The date of service on the claim must be the shipping date.
Method 3. Delivery of items to an LTC facility on behalf of the patient:

- Proof of delivery must be maintained in the supplier’s records as described in Methods 1 and 2.
- Suppliers must work with the LTC facility staff to implement inventory control to ensure that the:
  - LTC facility received delivery and was provided with receipt of what was delivered;
  - Supplies were identified and retained for use only by intended recipients;
  - Intended recipients use the supplies; and
  - Suppliers receive proof of delivery from the LTC facility.

- Medical records in the LTC facility must document use of all supplies/items billed to MHCP. Documentation may be in the nurse’s notes of a special treatment record or form.
- The date of service on the claim must be the date the DME item was received by the LTC facility if delivered by the supplier, or the shipping date if the supplier used the delivery/shipping service.

**Exception** to the preceding statements concerning date of service on the claim: when items are provided in anticipation of discharge from a hospital or LTC facility. If the DME item is delivered to a patient in a hospital up to two days prior to discharge (home) and for the benefit of the recipient for the purpose of fitting or training of the patient in its use, the supplier must bill the date of service on the claim as the date of discharge (home) and must use place of service “12” (home).

**Hospitalized Recipients**

- Equipment/supplies ordered for subsequent use in the patient’s home may not be billed to DHS prior to the date of the patient’s discharge (home). This includes:
  - Drugs, supplies used with the DME, or prosthetic devices; or
  - Surgical dressing, urological supplies, or ostomy supplies applied in the hospital, including items worn home by the patient.

* Suppliers are responsible for delivering the DME to the patient’s home.

**Authorization Requirements**

The provider must obtain authorization when required. Refer to the [Authorization chapter](#) (Ch. 5) and the [Benefits Code Guide](#).

**Billing**

- Use the Pharmacy Supply Invoice (DHS-3065) or CMS-1500.
• Use current HCPCS procedure codes and modifiers when billing for medical equipment and supplies. When billing, use a modifier to indicate rental, repair or replacement of part, or purchase. Additional modifiers may be appropriate depending on the item or service.

• Repairs to equipment or parts must be billed using the RP modifier to indicate that the equipment is being repaired. Charges should represent the materials needed to accomplish the repair.

• A physician, physician assistant, or nurse practitioner must order equipment or supplies in writing and specify the duration of need. The medical supply provider must have the original order on file.

• The medical equipment must not serve the same purpose as usable equipment previously purchased for the recipient.

• Repairs are not covered while the item is rented, under warranty, or are not medically necessary.

• Pick up and delivery expenses may not be billed. The cost of delivery is included in the reimbursement rate. Providers must not bill for the cost of loaner items provided during repair. These costs are included in the rental or purchase payment.

• Reimbursement will continue up to the DHS maximum allowed payment rate when renting any equipment. Do not continue to bill monthly rental after the DHS maximum rate has been reached. This is typically a 10-month period. Providers must apply full rental payments (including all payments received from primary third party payers) to all purchases. Once MHCP purchases the medical equipment or supply for a recipient, the item is the recipient’s property.

• Replacement of recipient-owned equipment and parts must be billed using HCPCS codes representing the item, and the NU modifier to indicate the item has been purchased. For repairs and replacements the appropriate HCPCS codes must be used to indicate the number of hours of labor and an hourly rate. Do not bill for setup and delivery or service calls that do not involve actual labor time for repairs.

• Providers may not dispense more than a one-month supply of medical supplies.

• If a claim does not cross over from Medicare, providers who have received payment from Medicare should submit a CMS-1500 to DHS for the coinsurance and/or deductible. Complete the claim exactly as Medicare requires and include the recipient’s MHCP ID number and your MHCP provider number. Attach a copy of the Medicare EOMB to the paper CMS-1500 or complete the Medicare screen on ITS software. Do not enter Medicare’s payment in box 29 of the CMS-1500 or the prior payment field on ITS.

• Highly technical equipment owned by the recipient, requiring service and calibration on a scheduled basis to ensure proper working order, should be put on a maintenance service agreement. Maintenance service agreements (service on patient-owned equipment made at routine intervals based on hours of use, or calendar days, to ensure that the equipment is in proper working order) always require authorization. Use the appropriate HCPCS codes with the MS modifier when requesting authorization from CDMI. One unit equals six months.

The Benefit Code Guide can be found on the Provider Relations Web site at www.dhs.state.mn.us/provider/ref/codeguide.htm. If you do not have access to the internet, contact the Provider Relations Help Desk at (651) 282-5545 or toll-free
LTC Facilities

Medical equipment and supplies are generally included in the LTC facility per diem. The following items can be reimbursed outside of the per diem, if not claimed on the facility cost report:

- **Pressure Reducing Support Surfaces:** Authorization required.

- **Wheelchairs:** Wheelchairs in intermediate care facilities for the mentally retarded (ICF-MR) are covered in the same way as for non-institutionalized recipients. Wheelchairs for residents of LTC facilities are included in the per diem unless provisions in this chapter are met. All wheelchair purchases require authorization.

- **Continuous Oxygen:** Oxygen ordered by the physician for the continuous use by the resident. Emergency oxygen must be covered by the facility per diem.

- **Ventilators, CPAP and BIPAP Equipment and Supplies:**
  - **CES Units**
  - **Prosthetics and Orthotics:** Including prosthetic and orthotic limbs, breast prosthesis, surgical or compression stockings, eyes, braces, and other orthotic and prosthetic items as defined by Medicare.

Coverage Criteria

- **Apnea Monitors Coverage Standards (E0618, E0619)**
  
  Authorization required for maintenance service only.
  
  **Documentation:** One of the following must be documented in the patient record:

  - Apnea and bradycardia episodes;
  - Tracheostomy;
  - Apparent Life Threatening Episode (ALTE);
  - Sibling death to Sudden Infant Death Syndrome;
  - Apnea of prematurity;
  - Central Hypoventilation Syndrome; or
  - Recurring airway obstruction.

  **Included with Rental:** batteries, cords, lights, connecting cable, printed instructions, carrying case, and battery charger. **Billed separately:** lead wires, electrodes, and rib belts.
Memory Monitor (Apnea) (E0619)

Rental only.

**Documentation:** One of the following criteria must be documented in the patient record:

- Standard apnea monitor used and reasons why it did not meet the needs of the patient or the requirements of the ordering physician.
- Unreliable caregiver situation when there are concerns the monitor won’t be attached to the infant at appropriate times.
- Unusual symptoms or reporting of alarms that cause the physician to request more information.

**Exclusions/Limitations:** Two channel pneumograms are not covered for patients with memory monitors or trend event recorders. Four channel pneumograms may be covered if the patient has symptoms that are still unexplained with memory monitoring.

**Included with Rental:** Data collection media, information dump/processing, patient connecting cable, batteries, electrical cords, lights, printed instructions, carrying case, and battery charger.

**Billed separately:** Lead wires, electrodes, and rib belts.

Trend Event Apnea Recording Equipment (E1399)

Rental only and authorization is always required.

Trend event recording equipment is covered for those situations where the patient data stored in the equipment must be retrieved and evaluated by the physician.

**Documentation:** The authorization request must include what special diagnostic information is sought and the length of time the physician wishes to gather this information.

**Exclusions/Limitations:** Two channel pneumograms are not covered for patients with memory monitors or trend event recorders. Four channel pneumograms may be covered if the patient has symptoms that are still unexplained.

**Included in Rental:** Recorders, monitors (other than the apnea monitor), data collection media, data retrieval/dumping, mileage, patient cables, lights, batteries, battery charger, and carts to hold equipment. **Billed separately:** Leads, electrodes, or probes other than those that are included with the apnea monitor.
Two & Four Channel Pneumogram Recording Equipment (E1399)

Rental only.
**Included in Rental:** Patient connecting cables, software, data collection equipment, paper, recording devices and media, cart, batteries, battery charger, transport of data to physician, setup, pickup of equipment, pulse oximeter (four-channel), probes, and catheters.

- **Bilirubin Lights (E0202)**

  Rental only—monthly.
  No authorization required.
  Limit: one

- **Blood Glucose Monitors (E0607, E0609/E2100, E2101)**

  E0607 purchase only.
  One monitor allowed every 4 years, if more than allowed quantity is medically necessary, providers must submit a paper claim with an attachment explaining circumstances.
  E0609/E2100 rent or purchase and always requires authorization.
  E2101 rent or purchase, but only after it has been documented why E0607 will not meet the recipient’s needs.
  **Documentation:** A written physician’s order for use to monitor diabetes. The patient must be diabetic (Type 1, Type 2, or Gestational).

- **Breast Pumps (E0602, E0603, E0604)**

  Breast pumps are covered when ordered by a physician, certified nurse midwife, or nurse practitioner for any nursing mother experiencing separation from her infant because of work, school, illness or any other medical reason.

  **Rental/Purchase:** Manual breast pumps (E0602) and personal electric breast pumps (E0603) are purchase only. Heavy-duty hospital grade electric breast pumps (E0604) are rental only.

  **Billing:** Manual breast pumps (E0602) and personal electric breast pumps (E0603) are billed using NU modifiers. Hospital grade breast pumps (E0604) are billed with an RR modifier. Bill accessory kits for E0604 breast pumps with an RP modifier. Bill breast pumps using the mother’s MHCP Recipient ID number, or the infant’s MHCP ID number if the mother is ineligible.

- **Chest Compression Vest Systems Coverage Standards (A7025, E0483)**

  Authorization is always required.
  A vest will not replace a percussor, caregiver, and/or self-administration unless it is demonstrated that these forms of therapy are no longer effective or available.

  Diagnosis must be:
• Moderate to severe cystic fibrosis;
• Ciliary dyskinesis; or
• Bronchiectasis.

Approval is based on the following questions:

• Does patient currently have a vest/generator? (Replacement for purchased units considered only when broken beyond repair and not under warranty.)
• What other bronchial drainage device/treatment has been tried, and how did these fail?
• Proof that patient can use the vest/generator effectively.
• Vest/generator effectively meets all bronchial drainage therapy needs.
• Documentation of at least one of the following:
  ■ The FEV level;
  ■ The FVC level;
  ■ Small airway score has decreased over a year;
  ■ History of oral steroid dependence greater than one year; or
  ■ Family history or other resources are insufficient to perform the necessary twice daily (or greater) bronchial drainage treatment.

Exclusions/Limitations: MHCP will not reimburse providers for bronchial drainage performed by a therapist or any other health care professional (including PCA’s) while the patient has a functional bronchial drainage vest.

• **CPAP: Adult Nasal CPAP (E0601)**

Rent or purchase
No authorization required.
Limit: One per four years. If more than allowed quantity is medically necessary, provider must submit a paper claim with attachment explaining circumstances.

**Included with Rental:** Compressor, manometer, CPAP valve (if separate from mask), filters, fuses, instruction manual, carrying case, and a disconnection alarm (if needed). **Billed separately:** Replacement parts, tubing, head gear, and mask.

• **Cranial Electrotherapy Stimulator (CES) (E1399)**

A Cranial Electrotherapy Stimulator (CES) is used for treatment of pain above the neck. DHS will consider coverage of CES for treatment of migraine and tension headache. CES will not be approved for treatment of anxiety, depression, or insomnia.

Rental/Purchase: A two-month trial rental period is required before purchase will be approved. Documentation of effective use will be necessary.

Authorization: Both trial and purchase require authorization.
Documentation:

- Diagnosis
- Can patient use CES effectively?
- Length of illness
- Previous treatments and results

- Disposable Diapers, Undergarments, Liners/Pads, and Underpads (A4521 – A4535, A4538, A4554)

Eligible Recipients:

- Over age four, with an underlying medical condition that involves loss of bladder or bowel control.
- Under age four, with diagnosis that results in excessive urine or fecal output requiring more than ten diapers per day.
- ICF-MR and nursing facility residents are excluded as these products are included in the facility per diem.
- Tabbed re-fastenable style products and guards/shields/liners are limited to 300 items a month. Authorization is required for quantities of over 300.
- Pull-on disposable undergarment style products are limited to 150 items a month. Recipient must be ambulatory and/or toilet training to receive this product. Authorization required for quantities over 150.
- Underpads are limited to 200 per month. Authorization required for quantities over 200. Underpad usage by recipients regularly using incontinence products should be minimal.

Eligible Providers: Pharmacy, home health agency, medical suppliers, and enrolled diaper services.

Authorization: Required if under age four and for quantities over monthly limits.

Documentation: Physician order required and must include the duration of need and the medical reason. Under age four: a physician’s order must also document a diagnosis or treatment that results in excessive urine or fecal output requiring more than ten diapers per day. Quantities over the monthly limits require documentation regarding recipient’s condition/diagnosis, type of incontinence, other products being used, any skin breakdown issues, and whether product is appropriate for recipient’s needs.

Exclusions/Limitations: Only a one-month supply may be dispensed at any time.

Billing: Bill one unit per item. When billing, manufacturer and product name must be on the claim. Shipping costs are included in the DHS maximum allowable payment and may not be billed separately. Diaper services billing for cloth diapers should use code A4538.

Other Information: Although specific brands are not required, DHS maximum allowable amounts may preclude the purchase of some products. The rate has been established so that the
majority of products on the market are obtainable. Providers should always provide the appropriate product for the recipient’s current needs.

Absorbency Distinction: MHCP expects providers to dispense a moderate absorbency product that will accommodate a majority of the Medicaid recipient’s incontinence needs. Supplying larger quantities of inferior products is not an acceptable practice.

Moderate absorbency – level 1
Youth 750 – 1000 cc
Small 900 – 1200 cc
Medium 1200 – 1700 cc
Large/Xlarge 1400 – 1900 cc
∪ Use appropriate HCPCS code with NU modifier.

Added absorbency – level 2
Youth 1000 – 1500 cc
Small 1200 – 1900 cc
Medium 1700 – 2200 cc
Large/Xlarge 1900 – 2400 cc
Use appropriate HCPCS code with NU and U1 modifiers.

Maximum absorbency – level 3
Youth – 1500 cc Minimum
Small – 1900 cc Minimum
Medium– 2200 cc Minimum
Large/Xlarge Minimum – 2400 cc
Use appropriate HCPCS code with NU and U2 modifiers, and include a diagnosis code to support the need for maximum absorbency.

• Enteral Nutritional Products (B4150-B4156)

Eligible Recipients: MHCP recipients who do not reside in an LTC facility.

Eligible Providers: An MHCP enrolled provider must prescribe the product. An enrolled pharmacy, home health agency, or medical supplier may dispense it.

Limitations: Enteral nutritional products for a recipient in an LTC facility or hospital cannot be billed separately. Authorization must be obtained for all orally consumed enteral nutrition after the first 30 days of dispensing.

Nutritional Product: A commercially formulated substance that provides nourishment, and affects the nutritive and metabolic processes of the body.
Covered Nutritional Products

MHCP covers enteral nutritional products when the patient’s diagnosis can be linked to the need for a nutritional product. Enteral nutritional products are:

- A reasonable and necessary alternative for patients with functioning gastrointestinal tracts, but for whom regular feeding is impossible;
- A substitute for food;
- Medically necessary for the patient to sustain life; and
- Not a supplement to a regular meal nor a convenient alternative to preparing and consuming regular foods.

MHCP covers enteral nutritional products without authorization for the following medically diagnosed conditions:

- Phenylketonuria (PKU);
- Hyperlysinemia;
- Maple syrup urine disease; or
- Recipient’s receiving enteral nutritional supplements through a feeding tube.

The following must be met for MHCP coverage:

- One of the diagnoses specified above must be documented in the patient’s medical record;
- Enteral nutritional products needed to treat conditions, other than those specified above, require authorization after the first 30 days;
- Coverage for products other than infant formulas will be considered when a medical need is demonstrated;
- Specially manufactured solid food products for treatment of PKU must be obtained from an enrolled PKU solid food supplier. Use procedure code S9435 to bill PKU solid food products; and
- MHCP does not cover grocery store products.

Non-Covered Nutritional Products

- Nutritional products for healthy newborns;
- Standard infant formula for children under the age of one;
- Nutritional products for persons living in LTC facilities (enteral products are included in the per diem);
- Food thickeners; and
- Sport Shakes.

Enteral Nutrition Authorization

Authorization is required after the first 30 days of use for recipients that are taking their enteral nutrition orally, a BO modifier is required to indicate oral administration. Enteral nutritional
supplements dispensed through an enteral feeding tube do not require authorization. When authorization is approved by CDMI, the information submitted on the claim to DHS must match the information on the authorization, including procedure code, and modifiers. Effective 7/1/2002, authorization requests for enteral nutrition no longer need the UPC on the authorization request. Due to the fact that special metabolic formulas (B4154) vary in price significantly, DHS requests the UPC to reimburse appropriately.

**Authorization Guidelines for Nutritional Products**

Nutritional products may be approved when both of the following apply:

1. The diagnosis can be linked to the need for the nutritional product and:
   - The individual has received chemotherapy or radiation that has caused damage to the neck or mouth resulting in a swallowing problem;
   - There is a failure to thrive diagnosis with an underlying diagnosis (e.g., cerebral palsy with uncoordinated swallowing);
   - HIV/AIDS diagnosis;
   - Complete allergy to breast milk, cow’s milk, soy milk, and another condition such as cystic fibrosis;
   - There is a diagnosis of oral aversion; or
   - The patient is being weaned from TPN; and

2. The request is for 50% or more of the daily calories or 50% or more of a major nutrient.

The following information must be supplied by the physician to the pharmacy, home health agency, or medical supply provider:*

- Ordering physician’s name and MHCP provider number;
- Recipient’s name, MHCP ID number, and date of birth;
- Type of request (e.g., initial, continuing – date enteral therapy began, or change in prescription);
- Date last seen by physician;
- Date of order and estimated duration of therapy per physician;
- Diagnosis and how it relates to the need for the nutritional product;
- Other diagnosis;
- Product requested (product name, 11-digit UPC, and appropriate B-code);
- Route of administration;
- Total calories needed per day;
- Total calories from enteral product per day;
- Total calories from other ingested foods and liquids per day;
- Height, weight, targeted weight; and
- Other therapy/treatment that may justify the need for the nutritional product.
* The provider billing for the enteral product requests authorization. The enteral
authorization information form (DHS-3971) is available at
http://edocs.dhs.state.mn.us/lfserver/legacy/DHS-3971-ENG.

Billing

Effective 7/1/2002, providers are no longer required to bill for enteral nutritional products with the
UPC. Approved authorizations and submitted claims must be identical to prevent a denial. All
products should be billed under the appropriate procedure code for the category the product falls
under. Providers unsure of what code to use with the product should refer to the SADMERC product
classification list available on their Web site: www.pgba.com. Due to the fact special metabolic need
products (B4154) vary in price significantly, DHS requests the provider include the product name or
UPC in the comments/description field to ensure appropriate reimbursement.

The following information must be on all claims for enteral nutritional products:

- A “BO”-modifier for recipients taking their enteral nutrition orally, authorization is required
  after the first 30 days of dispensing;
- A valid diagnosis code to the greatest specificity indicating a need for the product;
- A date span, indicating the appropriate amount of days for the quantity of product dispensed;
  and
- The appropriate amount of units, based on the recipient’s daily calorie intake, one unit = 100
  calories.

In situations where Medicare covers enteral/nutritional products as part of an enteral feeding kit,
MHCP will pay the Medicare coinsurance and deductible.

Parenteral nutritional products are considered drugs and only a pharmacy may dispense these
solutions. See the Pharmacy Services chapter (Ch. 22) for more information on parenteral
nutrition. Bill parenteral products with NDC codes, do not use HCPCS codes.

- Gloves (A4927, A4930)
  Authorization: Required for quantities over assigned limits.
  Limits: Non-sterile: 4 boxes of 100
  Sterile: 200 pair
  Criteria: For recipient use in their home or foster care.

- Hospital Beds
  Eligible Recipients: MHCP recipients who do not reside in an LTC facility.

  Standard Hospital Beds: (E0250, E0251, E0255, or E0256)
  Authorization not required.
• The prescription must establish medical necessity and include a description of the medical condition (e.g., cardiac disease, chronic obstructive lung disease, quadriplegia).
• The prescription must document severity and frequency of symptoms of the condition that necessitate a hospital bed for positioning versus fixed attachments used on an ordinary bed.

Semi-Electric, Total Head, and Foot Adjustment Beds: (E0260, E0621, E0294, or E0295)
Authorization is required after 3 months rental and for purchases.

• Meet requirements above for a standard hospital bed;
• Document that the patient’s judgment and skill level must be adequate to operate the controls;
• Provide a summary of the status of the attendant/caregiver; and
• A description of functional limitations that precludes use of a conventional bed or a standard hospital bed.

Total-Electric: (E0265, E0266, E0296, or E0297)
Authorization is required for rental and for purchases.

• Must meet above requirements and all of the following:
• A significant amount of care must be provided by a caregiver to the person in bed;
• A change of bed height is required at least once a day to enable the caregiver to assist with patient care; and
• The caregiver is physically unable to change bed height manually.

Extra-Heavy Duty, Extra-Wide Hospital Beds: (K0549, K0550)
Authorization is required after 3 months rental and for purchases.

• Must meet the requirements for a standard bed; and
• Patient’s weight must be documented to meet qualifications.

Bed Rails: (E0305, E0310)

• Covered when used with a hospital bed.

• Enclosed Bed Coverage Criteria
  E0316 bed enclosure (Vail, Posey, Pedicraft)
  E0300 hospital grade enclosed crib

Authorization: always required

This type of bed is considered medically necessary and the least costly alternative in only the most extreme conditions, due in part to the restrictive nature of the bed and the confinement it entails, and the high cost. Based on advice from medical consultants, MN Medicaid considers the bed medically necessary when the patient is mobile, but cognitively impaired, and his or her
unrestricted mobility results in documented injuries sustained as a result of wandering unsupervised. Even then it must be shown that other, less costly methods have been attempted and have failed to effectively treat the problem. Generally, such confinement is not medically necessary nor the least costly way of managing seizures or behaviors such as head banging, rocking, etc. Issues of sensory deprivation and the potential for overuse must also be addressed in this process.

Coverage will be considered for patients who meet the following criteria:

- Documented evidence of unsafe mobility (climbing out of bed, not just standing at the side of the bed), needs to include mobility that will put them at risk for serious injury, not just a possibility of injury.

1. Diagnosis of one of the following:
   a. TBI
   b. CP – moderate to severe
   c. Seizure disorder
   d. DD (cognitive impairment)
   e. Severe behavioral disorder

2. Cognitive and communication impairment

3. Documentation of medical necessity must include the following:
   a. daily seizure activity
   b. uncontrolled perpetual movement related to diagnosis
   c. self-injurious behavior, such as head banging, where a helmet was tried and failed, must be documentation to this effect

4. Evidence of need due to a proven safety risk (more than head banging, as a helmet can be used). Balance problems (padding and side rails can be used for this, explain why these did not solve the problem). History of injuries that have occurred up to this request.

5. Less costly alternatives must have been tried and demonstrated how they have failed.
   a. create a bed on the floor, mattress on the floor, or inside of a small portable tent
   b. padding around regular or hospital bed
   c. lining a crib with padding, or placing a crib tent over crib
   d. medications to prevent seizures and to correct behaviors. Also, other behavior modifications used for sleep disturbances that would promote/maintain sleep.
   e. helmets for head banging
   f. removing all safety hazards from the patient’s room and using a child protection device on the door knob or placing a baby gate across the door to prevent the child from leaving their room
   g. baby monitors to listen in on patient’s activity

6. When will this bed be used? List specific time periods. This bed should not be a substitute for responsible parenting or supervision of the child.

7. Are there outside caregivers providing care to this individual? If so, how many hours a day and what times during the day? (i.e., # days/week, etc.). Is the patient in school/daycare, and how many hours a day? Paid providers caring for the individual are considered a duplication of service with this bed.
8. There are other types of beds that have bumper pads, removable tops, adult sized cribs, etc. Many patients have been in a hospital and used the enclosed bed there and have not tried any of the other options.

9. There must be verification that the primary care giver is willing and able to clean the mesh canopy per the manufacturer’s recommendations.

DHS believes that there is no clear cut medical justification for the enclosed bed systems. The real need is to proactively address with intervention the underlying medical and/or behavioral issues that give rise to the risk of harm.

- **Pressure Reducing Support Surfaces**

Support surface products are divided into three groups, and are considered purchased after 10-months rental:

**Group 1 (E0180, E0182-E0199)**

Bed overlays such as static air mattress overlays, water beds, and foam mattresses.

**Coverage Standards:** Included as part of the LTC facility per diem and cannot be billed separately. Covered in a home setting.

**Authorization:** Not required, but provider’s record must indicate one of the following:

- Patient is completely immobile;
- Patient cannot independently make changes in body position; or
- Ulcer on trunk or buttock along with one of the following: impaired nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status.

**Group 2 (E0193, E0277, E0371, E0372, or E0373)**

Powered air flotation bed (low air loss) therapy, alternating pressure mattresses, powered air overlays, and non-powered adjustable zone pressure reducing air mattress overlays.

**Coverage Standards:** Covered in a home setting and LTC facility. The patient’s attending physician must order based on a comprehensive assessment and evaluation of the patient after conservative treatment has been tried without success and the physician must direct the home treatment regimen and reevaluate and re-certify the need for the bed on a monthly basis. Must have healing as the goal of treatment and any one of the following:

- Multiple stage II pressure ulcers located on the trunk or pelvis; patient has been on a comprehensive ulcer treatment for at least the past month and patient has used lower level support surface and ulcers have worsened;
- Large stage III or IV pressure ulcer(s) on the trunk or pelvis and the patient cannot be positioned off the ulcer areas;
• Recent mycutaneous flap or skin graft for pressure ulcer on the trunk or pelvis and they have been on a pressure reducing support surface immediately prior to discharge from a hospital or LTC facility (surgery within past 60 days);
• Patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or LTC facility (discharge within past 30 days);
• After 6 months on a group 2 support surface and there has been no improvement in the patient’s condition, alternative treatments must be considered before additional monthly rental will be authorized.

Authorization: Always required.

Group 3 (E0194)
Air-fluidized beds.

Coverage Standards: Covered in a home setting and LTC facility. Must have healing as the goal of treatment and all of the following:

• Stage III or IV pressure sore on the trunk or pelvis;
• All other alternative equipment has been considered and ruled out;
• Patient is bedridden or chair bound as a result of severely limited mobility; and
• After 6 months on a group 3 support surface and there has been no improvement in the patient’s condition, alternative treatments must be considered before additional monthly rental will be authorized (e.g., wound vac, wound warm-up therapy, dressings with silver or other additives).

Authorization: Always required.

Group 3 products will not be covered if the patient has co-existing pulmonary disease, and/or requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering (impervious covering will be re-considered if patient is undergoing aggressive treatment in a wound clinic, but must be measurable improvement within 30 days or authorization will not be approved).

Documentation, All Groups

There must be a comprehensive treatment plan in place for any of the support surface products to be covered. This includes:

• Appropriate turning and positioning;
• An effective nutritional plan addressing an adequate albumin level;
• Appropriate ulcer treatment;
• Management of moisture/incontinence; and
• Necessary medications including antibiotics when infection is present.

Authorization requests must include the following:
• Physician order;
• Recipient information: diagnosis, height, weight, mental status, mobility, nutritional status, continence, activity level, care setting, turning surface, and medications;
• Wound description: size, stage, location, wound bed color, texture, drainage, and surgery dates; and
• Therapies: treatment plan.

Billing: If using the miscellaneous medical equipment code to identify a support surface, authorization is always required and must include the following:

• Manufacturer and brand name of the product;
• What support surface group (1, 2, or 3) it has been placed in by Statistical Analysis Durable Medical Regional Carrier (SADMERC); and
• Why it is medically necessary for this patient.

• **Stationary and Ambulatory Infusion Pumps (E0779, E0780, or E0781)**

  **Documentation:** The physician’s order must include the length of need (number of days per month and/or total number of months), diagnosis, name of drug, frequency of administration, and a copy of the treatment plan.

  **Ambulatory Insulin Infusion Pumps (E0784)**

  **Authorization:** Always required.
  **Documentation:**

  • Three months of HbA1c levels;
  • Three months of blood sugars;
  • Number of injections per day and the coverage; and
  • Indication that the person is capable of following treatment regimen.

  **Other Information:** Implanted infusion pumps are paid for on an inpatient basis, an outpatient basis, or as a physician service. The pump does not require authorization when implanted during an inpatient stay. The pump does require authorization when implanted on an outpatient basis or as a physician service.

  **Enteral and Parenteral Nutrition Infusion Pumps (B9000, B9002, B9004, B9006, E0791)**

  Authorization required for maintenance service only.

  **Documentation:** The physician’s order must include the length of need (number of days per month and/or total number of months), diagnosis, name of drug, frequency of administration, and a copy of the treatment plan.
Nebulizer, with Compressor (Pulmo Aide Type) (E0570),
Nebulizer, Portable with Small Compressor With Limited Flow (Battery Operated) (E0570)

Authorization not required: One nebulizer allowed every 4 years, if more than allowed quantity is medically necessary, providers must submit a paper claim with an attachment explaining circumstances.

**Included:** Compressor, reusable nebulizer, tubing, mouthpiece, and mask.

**Billed Separately:** Replacement/disposable hand held nebulizer, replacement tubing, disposable mouthpieces, or face mask.

**Documentation:** The need for a battery operated model (a portable electric model does not meet the medical needs of the patient) must be documented, and the following authorization criteria must be met:

- Previous life threatening bronchospasms;
- Aerosol drug therapy is more frequent than twice per day for a recipient who is away from home at school or work on a daily basis;
- Cystic Fibrosis; or
- Bronchiecstasis.

**Oxygen Contract**

DHS contracts for oxygen equipment and supplies. Contract vendors may supply only in their designated contract regions. Refer to the list of vendors at the end of this chapter.

Non-contract oxygen vendors may provide oxygen if one of the following exceptions apply:

- Recipients that are dually eligible for Medicare or other insurance coverage and MHCP, may use non-contract vendors for their oxygen supplies. If Medicare or other insurance denies coverage, the non-contract vendor must refer the recipient to a contract vendor. The contract vendor must follow Medicare’s coverage criteria and retest blood gas levels at 3, 6, 9 and 12 month intervals;
- Non-contract vendors providing equipment to recipients using respiratory life support equipment, which requires oxygen as a driver/power source to sustain life or oxygen used in conjunction with life support equipment in the home, may also supply the patient’s oxygen;
- When a recipient is found retroactively eligible for MHCP, non-contract oxygen vendors will be reimbursed for oxygen services during the retroactive eligibility period through the date the county determines eligibility for MHCP; and
- LTC facilities that do not include oxygen in the per diem rate and own piped gas systems may purchase oxygen from non-contract vendors.
Billing: The cost of all disposable accessories are included in the contracted rates for gaseous and liquid oxygen systems. Do not bill disposable accessories separately. This applies to both contract and non-contract vendors.

Volume purchase oxygen contract: Contract is available under DHS website, reference materials for providers.

Oxygen

Documentation: Patients must have significant hypoxemia in the chronic stable state, a physician’s order is required and the following conditions must be met:

- The patient has been diagnosed as having a severe lung disease or hypoxia related symptoms that might be expected to improve with oxygen therapy;
- The patient’s blood oxygen levels, as evidenced by blood gas or oximetry, indicates the need for oxygen therapy; and
Alternative treatment measures have been tried or considered and deemed clinically ineffective.

Patient Lifts (E0625, E0630, E0635, E0636)

Authorization always required.

Documentation:

- A description of the current method of transfer;
- Documentation concerning why caretaker training (family and others, including personal care attendant) is not feasible;
- Patient weight (can be estimated) and height, and general strength and age of primary caretaker;
- Documentation of satisfactory patient and caretaker use of the lift;
- A statement of how the lift will be used in critical areas of the residence (e.g., in bedroom, from bed to chair, in bathroom, or from chair to toilet); and
- The plan of care.

Prosthetics and Orthotics

Physiatrist: A physician who specializes in physical medicine or who possesses specialized knowledge of rehabilitation and who is certified by the American Board of Physical Medicine and Rehabilitation.

Prosthetic or Orthotic Device: An artificial device, as defined by Medicare, to replace a missing or nonfunctional body part, to prevent or correct a physical deformity or malfunction, or to support a deformed or weak body part.
Eligible Recipients

All MHCP recipients.

Payment Limitations

A prosthetic or orthotic must be prescribed by:

- A physician who is knowledgeable in orthopedics or physiatrists;
- A physician in consultation with an orthopedist, physiatrist, physical therapist, or occupational therapist; or
- A podiatrist within the scope of their profession. MHCP covers podiatrist services to treat below the knee.

Authorization

Authorization is required when:

- The provider’s billing exceeds $3,000 per item or system;
- Replacement of a temporary prosthetic less than three months old;
- Replacement of a permanent prosthetic less than three years old; and
- Miscellaneous prosthetic/orthotic codes total billing over $400.

Covered Orthopedic Footwear

- **Custom Orthopedic Shoes:** Shoes that are custom molded and manufactured according to patient’s specifications and prescribed by a physician or podiatrist.
  
  **Coverage Guidelines:** Guidelines for custom shoes are foot deformity. Documentation should include description of the deformity, evidence of pain, indication of tissue breakdown or high probability of tissue breakdown, a description of any limitation on walking and a physician or podiatrist order. Custom shoes must have materials and labor costs itemized.

- **Stock Orthopedic Shoes:** An orthopedic shoe that is not built to a person’s individual specifications, as prescribed by a physician or a podiatrist.
  
  **Coverage Guidelines:** Therapeutic shoes, inserts, and modifications are covered by MHCP when the following coverage standards are met:
  
  - The patient has diabetes (ICD-9-CM diagnosis code required on claim); or
  - The recipient has one or more of the following conditions:
    
    - Previous amputation of the other foot, or part of either foot;
    - History of previous foot ulceration of either foot;
    - History of pre-ulcerative calluses of either foot;
− Peripheral neuropathy with evidence of callous formation of either foot;
− Foot deformity of either foot; and/or
− Poor circulation of either foot.

- **Inserts and Modifications for Therapeutic Shoes for Diabetes:** Separate inserts are covered when the patient has covered diabetic custom-molded or depth shoes. Inserts used in non-covered shoes are not covered.

  Shoe modifications can substitute for an insert. Common shoe modifications are: rigid rocker bottoms, roller bottoms, wedges, metatarsal bars, or offset heels.

Shoes, inserts and modifications must be prescribed by a podiatrist or other qualified physician knowledgeable in the fitting of diabetic shoes and inserts. The footwear must be fitted and furnished by a podiatrist or other qualified individuals such as a pedorthist, orthotist, or prosthetist.

**Non-covered Footwear**

- Stock orthopedic shoes, EXCEPT when attached to a leg brace.
- Repair costs for a prosthetic or orthotic device purchased by MHCP that is covered under warranty, or repair costs for any rented orthotic or prosthetic equipment.
- A device that serves to address social, recreational, and environmental factors and does not directly address the patient’s physical or mental health.
- A device that is supplied to the patient by the physician who prescribed the device, or by the consultant to the physician.
- A device that is supplied to the patient by an affiliate of the physician who prescribed the devices, or of the consultant to the physician. (“Affiliate” means a person that directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, the referring physician or consultant.)

**Billing**

Use the Pharmacy/Supply Invoice, the CMS-1500, or their electronic equivalents, and the appropriate HCPCS codes to bill. Claims for stock orthopedic shoes must include a copy of the physician’s order, specifying that the shoes will be attached to a leg brace. Claims without an attached order will be denied.

Prosthetic and orthotic devices for which fabrication has begun, but has not yet been completed as of the date of the recipient’s termination from MHCP eligibility, will be reimbursed on a prorated basis.

**Repairs**

Repairs to prosthetic/orthotics must be billed with the appropriate HCPCS code representing the item and the RP modifier. Charges should represent the materials necessary to accomplish the repair. Bill replacement of parts using the HCPCS code representing the replacement part, and
the NU modifier to indicate the item is a purchase. **Bill labor separately;** specify the number of hours of labor and the hourly rate. Do not bill for setup and delivery, or service calls that do not involve actual labor time for repairs.

- **SAD Lights (E0203)**

Authorization is always required

Criteria:
- Tabletop models only.
- Diagnostic assessment from a mental health professional.
- Well documented pattern of depressive episodes.
- Positive response to light therapy.
- Patient must be compliant with light therapy regimen.
- Medical reason to avoid antidepressant drugs, trial and outcome.

- **Standers (S8470, L1500, L1510)**

Authorization is always required. All accessories that will be added to the stander must be attached to the stander authorization request with the procedure code, quantity, description, and price list. Standers are reviewed as a complete package.

Documentation:
- Diagnosis;
- Age;
- Height and weight, or other information regarding size;
- Description of function (sitting ability, standing ability, mobility);
- Description of transfers;
- Functional goals;
- Current program directed toward functional goals;
- Daily activities;
- Relevant impairments (range of motion, bowel/bladder/intestinal function, history of fractures or risk for bone density issues, respiratory status); and
- Answers to the following questions:
  - What is the patient’s history of standing?
  - What is the patient’s current standing program? Does the patient stand in any other setting (school, work setting, etc.)?
  - Is the patient able to stand by any method other than a stander? (against furniture, with assist of caregiver, with a strap or support, with a walker, etc.)
  - How is the use of a stander related to the functional goals for this patient?
  - What activities require the use of a stander?
  - Does the home program or therapy program provide for regular use of a stander?
• Has the patient experienced a trial of the proposed stander or any other stander and what were the results?
• What other standing devices were considered, and why were they rejected?
• What other less costly alternatives were considered, and why were they rejected?
  (other approaches to identified needs - range of motion, prolonged stretching, splints, respiratory activities, other methods of weight-bearing, etc.)

• Suction Pump (Respiratory) (E0600)

  **Exclusions/Limitations:** Generally, portable suction may be used as a stationary suction. Therefore, MHCP will not cover both portable and stationary suction unless documentation supports the need for both types.

  **Included:** Pump, battery, battery charger, carrying case, permanent collection bottles, and overflow valve.

  **Billed separately:** Disposable collecting bottles, connecting tubing, and suction catheters.

• Topical Products Defined as Drugs

Skin care products classified as drugs and provided for patients with catheters, ostomies, or other conditions may be covered, but only under the following circumstances:

  • The item must be produced by a manufacturer CMS, formerly HCFA); and
  
  • A pharmacy provider must submit the claim electronically or on a Pharmacy/Supply Invoice using the 11-digit National Drug Codes (NDC). According to state law, medical equipment and supply providers or home health care agencies may **not** provide items that meet the definition of a drug.

The following items are defined as drugs and may be covered, but only as described above. This is not an inclusive list. Not all products that fit into one of the categories listed below are covered. An Interactive Voice Response (IVR) system is available to providers to verify drug coverage using the (NDC). The telephone numbers are: IVR 651/282-2599 or 1-800-657-3985.

  • Urea solutions
  • Antifungal compounds
  • Antiseptics
  • Topical anesthetic and antipruritic solutions
  • Topical corticosteroid
  • Topical anti-infective agents and cleaners
  • Anti-psoriasis and anti-eczema medications
  • Aluminum chloride, fluorouracil, and hydroquinone solutions
  • Sterile saline or water (includes irrigation solutions labeled as Rx legend)
• Aluminum acetate solution and lime sulfur dressing and soaks
• Antibiotic-steroid combinations
• Zinc oxide compounds
• Vitamin A & D ointments
• Scabicides and pediculicides
• Lactic acid lotion
• Anti-acne medications
• Burn anti-infective agents
• Wart medications
• Enzymes

Non-Topical Products: Lubricants for ostomy patients, non-legend sterile saline irrigation solutions, skin barriers, and other topical products that do not contain active ingredients, and are not classified as drugs, may be billed on the Pharmacy/Supply Invoice with the appropriate HCPCS code. These items require a written order from the physician that includes the exact description of the product to be dispensed, the amount needed, and the length of need.

• Respiratory Assist Devices (Suitable for 12 Hrs or Less Per Day) (K0532, K0533, K0534)

Authorization is not required.
Documentation: Authorization requests must include documentation of a diagnosis of one of the following:

• Chronic obstructive pulmonary disease;
• Central sleep apnea;
• Obstructive sleep apnea;
• Neuromuscular respiratory insufficiency;
• Thoracic deformity which inhibits respiration;
• Idiopathic or central hypoventilation syndrome;
• Post polio syndrome; or
• Other diagnosis which requires ventilation assistance for 12 or less for the spontaneously breathing patient.

Included with Rental/Purchase: Compressor unit, filters, carrying case, power cord, fuses, permanent circuit, swivel adapters, and instruction manual.

Billed Separately: Humidification device, mask, and headgear.

Equipment Repairs

Equipment repairs combined with labor charges totaling $400 or more will require authorization. This includes all repairs to the equipment; do not bill repairs over a span of dates.
When using E1399 for equipment repairs over $400, the labor and materials should be submitted together under this code; do not use E1340. Documentation should indicate the individual amounts for materials and labor.

When requesting authorization for a maintenance service agreement for a patient-owned equipment item, use the appropriate equipment procedure code with an MS modifier and include the date the warranty period ended. One unit equals six-months.

- **Ventilator, Stationary or Portable (E0450, E0454, E0460, E0461)**

  Authorization is not required.

  **Documentation:** Manufacturer make and model of ventilator, current settings, FIO₂ and other respiratory equipment in use.

  **Included with Rental:** Pole, cart, stand, PEEP valve, IMV devices, electric cord, hi/low/disconnect alarms, pressure manometers, exhaustion valves, spirometer, water traps, battery, carrying cases, and high pressure hoses.

  **Billed Separately:** Humidifiers, breathing circuits, oxygen, oxygen analyzers, remote alarms, and manual resuscitation bags.

- **Wheelchairs**

  **Eligible Recipients**

  MHCP recipients who are not residing in LTC facilities. (For recipients in LTC facilities see below.)

  **Wheelchair Providers**

  Wheelchair/scooter vendors must be enrolled as a medical equipment provider. Providers must be able to provide support services such as: emergency services, delivery, setup, repair service, warranty service, education, and on-going assistance with the use of the wheelchair. A copy of the warranty must be given to the consumer and also kept in provider records.

  The provider must have loaner chairs available for the recipient whose chair requires repair. When repairing a patient-owned chair, loaner chairs will be covered by one-month’s rental. Providers must have skilled and knowledgeable service personnel, with an adequate inventory of replacement parts to provide timely service and repair of chairs on-site (in the consumer’s home or work environment). MHCP does not cover repairs of loaner chairs.

  **Wheelchair Rental/Purchase**

  If the need for a wheelchair is permanent, wheelchair rental is not appropriate, and the authorization request should be for a purchase.
Authorization

- All wheelchair purchases require authorization.
- All wheelchair rentals require authorization at 3 months.
- Care Delivery Management Inc. (CDMI) will authorize the wheelchair base (K0001-K0014) and pediatric chairs (E1231-E1238). The base should include all standard options for a wheelchair; the standard options do not need to be listed separately and attached to the request.
- Non-standard options:
  - K0108 (wheelchair component or accessory, not otherwise specified) items should be listed in the documentation with a description, quantity, and charge. CDMI will only review for medical necessity if the individual item is $400 or greater.
  - Tilt’n Space (E1161) always requires authorization. Documentation of increased or excessive muscle tone related to the person’s diagnosis and that the condition is anticipated to be unchanging for at least one year.
  - K0028 (manual, fully reclining back) always requires authorization. Documentation of spinal cord impairments, inability to shift or recline to relieve skin pressure, or inability to tolerate full upright post.
  - Standing Feature (K0108) always requires authorization. Documentation of the patient’s wheelchair confinement and requirements for an independent standing frame. (Indicate if patient already owns a stander.)
  - Customized seating systems require authorization for recipients residing in an LTC facility:
    - K0115: Seating system, back module, posterior lateral control, with or without lateral supports, custom fabricated for attachment to wheelchair base; and
    - K0116: Seating system, combined back and seat module, custom fabricated for attachment to wheelchair base.

* Effective 8-1-02, prefabricated wheelchair backs (e.g., J2 back, Evolution back, LaBac) submitted using code K0108 will no longer require review for authorization. A detailed description including manufacturer and product name must be included on the claim to prevent a denial with EOB code 436 (procedure or service requires authorization, no prior authorization number on invoice). Claims staff will have a list of all common prefabricated wheelchair backs to compare to the claim description. If the information in the description area does not match any products on our list, the claim will be denied for needing further information.

All the above information must be submitted with the authorization request, even if not reviewed for medical necessity. It is necessary to have all of this information to view the wheelchair as an entire package.
Authorization Documentation

Wheelchair authorization requests must include the following:

- The physician’s order for the wheelchair;
- The authorization request form for the wheelchair and/or accessories. This form must be completed and signed by the person who is recommending and fitting the chair. The form must indicate the specialty (MD, PT, OT, etc.) of the person determining the need; and
- Authorization form: Wheelchair authorization form located on the DHS website, forms section.
  - The form must include a listing of all modifications or accessories.
  - List the recommended chair by name, the corresponding HCPCS code, and model number. Coverage determinations are based on the least costly, most effective, and medically necessary chair for the individual recipient; and

- **Power chairs:** The form must include documentation that the patient is sufficiently mature, capable, and responsible to operate the power wheelchair safely.

LTC Wheelchair Authorization Documentation

Authorization must be obtained for all wheelchair purchases and for wheelchair repairs when the total charges, repair plus labor, exceed $400. If the wheelchair is approved for payment outside the facility per diem, the wheelchair becomes the property of the resident, not the facility. If an LTC facility resident owns a wheelchair, or if an LTC facility resident has a wheelchair purchased by MHCP that met rule provisions for outside of the per diem, it must be stated on the request. The resident’s planned discharge date to the community must be documented.

Wheelchair Purchases in LTC Facilities

Approval of payment outside of the LTC facility per diem will be considered:

- If a resident needs a wheelchair that must be modified. Modified means the addition of an item to the wheelchair that cannot be removed without damaging the equipment, or that permanently alters the equipment.
- A wheelchair (including power wheelchairs) is necessary for the continuous care and exclusive use of a resident due to an unusual medical need. Exclusive use alone does not justify separate payment if the chair required is a stock chair. (The resident must also have a medical need that is unusual for the population of the facility.)
- In addition to the requirements listed above, the medical professionals working with the resident must indicate the extent to which it is medically necessary to provide a modified wheelchair. This documentation must be supplied with the authorization form. Wheelchairs manufactured in various widths and sizes for larger individuals are not considered to be modified wheelchairs.
- All wheelchairs will be purchased or rented outside of the ICF-MR per diem.
Standard wheelchair:

- Standard wheelchairs are included in the LTC facility per diem.
- Standard wheelchairs with customized features (e.g., Tilt’n Space) will be reviewed for medical necessity by CDMI.

Customized wheelchairs:

- Wheelchairs that must be modified for a recipient, and used exclusively and continuously by the recipient will be reviewed for medical necessity by CDMI.
- Customized wheelchair with standard additions (e.g., Roho cushion). A customized wheelchair may be approved for purchase outside a facilities per diem, but non-customized items requested with the wheelchair will still be included in the facilities per diem payment.

Repair of Patient Owned Wheelchair in an LTC Facility

- Repairs are covered on recipient owned wheelchairs that are medically necessary when residing in an LTC, and if the chair would be reimbursable outside of a facility per diem.
- Authorization is required when repair combined with labor is $400 or over.

Third Party Coverage

- When DHS is not the primary payer, other insurance must be exhausted before submitting a claim for payment. However, any DHS payment must be approved with an authorization through CDMI. CDMI will review an authorization request after the fact, but authorization must be obtained. Refer to the wheelchair authorization section for instructions. The wheelchair must meet all medical necessity requirements, and documentation included in the request must identify the wheelchair in detail. The amount the primary payer will reimburse for the wheelchair must be included in the authorization request.

- Providers must submit the same documentation that is submitted to Medicare to other third party payers.

Wheelchair Repairs/Modifications

- Wheelchair repairs and adaptations require authorization if the combined charges for parts and labor exceed $400. The authorization request should specify anticipated parts and the amount of time the repair will require. One repair may not be billed over a series of days.

- Replacement parts must be billed using the appropriate HCPCS code and the XP or NU modifier to indicate purchase of the part. Repairs of replacement parts with no assigned HCPCS code must be billed using the wheelchair HCPCS code with the RP modifier.
**Custom Wheelchair Seating Devices and Accessories**

Labor and material costs associated with fabricating an individually made sitting support spinal orthosis may be billed to DHS under one of the following HCPCS codes:

- K0115: Back module molded to fit a patient (orthotic seating system, back module, and posterior lateral control, with or without lateral supports, custom fabricated for attachment to wheelchair base). Authorization is required when the recipient resides in an LTC facility;
- K0116: Seat and back sections molded as one piece (orthotic seating system, combine back module and seat module custom fabricated for attachment to wheelchair base). Authorization is required when recipient resides in an LTC facility; and
- Repairs to these seating systems are billed using code K0115 or K0116 and the RP modifier. Providers must detail the cost of materials and the hours of labor spent on the repair. Documentation must clearly state that it is for a seating system and not wheelchair repairs. Do not use code E1340 for labor charges. Labor charges are included in the cost of the seating system. Repairs require an authorization when the cost of labor combined with the cost of repair is $400 or more.

**Authorization**

For residents of long term care facilities, authorization must be obtained for the purchase of wheelchair seating devices, head rests, and additions or modifications to the seating system regardless of the amount billed. Authorization requests for these items will not be processed when incorrect procedure codes are submitted, or required documentation is not provided.

The following pricing information must be submitted when requesting authorization: retail prices of any pre-manufactured components, itemization of materials, and retail price and labor (labor hours must be broken down into time spent on evaluation, measuring, design, fitting, and construction).

- K0108 when used for additions or adaptations for specialty seating systems (wheelchair component or accessory not otherwise specified).

Bill DHS for labor and material costs associated with additions or modifications to the seating system using code K0108. The patient’s medical condition must be described with the specificity to establish medical necessity. **It must be clear that this addition or modification is for a specialty seating system, or the claim will be denied with EOB code 436 (procedure or service requires prior authorization, no prior authorization number on invoice).** K0108 requires authorization when the cost exceeds $400, but not when used for specialty seating system adaptations, authorization is only required when the recipient resides in an LTC facility.

When billing a lead support attached to the seating device use code K0108. Do not use the codes for wheelchair head rests. Payment for a head support includes mounting hardware. Head support purchases always require authorization for recipients residing in an LTC facility.
Professional Services

Providers may also bill for professional services associated with the evaluation, molding, and fitting of these two systems by using codes K0115 with the NU and UD modifiers, or K0116 with the NU and UD modifiers. Evaluation includes design, physical exam, and simulation. Molding includes measurement, casting, and making a negative model of the patient. Authorization is always required for this service. Providers must include a statement that the provider is certified by the American Board for Certification of Orthotics and Prosthetics or Rehabilitative Engineering and Assisted Technology Society of North America (RESNA) and their certification number with their authorization request.

Other Custom Seating Items

Bill other wheelchair seating equipment with the appropriate HCPCS code for the accessories. Do not bill wheelchair parts or seating and positioning equipment with orthotics (L) HCPCS codes.

Trays:

- K0107: for a standard wheelchair tray (does not require authorization).
- K0108: for trays with special features such as unique angles, height, contours, dimension, material, rims, padding, perimeters, surfaces, and adjustable hardware require authorization when the recipient lives in a long term care facility. Make sure it is clearly stated on the claim that the tray is used with a custom seating system to avoid a denial for requiring an authorization at $400.

Belts:

- K0031: safety belts

Safety Vests and Harnesses:

- E0980: safety/support vests and harnesses.

Wigs (S8095)

Authorization always required
Criteria: Diagnosis of alopecia areata

Wound Therapy (Specialized)
(E2402, A6550, A6551 Negative Pressure Wound Therapy; A4575 Topical Hyperbaric Oxygen Chamber; A4649 Autologel Process)
(these are not all inclusive codes)
Authorization always required and approved in 30 day intervals. Approvals will be only be granted up to 3 months. If there is no significant improvement to the wound at that time, the authorization will be denied, and other treatments must be tried.

**Criteria for Specialized Wound Healing Treatments**

Wound must not have responded to standard wound treatment for at least a 30 to 60 day period before specialized wound therapy will be considered. Our specialized wound therapy form needs to be completely filled out with a physician’s order and submitted with the authorization form (DHS-3065).

The following comprehensive treatment plan must be in place prior to requesting authorization for a specialized wound therapy product:

- Record of wound etiology and stage, date of onset and evaluation, previous wound care and assessments done by a licensed medical professional (every 30 days by MD, PA, DO, NP is strongly recommended).
- Weekly wound measurements to assess the appropriateness of current wound treatment and if there is no improvement to the wound, the wound treatment needs to be changed. This should be done by nursing staff in the skilled facility or in the home setting.
- Application of dressings to maintain a moist wound environment must have been tried prior to requesting a specialized wound therapy product (e.g. wet to dry).
- Impregnated dressings when applicable (e.g. sodium, antimicrobial, silver, collagen, petroleum)
- Debridement of necrotic tissue – mechanical, surgical and/or chemical.
- Evaluation and provision for adequate nutritional status. (Albumin levels must be 3.5 – 5) (Baseline required and as medically necessary thereafter.)
- Patient is turned and positioned appropriately.
- Appropriate pressure management surface is in place while in bed and/or in wheelchair (when applicable).
- Moisture and incontinence have been addressed and appropriately managed.
- Compliance issues are addressed (i.e., refusing dressing changes, repositioning, poor nutritional intake or choices).
- Medical intervention and/or correction of underlying conditions that may cause the hindering of the wound to heal (i.e., if infection is present, that this is resolved).
- Document how this request is appropriate for the type of wound being treated

Are any of the following contraindications present for the wound vac?

- Untreated osteomyelitis within the vicinity of the wound
- Presence in the wound of necrotic tissue with eschar, if debridement has not been attempted
- Cancer present in the wound
- Presence of a fistula to an organ or body cavity within the vicinity of the wound

Are any of the following contraindications present for Autologel?

- Allergy to beef or dairy
- Currently on an immunosuppresant medication
- Necrotic tissue
- Concomitant Disease (Cancer, Bleeding Disorder, Hematological Disorder, etc.)
- Infection or Osteomyelitis at the site
Chapter 24

Home Care Services

Covered Services

- Home Health Aide
- Personal Care Assistant
- Private Duty Nurse
- Rehabilitation Therapies (Occupational Therapy, Physical Therapy, Respiratory Therapy, and Speech Therapy)
- Skilled Nurse Visit

Prior authorization is required for:

- All home health aide services
- All private duty nursing services
- Skilled nurse visits above nine visits per recipient, per calendar year
- All tele-home-care visits
- More than two face-to-face PCA assessment visits conducted by the county PHN, per recipient, per calendar year
- More than one service update assessment visit per recipient, per calendar year by the county PHN
- All PCA services and supervision of PCA services

Information about the authorization requirements and process can be found at the end of this chapter in the section titled Information for All MHCP Home Care Providers.

Eligible Providers

- Home Health Agency
- Private Duty Nursing Agency
- Registered Nurse
- Licensed Practical Nurse
- Personal Care Provider Organization (PCPO)
- PCA Choice Provider

Provider requirements: Medicare certified, Class A Licensed Home Health Agencies enrolled with MHCP.
Qualifying Services Must Be:

- provided to an eligible recipient;
- medically necessary;
- physician-ordered services provided to MHCP recipients in their own residence, that is other than a hospital, nursing facility (NF), or intermediate care facility (ICF);
- documented in a written service plan, which is reviewed by the recipient’s physician at least once every 60 days for home health agency or private duty nursing services, or at least once every 365 days for personal care services.

Providers must contact the appropriate health plan for information for prepaid health plan recipients.

Home Health Aide Services

Home health aide services are medically oriented tasks required to maintain the recipient’s health or to facilitate treatment of an illness or injury. Services must be ordered by a physician and have professional supervision provided by a Medicare Certified agency.

Eligible Recipients

Recipients must be eligible for services under one of the following programs:

- Medical Assistance
- Minnesota Care: Expanded Benefit Set (pregnant women and children under age 21); Basic; Basic Plus; Basic Plus One; and Basic Plus Two
- Waivered service programs, including Elderly Waiver (EW), Mental Retardation/Related Conditions (MR/RC), Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), and Traumatic Brain Injury (TBI); and
- Alternative Care Program recipients

GAMC recipients are not eligible for home health aide services.

- Assisting with personal cares such as bathing, dressing, grooming, feeding, toileting, routine catheter and colostomy care, ambulating, transfers or positioning;
- Simple dressing changes that do not require the skills of a licensed nurse;
- Assisting with medications that are ordinarily self-administered and do not require the skill of a licensed nurse to be provided safely and effectively;
- Assisting with activities that are directly supportive of skilled therapy services but do not require the skill of a therapist to be safely and effectively performed, such as routine maintenance exercises;
- Routine care of prosthetic and orthotic devices;
- Incidental household services necessary to the provision of one of the above health related services.
Home health aide visits for the sole purpose of providing household tasks, transportation, companionship, or socialization are **not covered**.

Home health aide services are normally paid on a per visit basis at a maximum of one home health aide visit per day. As a waiver program service, HHA may sometimes be authorized as approved units of service.

Authorization information/process in section titled Information for All MHCP Home Care Providers.

**Personal Care Assistant Services**

PCA services provide human assistance and support to persons with disabilities living independently in the community including the elderly and others with special health care needs.

**PCA Services must be:**

- medically necessary
- ordered by a physician, for an eligible recipient, whose illness, injury, physical or mental condition creates a need for the service; and
- provided under the supervision of a qualified professional or the recipient or his or her responsible party.

Recipients must be given a choice of either supervising PCA services or having a qualified professional supervise the services.

Prior Authorization is required for all PCA services. See [Authorization Requirements](#) section of this chapter.

**Eligibility**

PCA services are available to recipients covered by:

- Medical Assistance;
- Minnesota Care Expanded Benefit set; (pregnant women and children under age 21)
- Waivered Service Programs including, CAC, CADI, EW, MR/RC, and TBI
- Alternative Care Program.

PCA services are **not** covered for GAMC recipients, or non-pregnant adults enrolled in Minnesota Care.

**Providers**

- Personal Care Provider Organization (PCPO)
- Home Health Agency (HHA)
PCA Choice Provider

Provider Responsibilities

(Also refer to Requirements for Providers chapter (Ch. 1)

Personal Care Provider Organization (PCPO)

Business practice responsibilities:

- enrollment in the Medical Assistance Program as a PCPO;
- maintaining a surety bond and liability insurance;
- notifying DHS of cancellation or lapse of policy;
- maintaining documentation of services (Minnesota Rules 9505.2175);
- maintaining documentation of compliance with personal care assistant training;
- accounting or financial system using accepted accounting principles;
- developing and maintaining agency policies including the areas of: employment, operations, personnel, recipient directed supervision activities, and others as appropriate;
- verifying recipient eligibility on a monthly basis using EVS;
- coordinating with a Medicare Certified agency for services when appropriate to meet the recipient’s needs;
- obtaining initial and annual physician orders for each PCA recipient and maintain in recipient’s file;
- maintaining an individualized care plan in each recipient’s file;
- maintaining scheduling system;
- management of Shared Care and Flexible Use hours;
- notifying the county PHN when needs or health status changes;
- documenting who is the responsible party if recipient cannot direct own care.

Staff responsibilities:

- recruiting and hiring staff per agency policy and PCA criteria;
- providing required basic training (i.e. blood-born pathogen, etc);
- applying for criminal background checks for each staff at time of employment;
- applying for Hardship Waiver, if PCA meets the criteria;
- verifying Hardship Waiver approvals annually following your agency policy; [Repealed 7/1/03]
- providing qualified professional supervision of PCA services, if requested by the recipient in the assessment process.

Additional Responsibilities of PCPO

- owners with 5% interest or more, and managerial officials: comply with background study requirements as specified in MS 245A.
- document the provision of services as specified in Minnesota Rules 9505.2175, subpart 7.
• possess the capacity to enter into a legally binding contract.
• demonstrate the ability to fulfill the responsibilities described here.
• comply with general requirements for MA coverage.
• demonstrate a knowledge of, sensitivity to, and experience with the special needs, including communication needs and independent living needs, of the recipient.
• ensure that PCA services are provided in a manner consistent with the recipient’s ability to live independently.
• provide a quality assurance mechanism.
• disclose fully the names of persons with an ownership or controlling interest of five percent or more in the contracting agency.
• demonstrate a system of training and supervision of PCAs.
• document compliance with PCA training requirements for each PCA.
• if offering personal care services to a ventilator-dependent recipient: demonstrate the ability to train and to supervise the PCA and the recipient or responsible party in ventilator operation and maintenance.

PCA Choice Provider Criteria

(Also known as a Fiscal Intermediary)

• not related to the recipient, qualified professional, or the PCA;
• able to make objective ("arm’s length") decisions on behalf of the recipient about their services needs;
• a joint employer of the PCA and qualified professional; and
• pass a criminal background check. Owners with 5% interest or more, and managerial officials must also pass criminal background checks.

PCA Choice Provider Responsibilities

• enrolled in the Medical Assistance Program as a PCA Choice Provider;
• maintain a surety bond and liability insurance;
• notify DHS of cancellation or lapse of policy;
• accounting principles used in accounting or financial system;
• withhold and pay all applicable federal and state taxes;
• arrange and pay unemployment insurance, taxes, workers’ compensation, liability insurance, and other benefits, if any;
• verify and keep records of hours worked by the PCA and QP;
• develop and maintain agency policies specific to PCA Choice;
• verify recipient eligibility on a monthly basis using EVS;
• maintain individualized care plan in each recipient’s file;
• document responsible party if recipient cannot direct own care;
• apply for criminal background checks for each staff at time of employment;[Repealed 7/1/03]
• apply for Hardship Waiver if PCA meets the criteria;
• enter into a written agreement with recipient, PCA staff, and QP (if selected) before services begin.
Content of Written Agreement

- duties of the recipient, PCA, QP, and PCA Choice Provider
- salary and benefits for the PCA and the QP
- administrative fee of the PCA Choice Provider and services paid for with that fee, including the background checks
- procedures to respond to billing or payment complaints
- procedures for hiring and terminating the PCA and the QP

Reimbursement for PCA service is made at the MA rate. Reimbursement not designated as the provider’s administrative fee must be used to pay the salary and benefits of the PCA, and the qualified professional if one is chosen.

Personal Care Assistant

Criteria

- at least 18 years old.
- successfully completed at least one of the following training requirements before providing services. (The PCPO must maintain documentation that each PCA meets one of the following training requirements.):
  - nursing assistant training program or its equivalent for which competency as a nursing assistant is determined according to a test administered by the State Board of Vocational Education;
  - homemaker--home health aide pre-service training program using a curriculum recommended by MDH;
  - accredited educational program for licensed RNs or LPNs; or
  - training program that provided the individual with the skills required in order to perform the covered personal care services; or
  - If 16 to 18 years old, participated in a related school-based job-training program or completed a certified home health aide competency evaluation. (Documentation of the related school-based job training program or completion of the competency evaluation for home health aide must be maintained by the PCPO.)

- able to and provide covered PCA services according to the recipient’s care plan, and respond appropriately to recipient’s needs;
- report changes in the recipient’s condition;
- not be the responsible party;
- not be a recipient of personal care services; and
- undergo background study requirements as specified in MS 245A.
Qualified Professional (QP)

**Definition**
A qualified professional is a person who provides supervision for PCA staff and is employed by a PCPO or hired by a recipient using a PCA Choice Agency (the qualified professional must be identified in the written agreement).

A qualified professional is one of the following:
- A Registered Nurse as defined in MS 148.171
- Mental Health Professional as defined in MS 245.462, subd. 18 or 245.4871, subd. 27; or
- Licensed social worker as defined in MS 148B.21, subd. 3

**Responsibilities for Qualified Professional with a PCPO if supervision is selected by the recipient** (Minnesota Rules 9505.0335, subp. 4). The recipient may choose professional supervision of the PCA, or the recipient may provide his or her own supervision. Supervisory responsibilities include:

- Ensuring the PCA is capable of providing the required personal care services (including communication with the recipient) through direct observation of the assistant’s work or through consultation with the recipient.
- Ensuring the PCA is knowledgeable about the plan of personal care services before the PCA performs personal care services. (Develop the care plan, orient and train PCA.)
- Ensuring the PCA is knowledgeable about essential observation of the recipient’s health, and about any conditions that should be immediately brought to the attention of either the nurse or the attending physician. (Observe, respond, and report.)
- Evaluating the personal care services of a recipient through direct observation of the PCA’s work or through consultation with the recipient. Evaluation must be made:
  - within 14 days after the placement of a PCA with the recipient;
  - at least once every 30 days during the first 90 days after the recipient first receives personal care services according to the plan of personal care service; and
  - at least once every 120 days following the period of evaluations in subitem 2. The QP shall record in writing the results of the evaluation and actions taken to correct any deficiencies in the work of the PCA. (Ongoing supervision/monitoring of PCA)
- Reviewing, together with the recipient, and revising, as necessary, the plan of personal care services at least once every 120 days after a plan of personal care services is developed.
- Ensuring the PCA and recipient are knowledgeable about a change in the plan of personal care services.
- Ensuring the PCA keeps records, showing the services provided to the recipient by the PCA and the time spent by the PCA providing the services.
- Determining that a recipient is capable of directing his or her own care or resides with a responsible party.
- Determining with a physician that a recipient is a qualified recipient.
- Assessing the recipient for emergency services on holidays and weekends, and requesting service authorization within five working days from county PHN.
- Submitting requests for assessments and temporary increase of services to county PHN.
• Recording in writing the results of a PCA evaluation and actions taken to correct any work deficiencies of the PCA.
• Reporting any suspected abuse, neglect, or financial exploitation to the appropriate authorities.

Shared Care Option Requirements

• supervisory visits made at least monthly on the site
• evaluation of service outcomes
• evaluation of site and outcomes
• modification of care plan and re-training of PCA workers as needed
• documentation of all details of the QP supervision visits.

A Medicare certified home health agency that is also a PCPO, may bill for a skilled nurse visit in place of personal care supervision when supervision and skilled nursing care services are provided during the same visit.

If a qualified professional is not chosen, the recipient or his/her responsible party must:

• develop care plan in conjunction with recipient’s physician;
• orient PCA to recipient’s needs for assistance
• train PCA to provide hands-on assistance with special health care tasks with the help of the recipient’s physician;
• day-to-day supervision and evaluation of PCA;
• communicate changes in PCA service needs to agency, physician, or others.

Responsibilities of the QP in the PCA Choice Option, if the recipient chooses own supervision:

• enter into a written agreement with the PCA Choice Provider and the recipient.
• pass a criminal background check.
• assist recipient or responsible party in developing/revising recipient’s care plan to meet the recipient’s needs as indicated on the PHN assessment.
• based on the PHN assessment, determine which tasks require QP supervision, and which can be safely supervised by recipient or responsible party.
• help train PCA if requested by the recipient and is included in the written agreement.
• report any suspected abuse, neglect, or financial exploitation to appropriate authorities.
• Make a face to face visit at least one time per year.

If a qualified professional is not chosen, the recipient or his/her responsible party must develop the care plan in conjunction with the recipient’s physician and assume responsibility for performing the supervision duties, and communicating with the county PHN and PCA Choice Provider.
Personal Care Services

Qualifying Criteria for Service Reimbursement

To qualify for payment, a PCA service must be provided to an eligible recipient who meets all of the following criteria:

- needs PCA services to live in the community, is in a stable medical condition, and does not have acute health care needs that require inpatient hospitalization;
- is able to identify his/her needs, direct and evaluate PCA task accomplishment, and provide for their health and safety, or resides with a responsible party who is able to perform these functions for the recipient;
- lives in his/her own home that is not a hospital, nursing facility, intermediate care facility, health facility licensed by MDH, or foster care setting where there are more than four residents;
- has a service plan developed by the county PHN that specifies the personal care services required by the recipient; and
- has an approved service agreement for personal care services from DHS.

PCA Reimbursable Services

Personal care assistant service categories eligible for reimbursement

- activities of daily living (ADL’s)
- instrumental activities of daily living (IADL’s)
- health-related functions through hands-on assistance, supervision, and cueing
- re-direction and intervention for behavior including observation and monitoring

A PCA may accompany a recipient outside his/her home when normal life activities take him/her outside the home.

Non-covered PCA Services (not all-inclusive)

- PCA services not ordered by recipient’s physician;
- PCA assessments and reassessments done by an RN from a PCPO, HHA, or an independently enrolled RN;
- services that are not specified in the service plan developed by county PHN;
- services provided by recipient’s spouse, legal guardian, or parent of a recipient under age 18;
- services provided by a responsible party for a recipient who cannot direct their own care;
- services provided by a foster care provider of a recipient who cannot direct their own care (unless monitored by a county or state case manager);
- services provided to a recipient who resides in a foster care setting, and is unable to direct his/her own care and whose responsible party is either an employee of, under contract with, or has any direct or indirect financial relationship with the PCPO or PCA (unless monitored by a county or state case manager);
• services provided by the residential or program license holder in a residence for greater than four persons;
• services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules (this does include foster care providers);
• any sterile procedures;
• injections of fluids into veins, muscles, or skin;
• services provided by parents of adult recipients, adult children or adult siblings of the recipient, unless these relatives meet one of the hardship criteria and DHS approves the Hardship Waiver Request;
• home maintenance or chore services;
• services that are not covered PCA services;
• services provided without prior authorization from DHS;
• service provided and billed by a provider who is not enrolled to provide PCA services.

**Responsible Party**

A responsible party is required for a recipient not capable of directing his/her own care or who is under eighteen years of age, whether or not he/she is capable of directing his/her own care. . The responsible party is an individual who is capable of providing the supportive care necessary to assist the recipient to live in the community. The responsible party:

• must be capable of providing the support care necessary to assist the recipient to live independently;
• must be at least 18 years of age; and
• cannot be a personal care assistant.

“*Capable of directing his/her own care*”: This refers to a recipient’s functional impairment status determined by the recipient’s ability to communicate:

• orientation to person, place, and time;
• understanding of the plan of care, including medications and medication schedule;
• understanding of needs; and
• understanding of safety issues, including how to access emergency assistance.

**Parents or guardians of minors, or incapacitated persons** may delegate the responsibility to another adult during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party.

**Foster care license holders** may be designated the responsible party for residents of the foster care home if, case management is provided as required in MS 256B.0625, subd. 19a.
Assessments

Who Completes the Assessment?

- County Public Health Nurse for MA Home Care
- County Public Health Nurse for the MR/RC Waiver
- Service Coordinator for the CAC, CADI, EW, TBI Waivers and Alternative Care
- Contact for the PMAP health plan

PCA services are provided through MA Home Care, Waivered Services, Alternative Care and PMAP health plans. Because each group has different policy for the assessment process, the information in this section applies to MA Home Care only. See MHCP manual Chapter 26 for waivered services, and AC information.

Recipients requesting PCA services must have an assessment completed before services begin and at least annually thereafter. Physician's orders are not required for PCA assessments. The assessment must be completed within 30 days of a request from any of the following: the recipient/responsible party, agency, or other health professional. A copy of the MA Health Status Assessment and Home Care Service Plan must be provided to the recipient or responsible party, and PCPO(s) or PCA Choice Provider selected by the recipient.

An assessment must include:

- documentation of health status;
- determination of need;
- identification of appropriate services;
- coordination of services;
- referrals, and follow-up to appropriate payers and community resources;
- completion of required reports; the MA Health Status Assessment (DHS-3244), Home Care Service Plan, Payer Determination Form (DHS-3273), and any additional documentation as necessary to substantiate services;
- authorization recommended;
- recipient education; and
- evaluation of service effectiveness.

Face-to-Face Assessment (Code X5675)
The county PHN may conduct up to two face-to-face assessments per recipient per calendar year without prior authorization. This assessment is conducted when:

- a person is requesting PCA services for the first time;
- there is a significant change in the recipients condition; or
- there is a change in the need for PCA services.
- recipient is using PCA Choice Option
Service Update Option (Code X5693)
One service update is allowed per recipient per calendar year without prior authorization. The service update may be used when the recipient has not had a significant change in condition or does not require any changes in the authorized number of PCA units since the previous assessment. The county PHN determines whether this option is appropriate.

The service update option is conducted over the telephone by the PHN, and includes:

- review of initial baseline data;
- evaluation of service effectiveness;
- re-determination of service need;
- modification of service plan;
- appropriate authorization; and
- on-going recipient education;

It is recommended that a service update assessment be used no more than two consecutive years following a face-to-face assessment.

Temporary Service Increase (Code X5361)
A temporary service increase is used when a recipient requests an increase in PCA services due to a change in medical condition or caregiver status. This is based on medical necessity and **always** requires a prior authorization.

- The PHN conducts the temporary service increase by telephone with the provider's qualified professional, the recipient, responsible party, or other health care professional.
- The temporary service increase remains in effect for 45 days. If a recipient requests services to continue after 45 days, a new face-to-face assessment is done for a permanent increase in service.

The temporary service increase remains in effect for 45 days. If a recipient requests services to continue after 45 days, a new face-to-face assessment is done for a permanent increase in service. Refer to Information for All MHCP Home Care Providers later in this chapter for process to obtain Temporary Increase.

Temporary Start of Service
A 45-day temporary start of service may be authorized based on recipient assessment, identified needs and PHN recommendation to DHS. The level of services authorized under this provision has no bearing on a future prior authorization. Refer to Information for All MHCP Home Care Providers later in this chapter for how to obtain authorization.
County PHN Responsibility in the Assessment Process for MA Home Care

The county PHN, or certified PHN under contract with the county must:

- conduct all assessments face-to-face, service updates, and temporary service increase requests for PCA services;
- determine if recipient qualifies for PCA services;
- provide information about options available in PCA Program;
- develop service plan appropriate to recipient’s needs;
- recommend and provide referral information on other services as appropriate;
- assist recipient in identifying the most appropriate professional (if selected) to supervise the PCA;
- recommend the necessary amount of PCA service and supervision of PCA services (if selected) to DHS, including requests for temporary service authorizations and temporary service increases from DHS; and
- provide recipient or responsible party with a list of enrolled PCPO’s and PCA Choice Providers if requested.

A county PHN agency that is also a provider of PCA services cannot conduct assessments for their PCA recipients. These counties must contract with another PHN agency or an independent certified PHN they do not employ, or who is not employed or under contract with an enrolled PCPO to conduct the assessment and reassessments.

Recipient Options

PCA Flexible Use

Flexible Use of all PCA Hours
All PCA hours are available as flexible use. The need to choose this option is no longer required.

Definition of Flexible Use: The use of authorized units of PCA may vary within the length of the service authorization. Recipients may use their approved hours flexibly within the service authorization to meet their needs and schedules for medically necessary covered services as specified in the assessment.

Important Information about Flexible Use

- Flexible use does not increase the total amount of authorized units available.
- The recipient or responsible party, together with the provider, must work to monitor and document the use of authorized units and ensure that a recipient is able to manage services effectively throughout the authorized period.
- When requested by the recipient or responsible party, the provider must furnish regular updates about the amount of PCA units used.
PCA units may be used in varying amounts throughout the approved service authorization dates. The use of service units may differ from day to day or week to week, but must only be used for covered care.

Additional PCA units will not be authorized to supplement a service authorization exhausted before the end date, unless the county public health nurse determines a change in condition and establishes a need for increased services.

Flexible Use Restrictions: Flexible use of hours may not be used when it may jeopardize the health and safety of the recipient at any time for the duration of the service authorization.

Flexible use of service units can neither increase nor exceed the recipient’s total amount of authorized service units within the authorization period. The recipient/responsible party must carefully plan and monitor his/her use of PCA units.

Additional units for PCA services are not available to the recipient unless a change in condition occurs (e.g., post-hospitalization, exacerbated condition, illness or extended absence of primary caregiver).

If a change in condition occurs the recipient or agency staff must contact the county PHN for a 45-day temporary increase of service and/or a face-to-face assessment visit for a re-determination of need. If necessary, the county PHN will recommend an adjustment to the current service authorization to DHS.

Flexible Use/County PHN Responsibility:

- The county PHN is responsible to notify DHS that the recipient is requesting flexible use option.
- The PHN must complete a month-to-month plan of the recipient’s projected use of PCA services as part of the assessment and service planning process. The recipient works with the county PHN to develop the plan.
- An effective flexible service use plan assures that the PCPO/HHA meets the recipient’s PCA service needs during the entire authorization period and includes detail on:
  - use of service units;
  - using services within prior authorized amounts;
  - documenting and monitoring service units;
  - health and safety assurances.

The PHN must record the plan on the MA Home Care Service Plan or the Home Care Service Update (DHS 3244B).

The PHN must provide a copy of the plan to the recipient/responsible party and the PCPO, HHA, or PCA Choice Provider.
The recipient, the PCPO/HHA, and the county PHN must work together to achieve the recipient’s desired outcomes. Before selecting this option, the recipient must discuss with the PCPO/HHA their ability to supply flexible PCA services.

Providers are the primary resource for relaying information about the number of units used to recipients who have chosen the flexible service use option. If asked, providers must be able to tell recipients how many units of service have been provided. DHS is not able to give this information in a timely manner.

**PCA Shared Care Option**

Shared care is an option where **two or three** recipients choose to share PCA services in the same setting at the same time from the same PCA worker. The same PCA Choice Provider must be used for all of the recipients’ care sharing.

**Where Are Shared Care Services Covered?**

- in a recipient’s home;
- in a foster care home;
- in a child care program licensed under MS 245A and Minnesota Rules 9502.0315 to 9502.0445 or 9503.0005 to 9503.0170, or operated by a local school district or private school in which all recipients served by one PCA are participating. A PCA cannot replace or supplement required childcare center staff, or provide services to other non-PCA recipients in the childcare setting. The required childcare staff ratios for licensure must still be met; or
- outside the home or shared care site when normal life activities take the recipients outside the home.

**Authorization of Shared Care**

Recipient can select the shared care option **anytime** by contacting their PHN, or county case manager if on waivers or Alternative Care. **Providers do not select the shared care option for their clients.**

- When the recipient requests shared care, the PHN conducts a face-to-face assessment or service update to set up this option.
- The PHN assesses the appropriateness of shared care and approves the shared care option; and
- The PHN will also offer the shared care option during the assessment or service change process.

A recipient does not have to receive all PCA services in a shared care setting. A recipient may continue to use one-on-one PCA services for part of the hours and shared PCA services for the remainder.
Shared Care County Responsibility

The PHN, or county case manager for waivered services and Alternative Care recipients, along with the recipient or responsible party must determine if shared care is an appropriate and safe alternative, and how many service units should be shared, based on the following:

- Each recipient’s health status and psycho-social needs;
- suitability of site to meet the medically necessary needs of the recipients; and
- compatibility of the ages and needs of the recipients.

If shared care is appropriate; the PHN submits a Service Agreement to notify DHS that the shared care option has been selected.

Shared Care PCPO/HHA Responsibility

After the county PHN has authorized shared care for a recipient, but before starting services, the PCPO/HHA must work with the recipient to arrange shared PCA services by determining the following:

- the other recipients are approved for, or agreeable to, shared PCA services.
- the ages, needed PCA services, psychosocial needs, service expectations and geographical location of all potential shared care recipients are compatible.
- PCA units that will be shared by the recipients.
- there is a suitable, safe environment available based on the needs and preferences of all involved recipients.
- an alternative plan is in place for the days when shared care is not appropriate (due to illness, for example).
- all PCA workers are fully trained to meet the needs of each recipient sharing care.

For those recipients who choose qualified professional supervision of the PCA, the supervision must:

- occur on-site within the first 14 days of shared care followed by monthly visits and
- include the required supervision criteria along with the following:
  - development and review of the care plan that corresponds with the county PHN assessment, service plan or service update;
  - observing the PCA performing direct care services;
  - evaluation of service outcomes with the recipient/responsible party;
  - evaluation of the site and whether outcomes are being met;
  - modification of the care plan and re-train PCA workers as needed.

Document all details of supervision, including:

- date and time of supervisory visits;
- number of hours spent on supervision;
• changes in condition;
• action taken on changes;
• scheduling or other recommendations; and
• recipient comments.

Documentation Required:

• **MA Health Status Assessment** (DHS 3244);
• **Home Care Service Plan** or **Home Care Service Update** (DHS 3244B);
• written documentation of the orientation and training by supervising RN to PCA.
• if applicable, authorization or revocation signed and dated by the recipient/responsible party for others to receive shared services in the recipient’s residence;
• daily documentation of shared PCA services by the PCA including name and PMI # of each recipient, shared care site, start and end times the shared PCA services were provided, and PCA notes and reports to qualified professional/supervising RN regarding changes in condition, problems related to shared care, scheduling issues, care issues, etc;
• as applicable, the written notice from the recipient/responsible party needs to be included indicating the shared care option has been revoked.

**Billing For Shared Care**

When shared care is approved, the service agreement will state “shared care option selected,” with the appropriate one-to-one code. Refer to the MA Home Care Rate/Code Reference Sheet to determine which code to bill for shared care 1:2 (one to two), or shared care 1:3 (one to three) services:

Shared care payment rates apply if a PCA is caring for more than one recipient in one setting at the same time. When a PCA is providing services to three individuals in separate apartments in the same building, shared care rates do not apply.

**Pooled PCA Hours**

Pooling of PCA service units is a separate service delivery option that should not be confused with the shared care option. Recipients may choose to add their authorized units together to more fully meet their needs. Pooled hours are billed using procedure code X5645 for each recipient.

**PCA Choice Option**

An option for the PCA Program allowing the recipient more flexibility and responsibility to provide for their service needs. The recipient or responsible party finds their own staff, and chooses an enrolled PCA Choice Provider.
An overview of PCA Choice

The recipient or the recipient’s responsible party, a qualified professional, if requested, and a PCA Choice provider form a team to help meet the recipient’s needs.

- The recipient (or responsible party) recruits and hires a PCA, and provides training and supervision for some types of care.
- The qualified professional or the recipient’s physician, when no qualified professional is chosen, assists in developing the care plan and provides supervision if needed.
- The PCA Choice Provider provides fiscal support services including: MA billing; withholding federal and state taxes; and paying the PCA and qualified professional.

This option is offered to allow the recipient more choice and control over their services as well as decreased administrative overhead expense, which will allow the PCA to be paid a higher wage.

Recipient Eligibility Criteria

- able to direct their own care, or have a responsible party;
- recipient or responsible party must be knowledgeable about the recipient’s health care needs and be able to communicate them effectively;
- receive a face-to-face assessment by the county PHN.

PCA Choice Option Recipient/Responsible Party Responsibilities

- chooses PCA Choice Option during the assessment process.
- enters into a written agreement with a PCA Choice provider.
- develops and revises a care plan with the assistance of the qualified professional or physician when no qualified professional (QP) is chosen.
- recruits, hires, trains, supervises, and if necessary, terminates employment of their PCAs.
- recruits and hires a qualified professional when chosen.
- verifies qualified professional’s credentials, Registered Nurse (RN) or a Mental Health Professional.
- works with qualified professional or physician to assure recipient’s health and safety needs are met.
- verifies hours worked by PCA and qualified professional; submits time sheets to PCA Choice Provider.
- terminates the PCA(s) and/or QP (if necessary along with the PCA Choice provider).
- notifies county PHN of any change in condition or level of services needed.

PCA Choice Option Public Health Nurse Responsibility: At the time of assessment, the recipient chooses PCA Choice Option using a PCA Choice Provider. PCA Choice always requires a face-to-face assessment. The recipient may choose PCA Choice at any time during the service agreement period. If the recipient requests PCA Choice during a current service agreement period where the last assessment was a “service update,” a new face-to-face assessment must be conducted. All
subsequent assessments must also be face-to-face, as long as the recipient receives services through the PCA Choice option.

**Qualified Professional Responsibilities:** Refer to the Qualified Professional Section.

**PCA Responsibilities:** The PCA must meet all the qualifications for a PCA and enter into a written agreement with the recipient and the PCA Choice Provider.

**Written Agreements:** Refer to the PCA Choice Provider Section.

**Denial of PCA Choice Option:** DHS may deny, revoke, or suspend the authorization to use PCA Choice if:

- the county PHN or the qualified professional determines that use of this option jeopardizes the recipient’s health and safety;
- the parties have failed to comply with the written agreement; or
- the use of this option results in abusive or fraudulent billing for PCA services.

DHS decisions may be appealed by the recipient/responsible party. A provider may not appeal a denied PCA Choice request. The denial, revocation, or suspension to use PCA Choice will not affect the recipient’s authorized level of services.

**PCA Choice Option and HCBS Waivers:** For recipients receiving waivered services or Alternative Care, the recipient may choose the PCA Choice option and continue to receive waivered services. If the recipient requests this option, DHS recommends that the case manager arrange for the county PHN to conduct the assessment for PCA services.

**Over-Use of the Personal Care Assistant Services**

Any personal care provider found to be providing PCA services that are not medically necessary is prohibited from participating in MHCP. The Community Supports for Minnesotans with Disabilities Division (CSMD) or Surveillance and Integrity Review Section (SIRS) will determine whether excessive services have been provided according to Minnesota Rules 9505.2160 to 9505.2245. The termination of the provider will be consistent with the provider agreement between the provider and DHS.

**Private Duty Nursing (PDN) Services**

**Definition**

Professional nursing care based on an assessment of the recipient’s medical/health care needs. This service includes ongoing professional nursing observation, monitoring, intervention, and evaluation providing the continuity, intensity, and length of time required maintaining or restoring optimal health. Professional nursing is defined in the MN Nurse Practice Act.
Private Duty Nursing Services have been designated as either “Regular” or “Complex”.

**Complex Private Duty Nursing Care** is care provided to recipients who are either ventilator-dependent or who require an “intensive level of care”.

- **Ventilator Dependent**
  A recipient is considered ventilator dependent when mechanical ventilation for life support is needed for at least six hours per day and the person is expected to be or has been dependent for at least 30 consecutive days.

- **Intensive Level of Care**
  A recipient has medical needs that meet intensive level of care when the doctor’s orders require complex nursing assessments and interventions that are in response to life-threatening episodes of instability. The interventions would be needed immediately based on either anticipated or unanticipated changes in the recipient’s health status.

**Regular Private Duty Nursing Care** is nursing provided to a recipient who is not ventilator dependent and does not require an intensive level of care.

- Regular PDN assessments and interventions are needed for a recipient who is considered stable but has episodes of instability that are not immediately life threatening. Nursing observation, monitoring and assessment is needed to determine appropriate interventions that maintain or improve the recipient’s health status.

**Other Information**

- PDN services are for recipients who need more individual and continuous skilled nursing care than can be provided in a skilled nurse visit and the care is outside the scope of services that can be provided by a home health aide or PCA.
- PDN services are provided under a plan of care or service plan approved by the physician that specifies the level of care that the nurse is qualified to provide.
- PDN services are ordered by the recipient’s physician with updates as required
- Recipients authorized to receive PDN services in their home may use approved hours outside of their home during hours when normal life activities take them outside of their home.
- Total hours of service and payment for services outside the home cannot exceed that which is otherwise allowed in an in-home setting.
- PDN services must be provided by an RN or LPN who is not the recipient’s legal guardian, or related to the recipient as the spouse, parent, or foster care provider of a recipient who is under age 18 unless a hardship waiver is approved.
Eligible Recipients

- Medical Assistance recipients
- Minnesota Care recipients who are under age 21 or pregnant women
- Waiver program recipients including CAC, CADI, TBI, EW, and Alternative Care

GAMC recipients and non-pregnant adult MinnesotaCare recipients are not eligible for PDN services.

Eligible Providers of PDN Services

- Enrolled home health agency
- Enrolled PDN Class A licensed agency
- Enrolled independent RN
- Enrolled independent LPN with a Class A license from MDH

Authorization Requirements

Ongoing Requirements for PDN authorization and documentation:

- All PDN services require prior authorization
- PDN services require a physician order prior to initiating service
- Review/approval of the service plan by the recipient’s physician every 60 days
- Signed orders must be on file in the recipient’s chart at the provider agency’s office.
- The orders or plan of care must:
  - Specify the disciplines providing care;
  - Specify the frequency and duration of all services;
  - Demonstrate the need for the services and be supported by all pertinent diagnoses;
  - Include recipient’s functional level, medications, treatments, and clinical summary;
  - Be individualized based on recipient needs;
  - Have realistic goals;
  - Subsequent plans of care must show recipient response to services and progress since the previous plan was developed; and
  - Changes to the plan of care are expected if the recipient is not achieving expected care outcomes.

Authorization information/process in section titled Information for All MHCP Home Care Providers

Shared Private Duty Nurse

This option allows two recipients to share Private Duty Nurse (PDN) services in the same setting at the same time from the same private duty nurse. All regulations pertaining to private duty nursing services also apply to the shared care option.
A setting includes:

- The home or licensed foster care home of one of the recipients;
- Outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home;
- A child care program licensed under MS 245A, or operated by a local school district or private school; or
- An adult day care service licensed under MS 245A.

**PDN’s Providing Shared Care:** Services cannot be provided to two individuals in separate apartments in the same building, to other non-private duty nursing recipients in the setting, or replace or supplement required staff at licensed facilities.

**Prepaid Medical Assistance Program (PMAP):** Shared care provided through PMAP must be arranged through the recipient’s health plan. The PDN agency must contact the health plan for instructions on accessing shared care.

**Authorization Requirements**

A recipient, or a recipient’s legal representative, may select the shared care option at any time during the authorization period by contacting the PDN agency. Together with the recipient’s physician and the PDN agency staff, the recipient (or the legal representative) will determine:

- Whether shared care is an appropriate option based upon the needs and preferences of the recipient; and
- The number of shared care units that will be part of the overall authorization of private duty nursing services. A shared care arrangement does not reduce the total number of service units authorized for the recipient. The use of authorized service units should be divided between the shared care option and 1:1 services.

The recipient (or the recipient's legal representative) and the PDN agency will approve:

- The other recipient who is sharing the PDN services. This decision must be based on the ages of the recipients, their compatibility and the ability to coordinate their care needs; and
- The arrangement and the setting for the shared services.

**PDN Agency Responsibilities:** Shared care requires prior authorization. To request authorization for shared services, the PDN agency must:

- Complete the Medical Assistance (MA) Private Duty Nursing Home Care Assessment and include the number of shared hours and the number of 1:1 hours on page 4.
- Give a copy of the completed form to the recipient and maintain a copy in the agency files;
- Fax the completed form to DHS; and
- Submit the Service Agreement via ITS software or mail a paper copy to DHS.
**Instructions for completing the Service Agreement (DHS-3070):** On a separate line item, enter the procedure code, rate, and total number of units for 1:1 PDN services, and on a separate line item, enter the procedure code, rate, and total number of units for shared (1:2) PDN services.

Both 1:1 and 1:2 PDN services use the same procedure codes. To authorize 1:2 services a modifier and shared care indicator must be used. For the shared PDN line item, enter:

- “52” in the Modifier 1 (MOD1) field;
- “Y” in the Shared Care (SHR) indicator; and
- “5” in the Frequency (FREQ) field on Screen 2 in the ITS.

**Waiver or Alternative Care Program Recipients:** The county case manager follows the same criteria and process to determine whether the shared care option is an appropriate and safe alternative for a recipient on a waiver or AC program. If the recipient chooses the shared care option, document the number of shared PDN service units on the recipient’s waiver or AC service plan and calculate the cost of shared care into the overall cost of service plan. Use MA home care procedure codes for PDN services to the fullest extent possible (for all medically necessary nursing services) before using extended PDN codes on waiver service agreements. (This does not apply to AC recipients.)

**Complex Reimbursement Rates:** A complex care reimbursement rate is available only when the recipient is receiving 1:1 PDN services. A complex care rate is not available when the recipient is receiving shared (1:2) PDN services. This means that a recipient can share PDN services if they are authorized complex care, but the agency will only receive the complex rate during the hours the recipient is receiving the 1:1 services.

**Changing or Discontinuing Shared PDN**

The recipient or legal representative must notify the provider in writing if the recipient chooses to make a change in their shared care. Changes include:

- The number of authorized units the recipient wishes to share;
- Discontinuing participation in shared care; and
- Changing providers.

The written revocation or change must be maintained in the recipient’s file.

When services are changed or discontinued, the current provider must mail or fax the completed Home Care Fax Form to DHS indicating the change in the number of authorized shared care or the last date of shared PDN services, and the total number of units to be designated for shared care.

DHS will transfer shared care authorizations on the same service agreement. DHS reserves the right to request a copy of the private duty nursing assessment tool from the new provider agency at the time services are transferred or requested.
Documentation Requirements

Initial Documentation: Each recipient or legal representative must sign a consent form. A copy of the form is to be included in the recipient’s chart. The form includes:

- Permission for the agency to schedule shared care up to the maximum hours chosen by the recipient;
- Use of services outside the recipient’s home; and
- Permission to place the recipient’s name in the chart of the other recipient.

Ongoing Documentation:

- How the needs of the recipients are being appropriately and safely met;
- The setting in which the shared services will be provided;
- Ongoing monitoring and evaluation of the shared services by the PDN;
- Emergency back up plans to respond to the recipient’s illness or absence or the PDN’s illness or absence;
- Additional training, if needed, for the PDN to provide care to two recipients;
- The names of each recipient receiving shared private duty nursing services;
- The starting and ending times that the recipients received shared private duty nursing care; and
- Routine nursing documentation such as changes in the recipient’s condition and problems that may arise due to sharing services.

Billing Requirements

The process for billing shared PDN is the same as billing for 1:1 care with the following modification:

- Use a separate line item to bill the shared (1:2) PDN units; and
- Enter a “52” on the Modifier 1 field.

Rehabilitation Therapies

- Occupational Therapy (OT) Procedure Code X5282
- Certified Occupational Therapy Assistant Code X5282 TF modifier
- Physical Therapy (PT) Procedure Code X5280
- Physical Therapy Assistant (PTA) Procedure Code X5280 TF modifier
- Respiratory Therapy (RT) Procedure Code X5283, and
- Speech Therapy (ST) Procedure Code X5281
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Coverage

Rehabilitation Therapy procedure codes are daily, per visit codes, with the exception of Respiratory Therapy, which may be provided more than once per day.

Eligible Recipients

MinnesotaCare recipients, and Medical Assistance recipients. To receive payment for rehabilitation therapy, the services must be:

- Provided in the recipient’s home;
- Ordered by a physician;
- Appropriate to meet the recipient’s needs;
- Specified in the plan of care;
- Medically necessary;
- Provided to the recipient whose functional status is expected to progress toward or achieve the goals specified in the recipient’s plan of care within a 60-day period. (If the service is a Medicare covered service, and is provided to a recipient who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.)
- Rehabilitation services cannot be covered when the recipient can reasonably access these services outside his/her residence, excluding the assessment, counseling, and education. A recipient who leaves the home at will, or a parent who could easily transport the child, must obtain these services at the rehabilitation center, and will not be eligible for home care therapies.

GAMC recipients are not eligible for Home Care Rehabilitation.

Authorization Requirements

Prior authorization is not needed for rehabilitation therapies.

Eligible Providers

Therapists must be employed by a Medicare-Certified Home Health Agency enrolled with MHCP. Services may be provided by:

- Licensed Physical Therapist;
- Registered Occupational Therapist;
- Certified Occupational Therapy Assistant;* or
- Physical Therapy Assistant.*

* When services are provided by an assistant and the licensed or registered therapist is not on the premises (the recipient’s home), the services are billed with a TF modifier, and the payment will be at 65% of the therapist’s rate. The licensed PT or registered OT must provide in-person direction to the assistant at least every sixth visit. When a home visit is made jointly by the therapist and
assistant, the provider may bill only for the therapist’s visit. Providers may not bill for both the PT and PTA (or the OT and COTA) when a joint home visit is made.

**Therapy Classifications**

Therapies must be classified as to whether they are restorative or specialized maintenance.

**Restorative therapy** is a health service that is:

- Specified in the recipient’s plan of care;
- Ordered by a physician; and
- Designed to restore the recipient’s functional status to a level consistent with the recipient’s physical or mental limitations.

**Specialized Maintenance Therapy** is a health service that is:

- Specified in the recipient’s plan of care;
- Ordered by a physician;
- Necessary for maintaining a recipient’s functional status at a level consistent with the recipient’s physical or mental limitations; and
- May include treatments in addition to rehabilitative nursing services.

When billing for specialized maintenance therapies, use the XC modifier on your claim form, to differentiate these services. Home care therapy services are not subject to the one-time rehabilitative service thresholds.

**Skilled Nurse Visits**

**Definition**

**Skilled nurse visits:** Intermittent home visits to initiate and complete professional nursing tasks based on a recipient’s need for service as assessed to maintain or restore optimal health. Visits are made by a registered nurse (RN) or licensed practical nurse (LPN), employed by a Medicare certified home health agency, under the supervision of an RN.

Two visits per day can be authorized. If the necessary medical services are more complex and require more time than can be performed in a single or twice daily skilled nurse visit, private duty nursing services is an appropriate option.

**Eligible Recipients**

Medical Assistance recipients, Minnesota Care Expanded Benefit Set (children under age 21, and pregnant women) and Minnesota Care Basic, Basic Plus, Basic Plus One or Basic Plus Two coverage.
Recipients eligible for GAMC are not eligible for home care services.

**Eligible Providers**

Medicare certified, Class A Licensed home health agencies, enrolled with DHS.

**Prior Authorization Requirements**

- Skilled nurse services above nine visits per recipient, per calendar year require prior authorization
- All Tele-Home-Care SNVs must be prior authorized.
- Waiver recipients require prior authorization from the county case manager.

Prior authorization cannot begin before the date DHS receives the complete service agreement request with all corresponding documentation. Refer to Information for All MHCP Home Care Providers later in this chapter for authorization process.

**Covered Skilled Nursing Services**

A Skilled Nurse Visit is made according to the recipient’s written plan of care or service plan, ordered by the physician, and is an accepted standard of medical and nursing practice in accordance with the Minnesota Nurse Practice Act. Equipment and supplies that are usual and customary to completing a SNV are not billable (i.e., stethoscope, nail clippers, sphygmomanometer, alcohol wipes, etc.)

- Observation, assessment, and evaluation of a person’s physical or mental health status. These may be covered when the likelihood of a change in condition requires skilled nursing personnel to identify and evaluate the need for possible modification of treatment or initiation of additional medical procedures until the recipient’s treatment regimen is stabilized.
- A procedure that requires substantial and specialized nursing skill such as administration of intravenous therapy, intra-muscular injections, procedures, such as sterile catheter insertion or sterile wound cares.
- Teaching and training that requires the skills of a nurse. Examples could include, teaching self-administration of injectible medications or a complex range of medications; teaching a newly diagnosed diabetic person or caregiver on all aspects of diabetic management; teaching self-catheterization or bowel and/or bladder training.
- Postpartum visits to new mothers and their newborn infants if the mother and her newborn are discharged early from the hospital. Early discharge means less than 48 hours following a vaginal delivery or less than 96 hours following a caesarian section. Post delivery care includes a minimum of one home visits by a licensed RN. The RN must provide parent education, assistance and training in breast and bottle-feeding and conduct any necessary and appropriate clinical tests. The licensed RN must make the home visit within four days following hospital discharge. A separate plan of care is needed for the mother and newborn.
Community health nursing visits provided by a public health agency or home health agency for the sole purpose of maternal, child, and adult health promotion are covered when an authorized skilled nursing service is provided at the same visit.

Non-Covered Skilled Nurse Visits

Home visits made:

- For the sole purpose of supervising a home health aide or PCA. However, supervision may be done during a SNV that qualified for payment.
- For the sole purpose of monitoring medication compliance, with an established medication program for a recipient.
- For the sole purpose of monitoring a recipient’s overall physical status, when the recipient’s physical status has not changed and the person is considered stable.
- To set up or administer oral medications; pre-fill injections, such as insulin syringes for an adult recipient when the need can be met by an available pharmacy; or the recipient is physically and mentally able to self-administer or pre-fill a medication; or if the activity can be delegated to a family member or HHA.
- When the sole purpose of the visit is to train other home health agency workers.
- When the visit is performed in a place other than the recipient’s residence.
- For Medicare evaluation or administrative nursing visits required by Medicare but not qualifying as a SNV. (These visits are an administrative expense for the Medicare certified agency and cannot be billed to MA).
- By a licensed RN who makes a SNV but is employed by a Personal Care Provider Organization or non-Medicare private duty nursing agency.

ICF/MR Skilled Nurse Visits

DHS may authorize skilled nurse visits for fewer than 90 days for a recipient residing in an ICF/MR to prevent admission to a hospital or nursing facility, if the ICF/MR is not required to provide the nursing services. The home health agency must obtain prior authorization.

A skilled nurse may be authorized for venipuncture, if none of the above conditions can be met. Authorization requests must include full documentation in a clinical update on a CMS 485, or CMS 486.

Venipuncture as a Skilled Nurse Visit

If a SNV is needed for the purpose of performing a venipuncture from a peripheral site, the Home Health provider can submit a request for prior authorization if they have determined and documented:

- That there is not an available lab service that can visit the recipient’s home to obtain the venipuncture from the peripheral site;
- That there is not a service reasonably available to the recipient outside of his/her place of residence; and
• The recipient no longer qualifies for Medicare Part A skilled nurse services

**Tele-Home-Care X5284 with GT modifier**

• A tele-home-care visit is a SNV that is made via live, interactive audiovisual technology between the home care nurse and the recipient. It can also be augmented by utilizing store-and-forward technologies, which is a technology that does not occur in real time via synchronous transmission and does not require a face-to-face encounter with the recipient for all, or part of any such tele-home-care visit.

• A communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail or a consultation between two health care practitioners is not considered a tele-home-care visit.

• Coverage of tele-home-care is limited to 2 visits per day and all of the visits must be prior authorized.

**Combination PCA and Other Home Care Services**

PCA combinations, are service authorizations that include one or more of the following MHCP fee-for-services: Skilled Nursing (SNV), Home Health Aide (HHA), and/or Private Duty Nursing (PDN), along with Personal Care Assistant (PCA) services. Home care services must be medically necessary and cost effective. The home care rating determines the maximum dollar amount that can be authorized for all home care services. See PDN and PCA decision trees for further information.

**PCA Hardship Waiver**

The need to apply for the PCA Hardship Waiver to provide PCA services has been repealed. Parents of adult recipients and adult children or siblings of a recipient may now provide PCA services to a family member without applying for a PCA Hardship Waiver, if they meet the criteria to work as a PCA.

Family members who may **not** serve as the PCA:
• spouse,
• parent of a minor child, and
• the responsible party.

**PDN Hardship Waiver**

The PDN Hardship Waivers allows certain relatives to receive reimbursement for providing services to his/her relative who is an MA recipient. The provider agency is responsible for:

• Receiving the request from the recipient/responsible party;
• Obtaining the relative’s signature;
• Completing the request form, ensuring the accuracy of the information; and
• Submitting the form to DHS.

**PDN Authorization criteria:** A relative hardship waiver is now available for certain persons to provide PDN services. In order to qualify for a relative hardship waiver for a PDN Hardship Waiver, at least one of the following criteria must be met:

- The relative resigns from a full-time or part-time job to provide personal care for the recipient;
- The relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;
- The relative takes a leave of absence without pay to provide personal care for the recipient;
- The relative incurs substantial expenses by providing personal care for the recipient; or
- Because of labor conditions, intermittent hours of care needed, or special language needs, the relative is needed in order to provide an adequate number of qualified PCA’s or PDN’s to meet the needs of the recipient.

In addition, all of the following must be met:

- Services must be necessary to prevent the hospitalization of the recipient;
- The recipient is eligible for private duty nursing under an MHCP program;
- In order to provide nursing care to the recipient, the parent, spouse or guardian must meet at least one of the authorization Hardship Waiver criteria listed above.

**Requesting a PDN Hardship Waiver:** The PCPO/Home Health Agency provider must follow these steps:

- Complete the Hardship Waiver Request Form
- Obtain the relative’s signature, and
- Submit the hardship waiver request form along with the supporting documentation to DHS.

**Review of hardship waiver requests:** DHS will review and issue a response within 30 days of receipt of the request. A relative hardship waiver can be approved for no earlier than the date that the request is received by DHS. Written notice of the approval or denial will be mailed to the recipient and provider. If the request is denied, the notice will contain the recipient’s appeal rights and the rationale for the denial. The provider must keep this notice in the recipient’s file. Approvals will be lifetime, unless DHS is notified that qualifying conditions have changed. Verification of the hardship waiver approval may be confirmed by calling (651) 528-1680, 1-877-766-0644 or TTY 1-800-627-3529. Recipients/responsible parties may also phone the same number to have cards re-issued.

**PDN Eligible Persons**
Must be currently licensed in the State of Minnesota as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) and is employed by an MA Medicare-Certified Home Health Agency and is:

- The parent of a recipient;
• The spouse of a recipient; or
• A non-corporate legal guardian of a recipient.

The provision of these services is not legally required of the parent, spouse or legal guardian. Services provided by a parent, spouse or guardian cannot be used in lieu of nursing services covered and available under liable third-party payers including Medicare. Hours of service provided by the parent, spouse or guardian must be included in the recipient’s service plan. Hours authorized for the parent, spouse or guardian may not exceed 50% of the total approved nursing hours or 8 hours per day, whichever is less, up to a maximum of 40 hours per week.

Provision of paid service does not preclude the parent, spouse or guardian from his/her obligations for non-reimbursed family responsibilities of emergency backup caregiver and primary caregiver.

A parent or spouse may not be paid to provide private duty nursing if they fail to pass a criminal background check or if the home health agency, the waiver case manager or the physician, determine that the care provided by the parent, spouse or guardian is unsafe.

**Waivered Service Program Recipients:** Recipients on waivered services programs including: CAC, CADI, EW, MR/RC, TBI and the AC program follow the same process and must meet the same criteria.

### Hospice Elected While Under an Approved Home Care Service Agreement

The Hospice benefit is:

- A comprehensive package of services offering palliative care support to terminally ill individuals and their families.
- Is designed to supplement the care provided by primary care givers such as family (as the patient defines family), friends and neighbors.
- Is NOT intended to replace the supportive services provided by primary caregivers.
- Is NOT intended to duplicate health services or supports that relate to a pre-existing condition.

- Example: A home care service or supply is required for a condition *unrelated* to the terminal condition (e.g. quadriplegia, schizophrenia, cerebral palsy) and does not supplant or duplicate the covered hospice benefit.

- Is NOT intended to cover medical needs that arise during the period of the Hospice Benefit that are unrelated to the terminal illness.

Generally, the determination about whether a service duplicates a Hospice Benefit service will be made as part of the hospice provider’s general responsibility to provide care coordination. The hospice care coordinator assumes the lead responsibility for collaborating with the county case manager, home care agency, physician, or other providers providing the services that are outside of the Hospice benefit.
For further information and details about the hospice benefit, see Chapter 28.

**Individualized Educational Plan (IEP)**

Refer to Chapter 9 for additional information regarding Individualized Education Program (IEP) Services. Covered IEP services include nursing services, personal care assistants (PCA), physical therapy, occupational therapy, speech language pathology, mental health services, special transportation, and assistive technology devices.

The child may also be receiving these services through MA and/or a home and community-based services waiver. When services are provided through the school, they are considered IEP services and billed as such. IEP services are not considered or billed as home care, therapy or waiver services.

Coordination of IEP services and home care services are assessed on a 24-hour non-school day. A parent/guardian may choose to use authorized home care or waiver services in the school rather than have the school bill for the education plan service:

- Services must be listed in the child’s IEP/IFSP/IIIP; and
- Permission must be given by the parent/guardian in the care plan and retained by the provider in their records.

The education plan services do not count against the prior authorization cap for home care services, will not be counted against the waiver cap or affect the amount of services available under the waiver and are not counted against DHS service limitations or thresholds for therapies. The education plan team and the home care provider or waiver case manager, are responsible to coordinate and not duplicate services.

**Information for All MHCP Home Care Providers - Quick Reference**

The Quick Reference section is designed to assist providers in obtaining service authorization in a timely and productive manner.

**Authorization Requirements**

**Prior authorization is required for:**

- All home health aide services;
- All private duty nursing services;
- Skilled nurse visits above nine visits per recipient, per calendar year;
- All tele-home-care visits;
- More than two face-to-face PCA assessment visits conducted by the county PHN, per recipient, per calendar year;
• More than one service update assessment visit per recipient, per calendar year by the county PHN; and
• All PCA services and supervision of PCA services.

Prior authorization requests for SNV, HHA, and PDN are submitted directly to DHS by the provider agency.

Prior authorization requests for PCA services must be submitted to DHS by the county Public Health Nurse or the PHN under contract with the county.

For recipients enrolled in the Alternative Care (AC) program, the Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI) waiver, Community Alternative Care (CAC) waiver or the Traumatic Brain Injury (TBI) waiver, the county case manager authorizes all services.

For recipients enrolled in the MR/RC waiver, the PHN and Home Care agencies must work through the case manager to have services included in a waiver services authorization.

A start date will not be granted prior to the date of submission for prior authorization. DHS must receive all the required information before authorization can be approved.

Before Requesting An Authorization

• Call the Eligibility Verification System (EVS) to verify recipient eligibility and
• Obtain all health insurance coverage information

Insurance and Medicare benefits must be used before requesting Medical Assistance reimbursement.

Upon Receiving Service Authorization

• Review the Service Authorization immediately for content and comments.
• Line item dates may differ from header dates.

Unclear about comments or have questions about the authorization, immediately contact the Provider Help Desk at (651) 282-5545 or 1-800-366-5411.

Exceptions to Prior Authorization

Authorization may be requested after a home care service is provided to a recipient only under the following conditions:

1. Emergency Service Provision: The home care services were required to treat an emergency medical condition, that if not immediately treated, could cause a recipient serious physical or mental disability, continuation of severe pain, or death. You must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge history.
• **For SNV, HHA, and PDN:** Request retroactive authorization from DHS, no later than five working days after giving the initial service, by submitting the Home Care Fax Form to (651) 282-6044. If faxing is not an option, you may call The Home Care Intake Line at: (651) 296-7722 or 1-800-657-3606;

• **For PCA:** Request retroactive authorization, no later than five working days after giving the initial service, by contacting the county Public Health Nurse.

2. **Retroactive Eligibility:** Home care services were provided on or after the date on which the recipient’s eligibility began, but before the date the recipient was notified that their case opened. Authorization will be considered when:

• **For SNV, HHA and PDN**
  - The request is submitted by the provider to DHS within 20 working days of the date the recipient was notified that the case was opened; and
  - The required documentation for a long-term authorization as listed under each home care service in this chapter is provided; along with a
  - Copy of the notice of eligibility

• **For PCA**
  - The request is submitted to the county PHN within 20 working days of the date the recipient was notified that the case was opened.

3. **Third Party Payer:** A third party payer for home care services denied or adjusted a payment:

• **For SNV, HHA and PDN**
  - Authorization requests must be submitted by the provider to DHS, within 20 working days of the notice of denial or adjustment;
  - Submit required documentation for a long-term authorization as listed under each home care service in this chapter; and
  - Include a copy of the third party payer’s notice with the request.

• **For PCA**
  - The request is submitted to the county PHN within 20 working days of the date the recipient was notified that the case was opened.

4. **Administrative Error:** The local county agency or DHS made an error:

• **For SNV, HHA and PDN**
  - Submit required documentation for a long-term authorization as listed under each service in this chapter; and
The provider must include a statement that specifies which agency made the error, what the error was, and when it occurred. If a county agency made an error, supporting documentation from that agency must be included.

- **For PCA**
  - Submit the request to the county PHN

5. **Medical Need:** The professional nurse determines an immediate medical need for up to 40 skilled nursing or home health aide visits per calendar year:

  Exceptions to prior authorization requests are evaluated according to the same criteria applied to prior authorization requests.

**Requesting an Authorization**

Service agreements may be either temporary (45 days), or long-term (up to 365 days or 366 days in a leap year).

**SNV/HHA/PDN - Temporary Initial Service Authorization**

Within 5 working days of the first home visit, fax your request to DHS:

- On the [Home Care Fax Form](#)
- Call the Home Care Intake Line at (651) 282-6044 **only** if faxing is not an option.

Temporary Service Authorization requests will **not** be accepted more than 5 working days after the start of care.

- For requests submitted more than 5 working days after the start of care, follow instructions in “Long Term Service Authorization”.

**SNV/HHA - Long Term Authorization**

Within 20 working days of the first home visit, submit the following information to DHS:

- The Plan of Treatment (CMS 485 or comparable form)
- Current clinical summary (CMS 485, CMS 486, or nurses notes);
- [Payer Determination Form](#), page 4, DHS 3273;
- Service Agreement (submit via ITS software or mail paper form).

**PDN - Long Term Authorization**

Within 5 working days of the first home visit, submit the following information to DHS:

- The completed [MA Private Duty Nursing (PDN) Assessment](#);
- A concise current clinical update (CMS 485, CMS 486 or comparable form)
- Page 4 of the Payer Determination Form

**PCA - Temporary Initial Service Authorization**

Before providing service or, in the case of an emergency start, within 5 working days of the first home visit, contact the county PHN requesting an assessment.

- Provide a care plan indicating an immediate need for service.

**PCA - Long Term Authorization**

Within 30 days after receiving the referral for assessment, the county PHN

- Submits the recommendation for PCA units and service agreement span to DHS using ITS or the PCA Request Form

**Medical Status or Caregiver Status Changes**

Changes in medical status are either temporary for 45 days or less or long term for up to 365 days (366 days in leap years). These include, but are not limited to change in health or level of care, service addition, change in physician orders, recent facility placement, or change in primary caregiver’s availability. Documentation **must** support the requested change in service. Temporary authorizations can only be approved for 45 days or less. DHS cannot approve back to back temporary requests

**SNV/HHA/PDN - Temporary Service Increase**

The provider must submit the request:

- Use the [Home Care Fax Form](#), or
- Call the Home Care Intake Line at (651) 282-6044 **only** if faxing is not an option

**SNV/HHA - Long Term Change in Authorization**

The provider must submit:

- The Home Care Fax Form
- The updated Plan of Treatment (CMS 485 or comparable for) or current physician orders
- A concise current clinical update (CMS 485 or CMS 486) and
- An updated page 4 of the Payer Determination Form

**PDN - Long Term Change in Authorization**

The provider must submit:
• The Home Care Fax Form
• The completed MA Private Duty Nursing (PDN) Assessment;
• A concise current clinical update (CMS 485 or CMS 486) and
• An updated page 4 of the Payer Determination Form

PCA - Temporary Service Increase (Code X5361)

The temporary service increase for PCA is a billable service by the county PHN

• The PHN conducts the temporary service increase by telephone with the provider’s qualified professional, the recipient, responsible party, or other health care professional.
• PHN recommends increased units of PCA and/or QP units using the PCA Request Form
• The temporary service increase remains in effect for 45 days. If a recipient requests services to continue after 45 days, a new face to face assessment is done for a permanent increase in service

PCA - Long Term Change in Authorization

• Contact the county PHN; a face to face assessment is required.
• The current Service Agreement will be ended.
• A new Service Agreement with a span up to one year will be entered

Medicare Home Health Prospective Payment System (PPS)

This affects all dually eligible recipients; those covered under a Medicare home health plan of care and on Medical Assistance;

• Medicare requires consolidated billing of all home health services while a Medicare recipient is under a home health plan of care. All supplies and services listed under PPS are the responsibility of the Home Health Agency that has the recipient under an episode, and are not billable by other providers;
• During each 60 day episode, the home health agency is responsible to bill Medicare all home health services, including skilled nursing care, home health aide services, physical therapy, speech-language pathology, occupational therapy, medical social services, routine and non-routine medical supplies, medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a home health agency that is affiliated or under common control with that hospital, and care for the homebound patients involving equipment too cumbersome to take to the home.

Home health services are paid on a cost basis, therefore, the PPS rate assigned to the beneficiary includes all the above services. Home health agencies that do not have these services available need to hire staff and keep supplies on hand or contract services with other agencies.
Multiple Providers

Service authorization can be issued to more than one provider agency at the same time. Each provider agency must receive his/her own service authorization. Each provider agency can bill for the same type of service on the same day. Each agency must have an approved line item on the service agreement:

- Daily codes (i.e. PDN, and Rehabilitation Therapies) must only be billed in consecutive date spans, to avoid duplicative billing;
- 15-minute codes may be billed by more than one provider, per date of service.

Each provider must submit the Home Care Fax form, indicating:

- All provider names and numbers;
- Dates of service for each provider; and
- The number of units to be used by each provider;

If the total number of units requested by each provider exceeds what was originally authorized, follow the instructions for Change in Medical Status or Caregiver Status, to obtain an increase in services.

Recipients using the PCA Choice Option may not use more than one PCA Choice Provider or use a PCPO along with a PCA Choice Provider.

Provider Agency Change

Discontinuing Provider

Fax the Home Care Fax Form to (651) 282-6044 with the following information:

- Recipient ID#,
- Service agreement number being adjusted,
- Provider ID# of agency discontinuing services, last date of service with agency discontinuing services,
- Last date of service with agency discontinuing services and
- Total units to be transferred to the new agency.

Provider Initiating Services

Fax the Home Care Fax Form to (651) 282-6044 with the following information:

- Recipient ID#,
- Service agreement number being adjusted (if available),
- Provider ID# of agency beginning services, and
Date services will begin with the new agency.

In lieu of the discontinuing provider’s statement, the recipient, responsible party or legal guardian must provide a signed written statement indicating the last day of service, and the name of the new provider agency. A copy is to be given to the provider agency terminating and initiating services.

**Provider Number Terminated or Change in Ownership**

Notify DHS Provider Enrollment, as soon as possible about upcoming change of ownership. DHS will determine the termination date for the old provider number, and assign a new provider number if needed for the new provider agency. DHS will make sure there are no claims paid after the termination date.

- If claims have been paid past the termination date under the old provider number, DHS will take back those claims on the remittance advice.
- Once there are no paid claims after the termination date, DHS will take the following steps to coordinate services. The program the recipient is eligible for will determine DHS action.

**Home Care Service Agreements:** DHS will end the service agreement line item for the old provider ID#, enter the new provider ID# on the service agreement and transfer remaining units to the new line item. DHS will issue a new service agreement for the new provider ID# number and once the line item is approved, the provider may re-bill services with the new provider ID#.

**Waivered Services and AC Program Service Agreements:** The provider must notify the county case manager of the termination date for both the old and indicate the start date for the new provider ID#. The county case manager will end the line items for the old provider ID# and enter the new line items under the new provider ID#. Any remaining units will be transferred to the new provider number. A new service agreement is mailed to the new provider number, after the new line items are approved.

**Technical Changes or Corrections**

Technical changes/corrections include but are not limited to incorrect provider name and/or ID#, recipient name and/or date of birth, HCPCS code, units or rate, or ICD-9 codes. Submit the correct information on the [Home Care Fax Form](#) and use the comments section to explain why the correction is being requested.

**Change/Correction to SNV/HHA/PDN**

The provider must submit the completed Home Care Fax Form to DHS

- Stating the correct information, and
- Documenting in the comments section why the correction is being requested.
Change/Correction to PCA

The provider will contact the county PHN with the:

- requested change/correction,
- effective date of request, and
- the reason for the change/correction.

The county PHN will fax or mail the change/correction request to DHS.

DHS will make the requested change, and mail a new service agreement to the recipient and the provider.

Adoption Name Change

Change to SNV/HHA/PDN

The provider must submit the completed Home Care Fax Form to DHS indicating the:

- Previous name
- Previous PMI #
- New Name
- New PMI#
- Birth date, and
- Date of change to the new/PMI#

DHS will close the old Service Agreement and create the new Service Agreement with the new information. The Home Care Fax Form is then destroyed.

Change to PCA

The provider contacts the PHN with the:

- Previous name,
- Previous ID#, 
- New name, New ID#, 
- Birth date, 
- Effective date of new name, and 
- Indicates the change is due to an adoption.

The county PHN will fax or mail the change/correction request to DHS.

DHS will close the old Service Agreement and create the new Service Agreement with the new information. The Form is then destroyed.
Transition of Service from Non-Waivered to Waivered Services Programs

- The county case manager must:
  - Enter the waiver Service Agreement in a suspended state; and
  - Route to 580PWImw64.

- DHS will:
  - Identify overlapping home care service agreements; and
  - Will end it one day prior to the waiver start date;
  - Claims paid past the requested start date for waivered services will be taken back on the remittance advice;
  - Route the waivered service agreement back to the county case manager for approval.

After the new service agreement is approved, the provider can re-bill.

Transitioning of Home Care Service from Waivered Services to Non-Waivered Programs

The county case manager and the county financial worker must coordinate to ensure that the MA recipient eligibility is updated.

If a Service Authorization denial indicates a problem in eligibility, the correction must be submitted but the provider to DHS within 20 working days of the date the recipient was notified of the MA eligibility change.

Waivered PCA Service to Non-waivered PCA Home Care

County PHN will submit the completed PCA assessment to DHS 30-45 days prior to the transition date.

DHS will:

- Review the request,
- Make a determination on the medical necessity, and
- Issue a denial waiver status and all other edits.

PCA Provider will within 10 working days of receipt of Service Agreement Denial:

- Correct all of the items listed on the Service Agreement Denial excluding the waiver status.
- Within 20 days of recipient notification of eligibility status change:
  - Complete and submit the Home Care Fax Form correcting the waiver status denial.
If there is no change in condition or request, the Service Agreement will be approved.

**Waivered PCA Service to Non-waivered SNV/HHA Home Care**

Within 30-45 days prior to the transition date, the provider must submit to DHS:

- A concise current clinical update on the CMS-485, or CMS-486;
- The [Payer Determination Form](#) (PDF) page 4;
- A cover letter clearly identifying this is a request for a transition determination;

DHS reviews the request and makes a determination on medical necessity, frequency and duration. It is important to include a copy of the service authorization denial, the corrections and a brief cover letter indicating that these are corrections.

**DHS** will review the request:

- Make a determination on the medical necessity; and
- Issue a denial waiver status and all other edits.

The **Provider** will within 10 working days of receipt of Service Agreement Denial:

- Correct all of the items listed on the Service Agreement Denial excluding the waiver status.
- Within 20 days of recipient notification of eligibility status change:
  - Complete and submit the Home Care Fax Form correcting the waiver status denial.

If there is no change in condition or request, the Service Agreement will be approved.

**Waivered PCA Service to Non-waivered PDN Home Care**

Within 30-45 days prior to the transition date, the provider must submit to DHS:

- A concise current clinical update on the CMS-485, or CMS-486;
- The [Payer Determination Form](#) (PDF) page 4;
- The completed MA Private Duty Nursing Care Plan (for PDN services); and
- A cover letter clearly identifying this is a request for a transition determination;

DHS reviews the request and makes a determination on medical necessity, frequency and duration. It is important to include a copy of the service authorization denial, the corrections and a brief cover letter indicating that these are corrections.

**DHS** will review the request:

- Make a determination on the medical necessity, and
- Issue a denial waiver status and all other edits.
The Provider will within 10 working days of receipt of Service Agreement Denial:

- Correct all of the items listed on the Service Agreement Denial excluding the waiver status.
- Within 20 days of recipient notification of eligibility status change:
  - Complete and submit the Home Care Fax Form correcting the waiver status denial.
    If there is no change in condition or request, the Service Agreement will be approved.

Recovery of Excessive Payments

DHS will seek monetary recovery from home care providers who exceed coverage and payment limits. This does not apply to services provided to a recipient at the previously authorized level pending an appeal.

Non-covered Home Care Services

- Services provided to GAMC recipients;
- PDN or PCA services provided to Minnesota Care non-pregnant recipients;
- Services provided to a person who is not an eligible MHCP recipient;
- Services provided by a provider that is not enrolled or does not have a valid provider agreement with DHS;
- Services that are not ordered by the recipient’s physician;
- Services that are not specified in the recipient’s service plan or care plan;
- Services provided without authorization from DHS when required;
- Services that have already been paid by Medicare, health plans, health insurance policies, or any other liable third party at more than the MHCP allowable amount;
- Services to other members of the recipient’s household;
- Home care services included in the daily rate of a community-based residential facility where the recipient is residing;
- Services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules; and
- Services provided when the number of foster care residents is greater than four (unless the county responsible for the recipient’s foster placement made prior to April 1, 1992, requests that home care service be provided, and county or state case management is provided).

Billing MHCP-Order of Payers

MHCP pays for services after the recipient has used all other sources of payment. MHCP is the payer of last resort. The order of payers for an MHCP recipient is:

1. Third party payers or primary payers to Medicare (e.g., large and small group health plans, private health plans, group health plans covering the beneficiary with End Stage Renal
Disease for the first 18 months, workers compensation law or plan, no-fault or liability insurance policy or plan;
(2) Medicare;
(3) MHCP Medical Assistance or MinnesotaCare; and
(4) MHCP waivered services programs or Alternative Care (AC) program.

Providers must bill all third party payers, including Medicare, and receive payment to the fullest extent possible before billing DHS. MHCP becomes the payer only after all other pay options (other than an MA waiver program) have been exhausted. Services that could have been paid by Medicare, an HMO, or insurance plan, if applicable rules were followed, are not covered by MHCP.

Providers must be familiar with Medicare coverage for home care recipient. Billing Medicare when Medicare is liable for the service or, if the provider is not Medicare certified, referring the recipient to a Medicare certified provider of the recipient’s choice, and notifying recipients when Medicare is no longer the liable payer for home care services.

**DHS Internet Forms Available**

http://www.dhs.state.mn.us/provider/forms/

- **MA Health Status Assessment** (DHS-3244);
- **Home Care Service Plan**
- **Service Agreement** (DHS-3070);
- **Payer Determination Form** (DHS-3273);
- **Home Care Service Update** (DHS-3244B);
- **Personal Care Decision Tree** (MS-0520B);
- **Private Duty Nurse Decision Tree** (MS-0655);
- **MA Private Duty Nursing (PDN) Assessment**;
- **Home Care Fax Form**;
- **CMS 1500 Tri-fold**;
- **Hardship Waiver Form – PCN and PDN**;
- **Shared PDN Consent Form**.

**Forms Available from CMS or Office Supplier**

- Home Health Certification and Plan of Treatment (CMS-485 and 486);
- CMS-1500 claim form; and
- UB-92 claim forms (for home health agencies).
**Telephone Numbers**

Provider Help Desk (651) 282-5545 or 1-800-366-5411

Home Care Fax Line: (651) 282-6044

EVS: (651) 282-5545, or 1-800-657-3613 or Internet: [www.mnevs.state.mn.us](http://www.mnevs.state.mn.us)

**Home Care Service Procedure Codes For Billing**

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<thead>
<tr>
<th>MA/Minnesota Care Home Care Service</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Shared Indicator</th>
<th>Authorization Required</th>
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For shared PCA services (1:2 and 1:3) the service agreement will authorize procedure code X5645, and state shared care has been selected. Use X5357 and X5358 for billing purposes only.
* Authorization required after 2 face-to-face assessments per recipient, per calendar year.

** Authorization is required for more than one service update, per recipient, per calendar year.

*** Authorization is required after 5 skilled nurse visits per recipient, per calendar year, except for waived service program recipients, that always require authorization from the county case manager.

**Definitions**

**Activities of Daily Living:** Eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

**Assessment:** A review and evaluation of a recipient’s need for home care services.

**Care Plan – PCA:** A written description of personal care services developed by the qualified professional or the recipient/responsible party with the assistance of the recipient’s physician.

**Care Plan – PDN:** A written description of professional nursing services needed by the recipient as assessed to maintain and/or restore optimal health.

**Fiscal Agent Option:** See PCA Choice Option.

**Flexible Service Use Option:** When prior authorized, PCA units may be used in varying amounts over the duration of the Service Agreement. The use of service units may differ from day to day or week to week, but must only be used for covered care needs.

**Health-Related Functions:** Functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

**Home Care Agency (or Class A Agency):** An agency holding a Class “A” license from the Minnesota Department of Health (MDH), authorized to provide Private Duty Nursing only. To enroll as a home health agency, the provider must be a Medicare certified home health agency.

**Home Care Rating:** Cost limits that establish a rating system based on the common assessed needs of individuals.

**Home Care Services:** Home health agency, private duty nursing, and personal care services delivered to a recipient whose illness, injury, physical, or mental condition creates a medical need for the service.

**Home Health Agency (HHA):** A public or private agency or organization, or part of an agency or organization, that is Medicare certified and holds a Class A home care license from the Minnesota Department of Health (MDH).

**Home Health Aide (HHA):** An employee of a home health agency who is certified and is supervised by a nurse.
**Home Health Aide Services:** Medically oriented tasks required to maintain the recipient’s health or to facilitate treatment of an illness or injury. Services must be ordered by a physician and have professional supervision provided by a Medicare Certified agency.

**Home Health Agency Services:** Services provided by a Medicare Certified agency including skilled nursing visits, home health aide, physical, occupational, speech, and respiratory therapy.

**Instrumental Activities of Daily Living (IADL):** Meal planning and preparation, managing finances, shopping for food, communication by telephone and other media, getting around and participating in the community.

**Licensed Practical Nurse:** Must hold current licensure from the MN State Board of Nursing; Class A Licensure from MDH; and be enrolled with the Department of Human Services as an independent nurse.

**Medically Necessary or Medical Necessity:** A health service that is consistent with the recipient’s diagnosis or condition, is recognized as the prevailing standard or current practice by the provider’s peer group, and meets one of the following:

- Is rendered in response to a life-threatening condition or pain;
- To treat an injury, illness, or infection;
- To treat a condition that could result in physical or mental disability;
- To care for the mother and child through the maternity period; or
- To achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition.

**PCA Choice Option:** A recipient-directed option under which the recipient of services is responsible for hiring/firing, training and directing his/her PCA. The PCA Choice provider may provide technical guidance in employment matters, and bills for services, pays the PCA and qualified professional if any, along with related taxes and insurance.

**Personal Care Assistant (PCA):** Persons providing human assistance and support to persons with disabilities living independently in the community including the elderly and others with special health care needs. A PCA must meet required qualifications, and be employed by a personal care provider organization (PCPO), a home health agency, or is jointly employed by the recipient and a PCA Choice Provider.

**Personal Care Provider Organization (PCPO):** An agency that meets DHS standards and has signed a provider agreement with DHS to provide PCA services. Also known as a Personal Care Provider or PCA Agency.

**Personal Care Services:** Human assistance and support to persons with disabilities living independently in the community including the elderly and others with special health care needs. Services must be medically necessary, physician-ordered services, and approved in the recipient’s
service plan. PCA services are provided by a PCA under the direction of an RN or qualified
professional, or provided by a PCA under the supervision of the recipient or the recipient’s
responsible party and the recipient’s physician.

**PCA Choice Provider:** A provider who enrolls with DHS to provide fiscal intermediary supports to
recipients choosing the PCA Choice Option. Also known as a fiscal intermediary. Separate
enrollment is required for a PCA Choice provider.

**Private-Duty Nursing Agency:** An agency holding a Class A Home Care license and is enrolled
with the Department of Human Services to provide private duty nursing services

**Private Duty Nursing (PDN) Services:** Nursing services ordered by a physician, for a recipient
whose illness, injury, physical or mental condition requires more individual and continuous care by a
Registered (RN) or Licensed Practical Nurse (LPN) than can be provided in a single or twice daily
skilled nurse visit and requires greater skill than a Home Health Aide or Personal Care Assistant can
provide.

**Qualified Professional:** An RN or mental health professional who is responsible for supervision of
PCA services. The mental health professional must meet credentials of a licensed psychologist,
licensed psychological practitioner, licensed independent clinical social worker, psychiatrist, clinical
nurse specialist (mental health), or marriage and family therapist.

**Registered Nurse:** Must hold current licensure from the MN State Board of Nursing and be enrolled
with the Department of Human Services as an independent nurse.

**Residence:** The place a recipient lives. A residence does not include a hospital, nursing facility, or
intermediate care facility.

**Responsible Party:** An individual residing with a recipient of PCA services who is capable of
providing the supportive care necessary to assist the recipient to live in the community, who is at
least 18 years old, and is not the recipient’s PCA. A responsible party must be able to identify, direct
and evaluate the PCA’s task accomplishments, and provide for the recipient’s health and safety.

**Service Plan – PCA:** A written description of the services needed by the recipient based on the
assessment. The service plan must be developed by the county Public Health Nurse (PHN), or the
PHN under contract with the county who conducts the PCA assessment together with the
recipient/responsible party. The service plan must include a description of the home care services,
the frequency and duration of services, and the expected outcomes and goals. The
recipient/responsible party and the home care provider must be given a copy of the completed
service plan within 30 calendar days of the request for home care services.

**Shared Care Option – PCA:** An option for two or three recipients to share the same PCA in the
same setting at the same time.

**Shared Care Option – PDN:** An option for two recipients to share the same nurse in the same
setting at the same time.
**Skilled Nurse Visits:** Intermittent nursing services ordered by a physician for a recipient whose illness, injury, physical, or mental condition creates a need for the service. Services under the direction of an RN, are provided in the recipient’s residence by an RN, or LPN; and provided under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide.

**Tele-Home-Care:** The use of telecommunications technology by a home health care professional to deliver home health care services within the professional’s scope of practice to a recipient located at a site other than the site where the practitioner is located. Currently approved for skilled nurse visits only.

**Ventilator-Dependent Recipients:** A ventilator-dependent recipient, means a recipient who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

**Legal References**

- MS 256B.0625; 256B.06257
- Minnesota Rules 9505.0290 to 9505.0295
- Minnesota Rules 9505.0335
- 42 CFR 441.15
- 42 CFR 440.70
- 42 CFR 440.80
- 42 CFR 440.167
- 42 CFR 441.302
- Public Law 97-35: OBRA 1981
- Title XIX, section 1915 of the Social Security Act
Chapter 25: Day Training and Habilitation (DT&H)

Chapter 25

Day Training and Habilitation (DT&H)

When counties determine the need for DT&H services under MS 252.28, the county must contract with licensed providers as specified in MS 256B.092. Services must be provided in accordance with MS 252.40 to 252.47 and standards promulgated under these statutes. Following is a description of the available funding sources to pay vendors of DT&H services:

Medical Assistance (MA) funding covers individuals who are MA eligible and reside in an ICF-MR or are MA eligible and on a home and community based waiver program for persons with mental retardation or related conditions (MR/RC waiver).

- MA payment for DT&H services must not replace the Minnesota Division of Vocational Rehabilitation money for sheltered work or work activity services.
- MA reimbursable DT&H services must not exceed the number of days per calendar year as provided by MS 256B.501, subd. 5(e). DT&H services must not include:
  - Special education and related services which otherwise are available through a local educational agency; or
  - Vocational services which are otherwise available from a local vocational rehabilitation agency.

The Children and Community Services Act replaces the Community Social Service Act (CSSA) Chapter 256E, which was repealed as of July 1, 2003. The bill can be viewed at 256M.01 – 256M.80.

- The new law requires that counties assess the needs of the people they serve, prioritize the services they will provide over a two year period, meet with local constituents to review their plans, and then submit a plan to DHS of how they intend to best meet the needs of their residents with the funds available. The county and the DHS Children and Family Services Division then enter into a biennial service agreement.
- To the extent provided in the county service agreement, and in the Individual Service Plan (ISP), the county is responsible for providing DT&H services or alternative habilitation services during the day for persons with developmental disabilities. See Bulletin #03-68-10, pages 4 & 5.

DT&H Services are services related to a person’s employment or work, self-care, communication skills, socialization, community orientation, transportation needs, emotional development, development of adaptive behavior, cognitive development, and physical mobility. Includes training, supervision assistance, and other support activities designed and implemented in accordance with a person’s ISP, to help that person attain and maintain the highest level of independence, productivity, and integration into the community where the person lives and works. The ISP for each person requiring a 24-hour plan of care must provide services during the day outside the residence unless otherwise specified in their plan.
Intermediate Care Facility for Persons with Mental Retardation or Related Conditions (ICF-MR/RC): The provider of a program licensed to serve persons who are mentally retarded under MS 252.282; and a physical plant licensed as a supervised living facility under MS 144, which together are certified by the MDH as an intermediate care facility for persons with mental retardation or related conditions. Unless otherwise indicated, the term ICF-MR includes state-operated and community-based facilities.

Requirements for MA Reimbursement
Licensure under MS 245B (Consolidated Standards) and Minnesota Rules 9525.1580 and 9525.1600: Requirements for reimbursement include licensure under MS 252.40 to 252.47 and standards promulgated under these statutes.

- MA will directly reimburse vendors of DT&H services provided to residents of an ICF-MR when payment is authorized by the ICF-MR in accordance with procedures established in MS 256B.5015.
- Other conditions for provider enrollment in the MA program must be met.

Record Keeping and Retention
The vendor must maintain program records, fiscal records, and supporting documentation identifying the items below:

- Authorization from the county of financial responsibility, as provided by Minnesota Rules 9525.1250, subpart 2, for each recipient for whom service is billed;
- Attendance sheets and other records documenting that the recipient received the billed services from the vendor; and
- Records of all bills and, if applicable, all refunds to and from other sources for DT&H services.

Vendor records are subject to the maintenance schedule, audit availability requirements, and other provisions in Minnesota Rules 9505.2160 to 9505.2245.

- Vendor financial records must be available, on request, to the commissioner and the United States Department of Health and Human Services.
- The vendor must retain a copy of the records required as listed under the Record Keeping and Retention section above, for five years from the date of the bill unless an audit in process requires a longer retention period.
- The day service vendor must maintain such records as may be necessary to submit the annual report by March 1, as provided by MS 256B.501, subd. 9.
Two-Party Agreement and Assignment of Payment

Federal regulations stipulate that an ICF-MR whose residents receive licensed DT&H services outside the facility must have a two-party agreement with the vendor of services.

- The ICF-MR and DT&H sign the Two-Party Agreement (ICF-MR Training and Habilitation Agreement form). The ICF-MR completes an Assignment of Payment form that lists all DT&H vendors providing services, and the parties with whom they have an agreement. This form allows DHS to pay the DT&H services vendor. All paper invoices signed by the DT&H services vendor must also be signed by authorized personnel of the ICF-MR.

- Paper copies of the Assignment of Payment form and the Two-Party Agreement form are available from DHS Provider Enrollment. Copies of the signed agreements and arrangements must be retained by all parties and sent to DHS Provider Enrollment.

- The DT&H vendor must be in compliance with the standards in the Code of Federal Regulations, title 42, sections 483.410 (d) and 483.440.

- DT&H vendors using the DHS ITS electronic billing software must complete and submit DHS Form 2854a, an EDI Division form listing all ICF-MR signatures. The vendor must enter the authorized ICF-MR individual’s name in the “Second Signature” field.

- DT&H vendors using MN-ITS must enter information in the Other Provider Types dropdown on the Provider tab.

Three-Party Agreement

The ICF-MR, the county in which it is located, and the DT&H vendor sign a Three-Party Agreement (DHS-2638) which spells out the responsibilities of each party along with the rates, days of service and operating months.

- The county, the provider (ICF-MR) and the vendor (DT&H) retain a copy of the form, and one copy must be sent to DHS – Disability Services Division (DSD).

- Counties must also send a copy of this agreement to DHS when there is a rate change or provider rate increase or rate reduction (Cost of Living Adjustment [COLA] or legislated rate reductions).

When MA funds are used to pay for DT&H services for individuals living in an ICF-MR, the county case manager/service coordinator coordinates services, and completes any necessary screenings and ISP changes. The case manager/service coordinator contacts the county financial worker if there is a change in the recipient’s living arrangement.

Differences Between Two and Three-Party Agreements

Three-Party Agreements between the training and habilitation agency, ICF-MR, and the county are required annually in accordance with Minnesota Rules 9525.1240. These agreements outline the responsibilities of each party and reflect the current approved MA reimbursement rates, service hours, days of service, and operating months. Three-Party Agreements are necessary to comply with county contracting requirements found in statute and rule, and recognized by CMS as evidence of compliance with 42 CFR 447.10(e) which requires the ICF-MR to have a separate written agreement with each training and habilitation agency providing services to residents. DHS requires that a Two-
Party Agreement be completed between each ICF-MR and the DT&H service vendor providing residents with services. These agreements are completed only once unless there is a change in training and habilitation agencies. Parties to the agreement should keep a copy and submit a copy to the DHS - DSD.

**DT&H Services for Waivered Program Recipients**

The county case manager/service coordinator coordinates services, and completes any necessary screenings and ISP changes. The county case manager/service coordinator enters a service agreement that will authorize the DT&H vendor to bill DHS for services.

**Other Possible Service Options for DT&Hs**

Vendors who wish to provide waivered services that are different than DT&H bundled services can be licensed and enrolled with DHS as a waivered services provider.

Changes in the statute allow the same provider to provide both DT&H and residential services to a recipient, if certain conditions are met (MS 256B.092, subd. 5[b]).

- Work with your host county to determine need for services.
- Contact DHS Provider Enrollment by telephone at (651) 282-5545 or 1-800-366-5411, option 5, for a Home and Community Based Services Provider Enrollment Application (or on-line at http://edocs.dhs.state.mn.us/lfserver/legacy/DHS-4015-ENG).
- Contact DHS Licensing at (651) 296-3971 to obtain an application to become licensed as a 245B-WS (waiver services) provider.
- You may obtain additional information about waivered services and other developmental disabilities services licensure and lists of DHS-licensed providers at www.dhs.state.mn.us/licensing/
- You must obtain a separate license for each county in which services will be provided. The waivered services license is specific to the county where services are provided. The license allows you to provide waivered services to persons of any age, with no more than four persons at any one site at a time.
- If recipients who are supported through the waiver services license will be provided services at the DT&H site, these services are subject to the terms of the waivered services license, including the capacity limit of no more than four persons at any one site. If the DT&H site is a location where waivered services are provided, the physical plant must have current (at the time of waivered services licensure) building inspector and fire marshal approvals for this intended use.
- In some instances, the DT&H vendor for a recipient may also provide waivered services to that recipient. At the time the recipient begins receiving licensed waivered services, s/he is considered a new service initiation under the waivered services license. All consolidated standards and other applicable licensing requirements pertaining to service initiation apply to this consumer.
Any staff person who provides services under a DT&H license, and then provides services under one or more waivered services licenses held by the DT&H provider, will be considered a newly-hired staff person under the waivered services license(s). All consolidated standards and other applicable requirements pertaining to staff orientation will apply to this staff person.

Services DT&H Vendors May Provide Through Waivers

See Home and Community Based Waivered Services (Ch. 26) for a detailed description of who can provide the services, and related billing information.

Rate Determination

Regardless of the funding source, the county board in which an approved vendor is located recommends all service payment rates for approval by the Commissioner in accordance with MS 252.40 to 252.47 and standards promulgated thereafter.

At the county’s request, a program may be granted a rate variance if it meets specific eligibility criteria detailed in MS 252.46, subd. 6. The formal appeal process for DHS denial of a rate change request is described in MS 252.46, subd. 19.

All DT&H vendors submit rate increase recommendations to the host-county for approval on forms issued in DHS Informational Bulletin #01-56-28. DHS enters the new rate into the claims processing and payment system and counties make appropriate changes to service agreements.

Payment Rates

DT&H services must meet a minimum of 195 available service days. Vendors may negotiate additional service days with the county, and must send documentation of the change to DSD. Billable service units cannot exceed 23 per calendar month per recipient. MS 252.46 establishes three payment rates for providers of DT&H services:

- Full day service rate or payment for a full day of DT&H services. A full day must include six or more program hours, including the time it takes to transport the recipient to and from the service site. For persons choosing DT&H, the ISP must specify the amount of services.

- Partial day service rate or payment for less than a full day of DT&H services. This rate is for services provided less than six hours a day and must not exceed 75% of the full day rate.

- Transportation rate or payment for transportation from the recipient’s residence to the service site and back home. Except in unusual circumstances, the license holder must not transport the recipient for longer than 90 minutes per one-way trip. Service obligations identified in the ISP must be met.

Special Transportation

DT&H providers are reminded that trips to their services are not eligible for separate payment on a special transportation claim. Transportation to DT&H facilities is the responsibility of the facility. Relevant laws include MS 252.45, 252.46, and 252.44, and Minnesota Rules 9505.0315 and 9525.1200. Counties and county social workers/case managers cannot/do not authorize
transportation to DT&H through Special Transportation. The Special Transportation providers must determine whether a trip is eligible for Special Transportation payment. If other MA covered services are provided secondary to the DT&H services, the DT&H takes precedence and the payment for transportation must come through the DT&H facility through a subcontract and acceptance of the DT&H transportation rate.

**Hourly Rate Structures**

This information pertains to vendors and host counties who participate in a pilot hourly-rate payment system. The pilot rate system will not be implemented statewide. If desired, providers and counties can work with DHS to develop a revenue-neutral transition to the site based rate structure. Pilot payment rates and procedures are determined by DHS. Hourly services are authorized by counties and billed by providers using the following codes for both ICF-MR and waiver recipients:

- X5296 - A rate (1:1 services);
- X5297 - B rate (corresponding to a service authorization level of 1);
- X5298 - C rate (corresponding to a service authorization level of 2); or
- X5299 - D rate (corresponding to a service authorization level of 3).

Counties must authorize and complete the service agreement for all waiver recipient services and one-to-one services for ICF-MR residents. Payment for rates B-D corresponds to the level of service authorized in box 43 of the Screening Document for Persons with Developmental Disabilities.

**Special Needs Rate Exceptions for ICF-MR Residents**

Minnesota Rules 9510.1020 to 9510.1140 (Rule 186) governs the authorization of special needs rate exceptions for persons with special needs residing in an ICF-MR. A vendor and recipient specific service agreement and approval letter are generated and sent to the provider when a request is approved.

The billing code and rate is indicated on the approved service agreement:

- X7010 - Direct care staff
- X7020 – Equipment
- X5628 - Consultant

**Special Needs Rate Exceptions for Persons on the MR/RC Waiver**

The special needs rate exception for persons on the MR/RC waiver was first clarified in DHS Informational Bulletin # 95-61A dated April 20, 1995. The county cannot negotiate an individual rate for a recipient that is different from the established DT&H rates unless authorization is received from DHS in accordance with Rule 186 criteria. Recipients who receive a rate exception are considered to have the same level of need as recipients who reside in an ICF/MR. MS 256B.501, subd. 8, allows for additional dollars to be available a maximum of 12 months to allow a recipient to continue to receive DT&H services.
The following is the process for making the request:

- The provider submits a proposal to the CFR for the person. The proposal should be based on “above and beyond the current rate that they are receiving”. This is what will be needed to continue to serve the person. The proposal is based on services, which are clearly special services not covered under the established rate.
  - For example, the provider’s current full time rate is $50.00 and they need ________ amount, above this rate to serve a recipient due to medical or behavior issues. This could also be applied to just the transportation rate.
  - Typically the provider comes up with a rate based on 1:1 staff serving the person. This may include wages and a benefit component.

- The case manager will verify that the person meets the eligibility criteria and is screened and authorized for MR/RC waivered services.

- The county then submits the rate exception proposal to the DHS-DSD DT&H policy person. In addition to the provider information, the case manager should include the ISP, which indicates a need for a habilitation component that cannot be met within the established rate of the DT&H.

The maximum approval period is 12 months and cannot be renewed except in exceptional circumstances. It is expected that the need for the rate exception will be eliminated in the 12 month period. The costs for the rate exception must be managed within the county waiver pool.

DHS-DSD grants final approval and will override the rate file on the service agreement for the person who receives the special needs rate exception. Counties do not have the ability to override the rate file in the MMIS system.

**Services Provided to Recipients Under 21 Years of Age**

DT&H services provided to recipients under the age of 21 must be paid by the school district unless the Individual Education Plan (IEP) team determines that educational goals have been met and the recipient will graduate. In order for a vendor to bill and be paid by DHS for services provided to a recipient under age 21, the following steps must be taken:

- The recipient’s county case manager must send the following information to the DHS-DSD DT&H Policy Unit:
  - A copy of the recipient’s diploma;
  - Recipient name and MHCP ID or PMI (Person Master Index) number;
  - Date of graduation (diploma date);
  - The site where the recipient will receive DT&H service; and
  - The beginning date of service.

- DHS DT&H Policy Unit will respond to the case manager and vendor.

- If the recipient resides in an **ICF-MR**, the DT&H services must be billed on a paper CMS-1500 with a copy of the letter attached.
If the recipient is on an **MR/RC waiver**, the county case manager submits a service agreement to DHS for approval. In this case, DT&H services can be billed electronically using the service agreement number.

**Guidelines for Full Day, Partial Day, and Transportation**

If a recipient is sent home because of a weather emergency or illness, bill for a partial day if a full day of service is not provided. If a recipient stays home because of illness or inclement weather, DT&H services cannot be billed.

If a recipient is transported only one way (either to or from the training site), bill the full transportation rate if transportation is provided, arranged, or contracted for at least one way.

If a recipient leaves early or arrives late because of a scheduled doctor or dentist appointment, bill for the partial day rate if a full day of service is not provided. All efforts should be made to schedule medical and dental appointments at times that do not interfere with required training and habilitation services. This also applies to a scheduled therapy, program, or vocational service that is not a DT&H service or included in the MA per diem but is scheduled in accordance with the ISP.

**Billing for Full Day, Partial Day, and Transportation**

- Use the CMS-1500 claim form, ITS, or MN-ITS (837P in MN-ITS Interactive for individual claim entry or **Batch** for multiple claim submission) to bill for DT&H services. Bill only one calendar month on each claim.

- A diagnosis code is required when the recipient resides in an ICF-MR. Contact the ICF-MR or the county case manager/service coordinator for diagnosis code information. Diagnosis codes are required for billing services provided to a waivered service program recipient as of October 16, 2003, to comply with HIPAA regulations.

- When services are provided to a waivered service program recipient, a service agreement number is required in box 23 on the CMS-1500 claim form, in the Authorization Number field in ITS, or in the Authorization Number field on the Claim Information tab in MN-ITS Interactive. A service agreement number is not required when the recipient resides in an ICF-MR. (See the DHS 837P training module for CMS-1500 billers at [http://www.dhs.state.mn.us/Provider/training/tutorials/837P/default.htm](http://www.dhs.state.mn.us/Provider/training/tutorials/837P/default.htm) and choose the **Interactive** option on the menu if billing one claim at a time. Batch billers will choose the **Batch** option)

- Use the following codes to bill for services provided to a recipient in an ICF-MR. These services **do not** require prior authorization (service agreement):
  - X7000 - Full day rate (six or more hours)
  - X7001 - Partial day rate (less than 6 hours)
  - X7002 - Transportation

- Use the following codes to bill for services provided to home and community based MR/RC waivered service program recipients. These services require prior authorization (service agreement) by the county case manager:
  - X5680 - Full day
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- X5679 - Partial day
- X5681 – Transportation

If the service agreement does not have an appropriate number of partial days do not substitute and bill for a full day. This is considered a fraudulent billing practice. Contact the county case manager to have the service agreement adjusted to include additional partial days.

- Enter the ICF-MR provider number in the “Treating Provider Number” box 24K, or the electronic equivalent when billing for DT&H services for a recipient who lives in an ICF-MR.

- A partial day and a full day may be billed on the same CMS-1500 claim form using separate lines. Enter a “from” and “through” date if services are provided on consecutive days. The unit box must contain the day(s) the recipient was present in the day training program. The combined units of services must not exceed the monthly limitations. Daily attendance records must be kept on site and are subject to audit.

- Transportation cannot be billed using “from” and “through” dates of an entire month if a recipient resides in an ICF-MR and attends DT&H for some partial and some full days in that month. Bill transportation line by line to match partial and full days of service.

- Extended transportation billing code X5601 cannot be used to supplement the DT&H transportation rate. Minnesota statute and the federal MR/RC waiver plan prohibit additional payment for transportation when it is included in the established rate.

Multiple Providers of DT&H for the Same Recipient/Same Day

Waivered service agreements must include separate line items for each vendor if the service is rendered on the same day by more than one agency. More than one vendor may bill for approved partial day services provided on the same day. Only one provider may bill for daily service codes per day. If there is more than one vendor of service, services need to be coordinated and only the actual dates of service should be billed. Date spans can be used when services are provided on consecutive days.

DT&H and ICF-MR Signature Requirements

The DT&H and ICF-MR may make any legal arrangement to secure authorized signatures on billing invoices. Each ICF-MR is responsible for ensuring that required services are provided to its residents regardless of whether or not it has given the DT&H “power of attorney” to act on its behalf. As stated in the Two-Party Agreement section, when ICF-MR personnel sign the CMS-1500 claim form, they are accepting responsibility for the accuracy and legitimacy of the bills they authorize for submission to DHS. This means they are verifying the accuracy of the stated charges, days of service, and transportation provided for each recipient who is a resident of the ICF-MR. The Two-Party Agreement also states that the DT&H accepts responsibility for the accuracy and legitimacy of bills it submits to the ICF-MR for signature.
Legal References

Children & Community Services Act
42 CFR 447.10(e)
42 CFR 483.410(d)
42 CFR 483.440
Minnesota Rules 9505.2160
Minnesota Rules 9505.2245
Minnesota Rules 9505.1240
Minensota Rules 9525.1250
Minnesota Rules 9525.1580
Minnesota Rules 9525.1600
MS 144
MS 245B
MS 252.28
MS 252.282
MS 252.40-252.47
MS 256B.092
MS 256B.092, subd. 5(b)
MS 256B.501
MS 256B.5015
Chapter 26

Home and Community-Based Services (HCBS) Waiver Programs and the Alternative Care (AC) Program

Introduction

HCBS waiver programs allow the Department of Human Services (DHS) to use Medical Assistance (MA) and state funds to provide services and support to people in their homes or a community setting as an alternative to hospital, intermediate care facility for persons with mental retardation or related conditions (ICF/MR), or nursing facility (NF) care. Their purpose is to promote community living and independence based on an individual’s needs. HCBS programs pay for different services or more services than are otherwise available under the MA program. All HCBS program applicants must qualify for MA as a basis of eligibility, except for the Alternative Care (AC) program.

The following HCBS waiver programs currently available under MA are for individuals who are under age 65 at the time of enrollment and who have a disability:

- Community Alternative Care (CAC) Waiver;
- Community Alternatives for Disabled Individuals (CADI) Waiver;
- Home and Community Based-Services Waiver for Persons with Mental Retardation or Related Conditions (MR/RC Waiver); and
- Traumatic Brain Injury Waiver (TBIW).

Individuals who are under 65 and who qualify for MA under the Employed Persons with Disabilities program (MA-EPD) are eligible for all of the above waivers if they meet all other eligibility criteria.

The following HCBS programs are for people aged 65 and over whose care needs would otherwise require the level of services provided by a nursing facility:

- Elderly Waiver (EW)
- Alternative Care (AC)

Determining Recipient Eligibility for HCBS Waiver Programs

The public health or human services agency in the county where the recipient resides determines eligibility for most waiver programs and AC. Waiver and AC program applicants must meet specific eligibility requirements. Each waiver program and the AC program have different application processes, eligibility requirements and covered services.

The county provides Long Term Care Consultation (LTCC) services including a community assessment of the recipient’s needs, assistance with the application process, and development of an individual service plan or care plan. Recipients approved for a waiver or the AC program receive case management services from a county public health nurse or social worker who implements and
monitors the service or community support plan (care plan). Counties must ensure that the health and safety needs of recipients are met under these care plans. Counties manage the funds for all the waiver services provided to eligible recipients.

Service Agreements (Prior Authorizations)

All waiver services and AC services require prior authorization by a county case manager in the form of a service agreement (SA). The SA lists all the authorized waiver or AC services that a recipient has chosen to help him/her remain in a community setting. The SA lists the Minnesota Health Care Programs (MHCP) enrolled provider who is authorized to provide the service, the rate of payment, date or date span of authorization, and approved procedure code(s). The SA allows the provider to bill DHS and receive payment; however, an approved SA is not a guarantee of payment. Providers should verify program eligibility for each recipient each month. Recipient eligibility information may be accessed by calling the DHS Eligibility Verification System (EVS) automated touch-tone telephone service at 1-800-657-3613 or (651) 282-5354, or on the Internet at www.mnevs.state.mn.us.

- The county case manager authorizes all waiver and MA home care services or AC Services on a service agreement.
- The Payer Determination Form (PDF) is completed and kept on file at the provider and county agencies.
- The case manager is ultimately responsible to make sure that the SA is accurate when it is entered into the DHS computer system (MMIS).

Services Extending Beyond Increments Listed on SA Are Not Approved and Cannot be Paid: Waiver and AC providers need to use their professional judgment when services they provide go over or under the time increments listed on the SA, taking into consideration how the plan of care is written and how many units are allotted on the SA.

Changing the SA: The case manager is responsible for any changes made to a recipient’s SA. If the rate, procedure code(s), or begin and end dates on the SA are incorrect, contact the case manager. If an SA line item is changed and approved, DHS will automatically generate or the county will send a revised SA letter to the provider. Letters are generated overnight and mailed the following day.

Copies of SA Letters: The county is able to generate additional copies of provider SA letters, if needed. Counties have the option of allowing the DHS generated letter to be sent to the recipient or to suppress the letter and send a county generated letter.

Eligible Providers

Waiver and AC providers must enroll with DHS Provider Enrollment, and meet specific standards in order to bill and receive payment for services provided to waiver and AC recipients. Providers must determine which program services they are qualified to provide. The Elderly Waiver or Alternative Care Program Provider Standards can be viewed at
Provider Enrollment

Contact DHS Provider Enrollment at 651-282-5330 or 1-800-657-3991, or e-mail them at: provider.enrollment@state.mn.us to get a HCBS Provider Enrollment Application and a Provider Agreement. The application is available online at: http://edocs.dhs.state.mn.us/live/DHS-4015-ENG.pdf. The provider agreement is available online at: http://edocs.dhs.state.mn.us/lfserver/legacy/MS-1302-PDF.

Be aware that each type of service may have different licensing requirements and proof of appropriate licensing or certification is required.

Licensing

Some services may require a DHS license, such as an Adult Foster Care License or an Adult Day Care License. Other services, such as Assisted Living or home care may require a home care license issued by the Minnesota Department of Health.

When providing services funded by the MR/RC Waiver, contact DHS licensing at (651) 296-3971 to obtain an application to become licensed as a 245B-WS (waiver services) provider. This license is specific to the county where services are provided. A separate waiver license must be obtained for each county in which waiver services will be provided.

Recipient Eligibility Criteria By Program

Program funding must not replace other sources of available funding.

CAC (Community Alternative Care)

- Under age 65 at the time of screening (recipients who are on CAC and turn 65 are allowed to continue services if all other eligibility factors are met);
- A resident of a hospital or at risk of frequent or prolonged chronic inpatient hospital care;
- Eligible for MA (may be based solely on the individual's income and assets);
- Certified disabled by the Social Security Administration (SSA) or State Medical Review Team (SMRT);
- Individual/responsible party chooses HCBS services;
- County service plan reasonably ensures individual's health and safety;
- Average statewide MA community costs are less than the average statewide institutional costs;
- Program funding must not replace other sources of available funding; and
- Requires interdisciplinary team assessment which recommends waivered services.
CADI (Community Alternatives for Disabled Individuals)

- Under age 65 at the time of screening (recipients who are on CADI and turn 65 are allowed to continue services if all other eligibility factors are met);
- Eligible for MA (may be based solely on the individual's income and assets);
- Certified disabled by the SSA or SMRT;
- Individual/responsible party chooses HCBS services;
- County service plan reasonably ensures individual's health and safety;
- Average statewide MA community costs are less than the average statewide institutional costs;
- Require nursing facility level of care;
- Requires LTCC conducted by the local county agency; and
- Program funding must not replace other sources of available funding.

Recipients who have mental illness may be eligible for CADI if they meet the CADI eligibility criteria. This applies when mental illness is the only diagnosis or when the recipient has another type of disability and a mental illness.

MR/RC (Recipients with Mental Retardation/Related Conditions)

- No age requirement;
- Diagnosed with mental retardation or related conditions as delineated in Minnesota Rule, parts 9525.0004-9525.0036 or Minnesota Statute 256B.092;
- Eligible for MA (may be based solely on the individual's income and assets);
- At risk of ICF/MR level of care;
- Requires a 24-hour plan of care;
- The recipient and/or his/her legal representative have made an informed choice of HCBS services as an appropriate alternative to ICF/MR services;
- Has received a screening for HCBS services;
- Health and safety in the community is ensured by plan of care;
- Program funding must not replace other sources of available funding; and
- Average statewide MA community costs are less than the average statewide institutional cost.

TBIW-NF (Traumatic Brain Injury Waiver - Nursing Facility Level)

- Under age 65 at the time of screening (recipients who are on TBI and turn 65 are allowed to continue services if all other eligibility factors are met);
- Eligible for MA (may be based solely on the individual's income and assets);
- Certified disabled by the SSA or SMRT;
- Individual/responsible party chooses HCBS services;
- County service plan reasonably ensures individual's health and safety;
- Average statewide MA community costs are less than the average statewide institutional costs;
Diagnosed with traumatic or acquired brain injury which is not congenital (documentation of the diagnosis or brain injury caused by an event is kept on file in the individual local agency record);

Requires nursing facility level of care;

The individual demonstrates significant cognitive and behavioral needs related to the brain injury;

Requires preadmission screening conducted by the local county agency;

If not for the provision of waiver services, the individual would reside in or requires the level of care provided in a specialized nursing facility (e.g., unit designated to work with brain injury or behavioral management); and

Program funding must not replace other sources of available funding.

### TBIW-NB (Traumatic Brain Injury Waiver - Neurobehavioral Hospital Level)

- Under age 65 at the time of screening (recipients who are on TBI and turn 65 are allowed to continue services if all other eligibility factors are met);
- Eligible for MA (may be based solely on the individual's income and assets);
- Certified disabled by the SSA or SMRT;
- Individual/responsible party chooses HCBS services;
- County service plan reasonably ensures individual's health and safety;
- Average statewide MA community costs are less than the average statewide institutional costs;
- Diagnosed with traumatic or acquired brain injury which is not congenital (documentation of the diagnosis or brain injury caused by an event is kept on file in the individual local agency record);
- Requires neurobehavioral hospital level of care;
- The individual demonstrates significant cognitive and severe behavioral needs related to the brain injury;
- Requires interdisciplinary team assessment which recommends waiver services; and
- Program funding must not replace other sources of available funding.

### EW (Elderly Waiver)

- 65 years or older;
- Screened by a Long Term Care Consultant who has determined that but for the provision of home and community based services, the recipient would require a nursing facility level of care;
- Eligible for MA;
- Choose community care;
- MA community care costs are less than MA institutional care costs (for an individual);
- Health and safety is ensured by plan of care; and
- Program (MA) funding must not replace other sources of available funding.
Alternative Care (AC) Program

- 65 years or older;
- An LTCC has determined that the recipient’s needs would otherwise require nursing facility level of care;
- Would be financially eligible to receive MA within 180 days after admission to a nursing facility;
- Community care costs are 75% or less of institutional care costs;
- Health and safety is ensured by plan of care; and
- Program (State) funding must not replace other sources of available funding.

Persons eligible for the AC program may be assessed a premium for services.

Covered Services

CAC

- All MA covered services
- Case Management
- Case Management Aide (Paraprofessional)
- Family Counseling
- Family Training
- Foster Care
- Home Health Aide, Extended
- Homemaker
- LPN (Regular Home Health, Extended; Shared Home Health, Extended 1:2)
- LPN (Complex Home Health, Extended)
- Modifications
- Nutritional Therapy, Extended
- Occupational Therapy or Assistant, Extended
- Personal Care Assistant (Extended 1:1; Extended 1:2; Extended 1:3)
- Physical Therapy or Assistant, Extended
- Prescription Drugs, Extended
- RN (Regular Home Health, Extended; Shared Home Health, Extended 1:2)
- RN (Complex Home Health, Extended)
- RN (Supervision of Independent PDN)
- Respiratory Therapy, Extended
- Respite Care (In-home; Out-of-home)
- Speech Therapy, Extended
- Supplies/Equipment
- Transportation (One Way Trip)
- Transportation-Mileage
- Transportation-Mileage (Noncommercial Vehicle)
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- Transportation-Attendant

CADI

- All MA covered services
- Adult Day Care
- Adult Day Care Bath
- Assisted Living
- Assisted Living Plus
- Case Management (PHN/Social Worker)
- Case Management Aide (Paraprofessional)
- Family Counseling and Training
- Foster Care
- Home Delivered Meal
- Home Health Aide, Extended
- Homemaker
- Independent Living Skills
- LPN (Regular Home Health, Extended; Shared Home Health, Extended 1:2)
- LPN (Complex Home Health, Extended)
- Modifications
- Occupational Therapy or Assistant, Extended Home Health
- Personal Care Assistant (Extended 1:1, Extended 1:2; Extended 1:3)
- Physical Therapy or Assistant, Extended Home Health
- Prevocational Services
- RN (Regular Home Health, Extended; Shared Home Health, Extended 1:2)
- RN (Complex Home Health, Extended)
- Residential Care Services
- Respiratory Therapy, Extended Home Health
- Respite Care (In-home; Out-of-home)
- Speech Therapy, Extended Home Health
- Supplies and Equipment
- Supported Employment
- Transportation (One Way Trip)
- Transportation-Mileage
- Transportation-Mileage (Noncommercial Vehicle)
- Transportation-Attendant

MR/RC

This waiver program also includes all MA covered services including home care services, if they are medically necessary, ordered by a physician, and part of a plan of care. If the recipient or their representative chooses to use home care services, including home health, private duty nursing, personal care attendant services, and skilled nurse visits, those services must be arranged with the assistance of the case manager and authorized by the county public health nurse.
• Adult Day Care
• Assistive Technology
• Caregiver Training and Education
• Case Management
• Chore Service
• Crisis Respite
• Consumer-Directed Community Supports
• Consumer Training and Education
• DD Screening
• Day Training and Habilitation
• Environmental Modifications
• Homemaker
• Housing Access Coordination
• In-Home Family Support
• Live-in Personal Caregiver Expenses
• Personal Care Assistant Services (PCA)—(Extended 1:1; Extended 1:2; Extended 1:3)
• Personal Support
• Respite Care (In-home; Out-of-home)
• Specialist Service
• Supported Employment
• Supported Living (Adult; Child)
• Transportation, Extended
• 24-Hour Emergency Assistance

TBIW

• All MA covered services
• Adult Day Care
• Adult Day Care Bath
• Assisted Living
• Assisted Living Plus
• Behavioral Programming (by Professional; Analyst; Specialist; Aide)
• Case Management
• Case Management Aide (Paraprofessional)
• Chore Services
• Cognitive Therapy (by Professional, Extended; by BA/BS Personnel, Extended)
• Companion Services
• Family Counseling and Training
• Foster Care
• Home Delivered Meals
• Home Health Aide, Extended
• Homemaker Services
• Independent Living Skills (Counseling; Maintenance)
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- Independent Living Skills Therapies (ILS: Individual; Group)
- LPN (Regular Home Health, Extended; Shared Home Health, Extended 1:2)
- LPN (Complex Home Health, Extended)
- Mental Health Explanation of Findings, Extended
- Mental Health Psychological Testing, Extended
- Modifications
- Night Supervision
- Occupational Therapy or Assistant, Extended Home Health
- Personal Care Assistant (Extended 1:1; Extended 1:2; Extended 1:3)
- Physical Therapy or Assistant, Extended Home Health
- Prevocational Services
- RN (Regular Home Health, Extended; Shared Home Health, Extended 1:2)
- RN (Complex Home Health, Extended)
- Residential Care
- Respiratory Therapy, Extended Home Health
- Respite Care Worker (In-home)
- Respite Care (Out-of-home)
- Speech Therapy, Extended Home Health
- Supported Employment
- Structured Day Program
- Supplies and Equipment
- Transportation (One Way Trip)
- Transportation-Mileage
- Transportation-Mileage (Noncommercial Vehicle)
- Transportation-Attendant

EW

- Adult Day Care
- Adult Day Care Bath
- Assisted Living
- Assisted Living Plus
- Caregiver Training and Education
- Case Management (by Paraprofessional; PHN/Social Worker)
- Chore Services
- Companion Services
- Corporate Foster Care
- Family Foster Care
- Home Delivered Meals
- Home Health Aide, Extended
- Homemaker Services
- LPN (Home Health, Extended; Shared Home Health, Extended 1:2)
- Modifications and Adaptations
- Personal Care Attendant (Extended 1:1; Ext. Shared 1:2; Ext. Shared 1:3)
Residential Care
Respite Care (Certified Facility; Hospital; In-Home and Out-of Home)
RN (Extended Home Health; Extended Shared Home Health 1:2)
Supplies and Equipment, Extended
Transportation

AC

Adult Day Care
Adult Day Care Bath
Assisted Living
Assisted Living Plus
Caregiver Training and Education
Case Management (Paraprofessional; PHN/Social Worker)
Case Management (Conversion)
Cash Payment
Chore Services
Companion Services
Corporate Foster Care
Discretionary Services
Environmental Modifications
Family Foster Care
Home Delivered Meals
Home Health Aide
Home Health Service (Skilled Nurse)
Homemaker Services
Nutrition Service
Personal Care Assistant (1:1; Shared 1:2; Shared 1:3)
Private Duty Nursing (LPN regular, shared, or complex; RN regular, shared or complex)
Residential Care
Respite Care (Certified Facility; Hospital; In-Home and Out-of-Home)
RN, Supervision of a PCA
Supplies and Equipment
Transportation

A comprehensive description of services is located at the end of this chapter.

Home Care Services Provided to Waiver and AC Recipients

All waiver and AC program recipients are expected to maximize access to other federal or private program benefits for primary health care coverage either through Medicare benefits, private insurance, Medicare Supplement policies, and long term care insurance policies.
All waiver recipients, with the exception of AC recipients, are eligible for waiver services and MA benefits.

MA covers the following home care services:

- Personal Care Assistant (PCA)
- PCA Supervision
- Home Health Aide (HHA)
- Skilled Nursing Services (SNV)
- Private Duty Nursing (PDN)
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Respiratory Therapy (RT)
- Speech Therapy (ST)
- Supplies and Equipment

**EW, CAC, CADI, TBI waivers:** With the exception of therapies, the county case manager determines the amount of home care services and approves the service agreement. For Prepaid Medical Assistance enrollees, the designated PMAP provider is responsible for approval and provision of all home care services.

**AC Program:** With the exception of therapies, the county case manager determines the amount of home care and AC services and approves the service agreement.

**MR/RC waiver:** The public health nurse conducts all PCA assessments and reassessments and recommends the necessary amount of PCA services, determines the appropriate level and amount of all other home care services, and participates in the development of the Individualized Service Plan (refer to Bulletin 96-61-2, pg. 2).

**Extended Home Care Services:** Recipients must first access needed home care services through MA home care or PMAP before “extended home care” benefits may be approved. Home care service needs which exceed the limits those programs impose may be approved and billed to the waiver as “extended MA services.” These extended services include extended PCA, extended Home Health Aide, extended Home Health Nursing (RN/LPN) and for CAC, CADI and TBIW, extended therapies. For EW, this also includes extended supplies and equipment.

*Refer to Home Care Services chapter (Ch.24) for more information about MA home care services.

**Payment Rates**

DHS establishes upper rate limits for waiver and AC services. Upper limits are published in DHS bulletins at [http://www.dhs.state.mn.us/fmo/legalmgt/bulletins/](http://www.dhs.state.mn.us/fmo/legalmgt/bulletins/). For upper limit rates specific to home care, CAC, CADI, MR/RC, and TBIW services, refer to Bulletin #02-56-11. For the Elderly Waiver and AC program’s upper limit rates, refer to Bulletin 03-25-03.

Lead agencies for HCBS programs negotiate contracts with providers and set service provider payment rates. Negotiated service rates may not exceed DHS’s published maximum allowable service rate.
Counties have the option to pay providers directly, or have a provider bill DHS. If the county pays the provider directly: 1) the case manager enters the county’s provider number on the SA; 2) the county bills DHS, and 3) the county pays the provider for services rendered to the recipient. If the provider bills DHS directly: 1) the case manager enters the provider’s number on the SA, and 2) the provider bills DHS. The manner in which counties keep track of payments to providers is up to each individual county.

There is no policy requiring case managers to complete SAs within a certain time period. DHS instructs counties to enter SAs in a timely manner to ensure provider payment. There is also no state policy that requires providers to inform counties when SAs expire. There are many advantages for both providers and counties to coordinate their efforts to ensure that recipients receive necessary services, and that providers receive timely payment.

**Exceeding Waiver Funding Limits (Bulletin #01-56-18):** When CAC, CADI, TBI-NF and TBI-NB waiver recipients needs cannot be served under their waiver caps (according to case mix, hospital or DRG limits), the case manager may request additional funding. Please refer to Bulletin #01-56-18 for additional information.

**Exceeding Waiver Funding Limits for EW:** Refer to Bulletin 03-25-03 for additional information.

**Payer Determination:** All providers and counties are responsible for billing available payers for services. The Payer Determination Form (PDF) is used to determine the appropriate payer source. The county case manager keeps this form on file. The order of payers are as follows:

1) Third party payers (e.g., large and small group health plans, private health plans, group health plans covering the beneficiary with End Stage Renal Disease for the first 18 months, workers’ compensation law or plan, no-fault or liability insurance policy or plan);
2) Medicare and Medigap Policies (Medicare must always be billed unless the item is a Medicare non-covered service);
3) Minnesota Health Care Programs; and
4) Waiver Programs.

**Miscellaneous Information for All HCBS Providers**

**Multiple Providers Providing the Same Service at the Same Time:** More than one provider may be authorized to provide the same service to the same recipient. Each provider has a separate line item on the recipient’s SA. Some services may also be provided by more than one provider on the same date of service, except if the service has a daily or monthly procedure code. If two providers are providing the same service to one recipient, services must be coordinated. Each provider bills for the actual dates of service. Use date spans on claims when services are provided on consecutive days. County case managers should contact all providers who will bill for the same daily or monthly procedure over the same time period to coordinate services.
Changes in Recipient Status: County case managers inform providers and the county financial worker of changes to the recipient’s case, such as the recipient’s MHCP ID number, living arrangement, address and/or phone number, or an incorrect birth date. The county financial worker also notifies the case manager of any changes. Providers and case managers notify one another when a recipient is hospitalized, so providers can bill around the dates of hospitalization. They should also notify one another when a recipient is admitted to a long term care facility, so the financial worker can update the recipient’s living arrangement and appropriate changes can be made to the SA line items.

Change of Providers: Providers contact the case manager when services to a recipient are discontinued, or changes need to be made to the SA.

Transitioning from MA Home Care to Waiver Services or Waiver Services to MA Home Care Services: Refer to the Home Care Services chapter (Ch. 24) for more information.

Waiver Recipients Enrolled in Prepaid Health Plans: All regular MA-covered services must be billed through the health plan. Contact the health plan for coverage information. All other services not covered under the health plan should be listed on the SA and billed to DHS under the waiver.

Private Duty Nurse (PDN) Payment for Spouses on the CAC Waiver: Licensed nurses who are spouses of recipients on the CAC waiver may be reimbursed for PDN services under certain conditions. This, however, does not change spousal responsibilities that include the role of a primary and emergency backup caregiver.

- **Recipient criteria:** To receive spousal PDN services, the recipient must be on the CAC waiver and direct his or her own care. The recipient must meet the following criteria:
  - Be oriented to person, place and time;
  - Have an understanding of his/her care needs;
  - Have an understanding of his/her plan of care, including his/her medication and medication schedule;
  - Have an understanding of safety issues, including how to access emergency assistance; and
  - Have a documented medical necessity for private duty nursing.

- **Spouse criteria:** In order for the spouse to be reimbursed for PDN services, the following criteria need to be met. The spouse must:
  - Be a licensed nurse and have a current Minnesota nursing license;
  - Be needed in ordered to prevent the hospitalization of the recipient;
  - Pass a criminal background check;
  - Be needed to provide services due to a lack of a sufficient number of qualified PDNs available for the recipient; and
  - Agree to provide the authorized and assigned hours of nursing services.

Limitations in authorization for spousal PDN services include:
Third party liability for nursing coverage must be exhausted first, followed in order by Medicare and by MA up to the number of hours that PDNs are available. A spouse can cover up to 24 hours per week but no more than 50 percent of the total approved amount of nursing hours or eight hours per day, whichever is less.

- **Interdisciplinary team responsibilities:** The interdisciplinary team, which includes the recipient, spouse, home health agency(s) and the recipient’s physician decide if it is appropriate for the spouse to be paid under the spousal PDN provision. Assurances for health and safety must be met.

- **Case manager responsibilities:** The case manager ensures that all nursing services are appropriately authorized and billed. Additionally, the case manager documents that this option has been chosen and approved by the interdisciplinary team and all requirements have been met. This documentation in the plan of care should include:
  - The number of PDN hours that the spouse is authorized to provide and appropriate procedure codes:
    - X5267-LPN-Home Health, extended;X5266-RN-Home Health, extended
    - X5437-LPN-Ventilator Dependent-Home Health, extended
    - X5434-RN-Ventilator Dependent-Home Health, extended
    - X5436-LPN-ICU-Home Health, extended
    - X5433-RN-ICU-Home Health, extended

  When billing for PDN services provided by a spouse, only CAC extended procedure codes may be used.

- **Provider requirements:** Home health agencies providing PDN services:
  - Complete a criminal background check on the potential spousal PDN;
  - Complete the DHS Payer Determination Form;
  - Follow the service authorization in payer determination as directed by CAC waiver case manager;
  - Document in the plan of care, all PDN services to be provided by the spouse;
  - Schedule the hours covered by the spouse; and
  - Bill the hours using the appropriate CAC procedure codes, as directed by the case manager.

**Individual Education Plans (IEP):** A recipient may receive these services through MA and/or HCBS waivers. When the services are provided through the school, they are considered IEP services and billed as education plan services. IEP services are not considered or billed as home care, therapy, or waiver services. Refer to the [Children’s Services chapter](Ch. 9) for additional information regarding IEP services.
Coordination of IEP services and home care services are assessed on a 24-hour non-school day. A parent/guardian may choose to use authorized home care or waiver services in the school rather than have the school bill for the education plan service:

- Services must be listed in the child’s IEP/IFSP or IIIP; and
- Permission must be given by the parent/guardian in the care plan and retained by the provider in their records.

Education plan services:

- Do not count against the prior authorization cap for home care services;
- Will not be counted against the waiver cap or affect the amount of services available under the waiver; and
- Are not counted against MA service limitations or thresholds for therapies.

The education plan team and the home care provider or waiver case manager must coordinate and not duplicate services.

**Waiver Recipients Admitted to a Hospital or Long Term Care Facility:** Waiver services are not covered during a hospital, nursing facility, or ICF/MR stay. Providers may bill DHS for waiver services provided on the date of the admission and/or the date of discharge, if services were provided prior to the time of admission or after the time of discharge. **Exceptions:** CADI, EW, and AC allow payment for respite care provided in a hospital or long term care facility using waiver or AC respite care procedure codes. TBI allows payment for respite care in an ICF/MR setting. CAC waiver allows payment for regular case management only for the first 30 days of a hospitalization. AC case management conversion may be provided during the nursing facility stay and billed against the AC service agreement for AC recipients. Other HCBS recipients may receive relocation service coordination/case management while in a hospital, Nursing Facility or institution for up to 180 days before discharge.

It is important to bill for the dates services were provided (e.g., if the recipient was hospitalized from 1/15 through 1/25, bill 1/1 through 1/14 or 1/15 on line one of the claim, and 1/25 or 1/26 through 1/31 on line two). In this case if the entire month is billed, the claim will deny. If the waiver claim is paid prior to the hospital or long term care facility claim, DHS will automatically take back the waiver payment.

**Waiver and AC Services in a Residential Setting:** Waiver services provided in a residential setting such as assisted living, assisted living plus, residential care services, foster care, and supported living services are covered. Waivers do not pay for room and board. Room and board may be covered by other sources such as:

- The recipient’s income;
- Social Security Disability Insurance (SSDI);
- General Assistance (GA); and
- Supplemental Security Income (SSI).
When the above sources do not cover the total cost of room and board, Group Residential Housing (GRH) funding may be accessed up to the base rate. The county financial worker must determine all appropriate payment sources for room and board.

**Billing for Leave Days in an Assisted Living, Residential Care, Foster Care, or Assisted Living Plus Setting:** Bulletin #00-56-30 dated November 8, 2000; titled "DHS Clarifies Policy on Leave Days used by Persons on HCBS Waivers and AC" must be reviewed for policy interpretations of "leave days."

Claims for the above mentioned community settings cannot include periods that overlap with a period of hospital confinement, nursing facility stay, or other periods defined as "leave days." In order for a provider to be paid for days in which the person was not in the community, the county contract must include a provision allowing for payments in a month that includes leave days.

- Electronic or paper claims must include one line item that represents the adjusted negotiated monthly rate as identified in the county contract;
- The unit field must be one (1);
- The period is a time span that does not overlap with any leave days; and
- The total amount field is the total number of days in the setting for that month multiplied by the adjusted negotiated monthly rate.

If the person is on a leave day status for more than one period during the month (example: 4/6/02 - 4/12/02 and 4/20/02 - 4/25/02) you must choose a period that does not overlap these time spans. A notation on the claim form and in your records must explain why you are unable to bill multiple periods and that the total amount represents the correct number of days the person was in the community setting.

**Waiver Recipients Who Elect Hospice:** When a waiver recipient elects the MA hospice benefit, waiver services needed by the recipient, unrelated to the terminal illness, may be covered by the waiver program. Refer to the Hospice Services chapter (Ch. 28) for more information.

**Billing**

Waiver services must be billed using the HCFA-1500. Refer to the Billing Policy chapter (Ch. 4) for more information.

**Diagnosis Codes on Claims:** Some home care procedure codes require a diagnosis code on the claim. These procedure codes are: X5285, X5282, X5645, X5357, X5358, X5280, X5283, X5284, and X5281. When required, it must be the most specific code. Contact the physician or PHN for the appropriate diagnosis code. Waiver claims do not require diagnosis codes. However, if a waiver recipient is also receiving these MA home care services, a diagnosis code (or codes) is required.

**Authorized Services vs. Non-Authorized Services:** Services that require a SA cannot be billed on the same claim as services that do not require SA. For example, home care therapy services
AC Allocation Cutback Base Rate Reason 17: When a claim is paid zero dollars, with a base rate reason code of 17 for an AC recipient, the county has run out of AC funds for that time period. The provider must notify the case manager. The case manager will contact DHS and request additional AC funds. Once additional funds are approved, the case manager will notify the provider, and the provider should submit a replacement claim.

EW Obligation: Some EW recipients no longer have a medical spenddown. Instead, some EW recipients will have to pay a portion or all of their EW service costs through a waiver obligation. The recipient’s county financial worker who enters the amount into the state computer system determines the amount of the obligation. This obligation is similar to a potluck spenddown, whereby, when a provider bills DHS for certain services listed on the EW service agreement, the recipient will be responsible for part of the cost of care. DHS will notify the provider with a base rate reason code on the RA. This means that the dollar amount listed as the cutback is the recipient’s responsibility for EW services rendered during the month. If the obligation amount is more than the first provider’s billing costs for that month, subsequent providers who bill for services in the same month will need to collect the rest of the obligation amount from the recipient until it is paid in full for that month.

Note: Effective December 15, 2000, a recipient may select a designated provider to whom to pay his/her obligation. This may selected only for a future month. The recipient must notify his/her county financial worker to choose this option.

HCBS Covered Services, Billing Codes, and Provider Standards

The following information is a summary of waiver program services and applicable provider standards. There may be variations in the service descriptions, billing codes, or provider standards that are specific to each program. This summary may not reflect the most current regulatory citations. The following services and requirements are the minimum guidelines. Individual counties may negotiate with providers in their county contracts to have higher provider standards under each service category than those noted below. Footnotes (aa – kk) can be found at the end of this summary section.

Adult Day Care

Available through: CADI, TBI, EW and AC (X5486-30 minutes; X5487-full day), MR/RC (X5682-30 minutes; X5683-full day). EW and AC only - county may contract with a provider for either rate unit or both rate units (counties may not approve both rate units for the same client on the same day).

The purpose of adult day care is to provide integrated supervision, care, assistance, training and activities to recipients, based on the recipient’s needs and directed toward the achievement of specific outcomes as identified in the care plan. Adult day care services may be provided to recipients only when the service planning team has determined after reviewing the recipient’s
assessments and offering an informed choice of services to the recipient’s legal representative, if any, that adult day care is the most appropriate service for the recipient. Adult day care is available to recipients who are 18 years of age or older and is a means to help a recipient to be as involved in the community as possible and have meaningful social experiences with non-disabled peers. It encompasses both health and social services needed to ensure the optimal functioning of the recipient. Meals and transportation are covered by this service. Specialized therapies such as physical, occupational, and speech therapy and adaptive equipment may also be provided in addition to day care, if the provider is appropriately licensed. For some waiver types, a recipient can choose adult day care services instead of DT&H services when it has been decided that DT&H services are no longer appropriate to meet the recipient’s needs. Services may be furnished two or more hours per day, one or more days per week, on a regularly scheduled basis.

Provider Standards:

Providers of adult day care services must be licensed by DHS under Minnesota Rules, parts 9555.9600 to 9555.9730.

A licensed adult foster care provider may provide family adult day care under their foster care license if all the recipients are 55 years and older, none of the recipients are seriously and persistently mentally ill or developmentally disabled and the combined number of people receiving adult foster care and adult day care does not exceed the number licensed for adult foster care. The commissioner may grant a variance which would allow up to seven individuals to receive adult day care services if the variance is requested as defined in Minnesota Statutes 245A.04, subdivision 9, a second caregiver is present whenever six or more clients are being served and the variance is recommended by the county social service agency in the county where the provider is located.

**Adult Day Care Bath**

Available through: CADI, TBI, EW, and AC (billing code X5293-15 minutes; limited to two units per day). EW & AC only: The second unit may be provided only if the recipient requires longer than 15 minutes to complete the bath; this code may only be used if the recipient has a separate adult day care service approved for the same time period.

EW and AC only: Adult day care providers may provide a bath to a recipient attending adult day care if required, and if the bath is specified on the recipient’s individual plan of care. CADI, TBI, and EW only: Recipients enrolled in a PMAP may not access this service as they receive assistance with a bath as part of their basic PMAP benefit. (The health plan may choose to contract with and pay the adult day care provider to provide a bath.)

Provider Standards:

Providers of adult day care services must be licensed by DHS under Minnesota Rules, parts 9555.9600 to 9555.9730.
Assisted Living Services (aa)

Available through: CADI, EW and AC (billing code X5292-monthly). TBI (X5292-monthly, X5604-daily). CADI, EW, and AC: Providers must not bill for full days on which the recipient is absent.

Assisted living services must be provided by the management of the residential center or by providers under contract with the management or local agency. Individuals receiving assisted living services are not eligible for homemaking services in addition to assisted living services. Assisted living services include “individualized” supports that are chosen and designed specifically for each recipient’s needs. These services may include the following services (however, services are limited to those allowed by the individual site’s home care license):

- **Up to 24 hour supervision and oversight:**
  Supervision is defined as ongoing awareness of the recipient’s needs and activities, which is provided by an employee of the assisted living provider who is not a recipient of services, whose primary job responsibility is to provide supervision to recipients of the congregate living setting, and is capable of:
  
  - Communicating with recipients;
  - Recognizing the need for assistance;
  - Providing the assistance required or summoning appropriate assistance; and
  - Following directions.

  The environment must provide the recipient with a means to summon assistance, and the employee must be able to respond, in person, to the request for assistance within a reasonable amount of time, not to exceed 10 minutes, depending upon the physical plant.

- **Supportive services:**

  Socialization when it is part of the plan of care, has specific goals and outcomes established and is not diversional or recreational in nature, assisting recipients in setting up meetings and appointments, and transportation when provided by the residential center only.

- **Individualized home care aide tasks:**

  - Preparing modified diets, such as diabetic or low sodium diets;
  - Reminding recipients to take regularly scheduled medications or perform exercises;
  - Completing household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease, or when the recipient's care requires it for the prevention of exposure to infectious disease or containment of infectious disease; and
  - Assisting the recipient with dressing, oral hygiene, hair care, grooming and bathing if the recipient is ambulatory and if the recipient has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.
• **Individualized home health aide-like tasks:**
  - Administrations of medications, as provided by subpart 2 of 4668.0100;
  - Performing routine delegated medical or nursing or assigned therapy procedures, as provided by subpart 4, except item C2H;
  - Assisting with body positioning or transfers of clients who are not ambulatory;
  - Feeding of recipients who, because of their condition, are at risk of choking;
  - Assistance with bowel and bladder control, devices and training programs;
  - Assistance with therapeutic or passive range of motion exercises;
  - Providing skin care, including full or partial bathing and foot soaks; and
  - Assistance with hygiene of the recipient’s body and immediate environment, to satisfy nutritional needs, and to assist with the recipient’s mobility, including movement, change of location, and positioning, and bathing, oral hygiene, dressing, hair care, toileting, bedding changes, basic housekeeping, and meal preparation during episodes of serious disease or acute illness. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

• **Home management tasks:**
  - Housekeeping;
  - Laundry;
  - Preparation of regular snacks and meals; and
  - Shopping

Management tasks are provided to recipients of a residential center living in his/her unit/apartment with a full kitchen and a bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space and a kitchen utensil storage compartment.

• **Assisting the recipient with personal funds**

• **Additional services available through providers that are licensed to provide home care services include:**
  - Home health aide;
  - Incidental nursing; and
  - Central storage of medications

Central storage of medication, individualized home health aide tasks, individualized home health aide-like tasks and incidental nursing services may be provided as allowed by home care licensure.

Assisted living services are paid for through a recipient’s waiver. Room and board or rent, while a recipient receives assisted living services, may be paid for through the recipient’s income sources first, which may include: Social Security Disability Insurance, General Assistance, Minnesota Supplemental Aid, or Supplemental Security Income. If the recipient has inadequate income for
room and board or rent charges, he/she may be eligible for Group Residential Housing (GRH) payment to the provider.

**Provider Standards:**

A Class A home care agency and/or Class E assisted living programs meeting the standards and are licensed by the MDH under Minnesota Rules, parts 4668.0002 to 4668.0240. Assisted living home care providers that meet the standard and are licensed by the MDH under Minnesota Rules, parts 4668.0002 to 4668.0870.

A Class A home care license (Medicare certified or non-Medicare certified) or an assisted living home care provider license (available only to a setting registered as a Housing with Services Establishments), or a Class E home care license (only if the setting is a residential center). All home care licenses are issued by the MDH under Minnesota Rules, Chapters 4668 and 4669. Certain settings may be required to register with the MDH as Housing with Services Establishments.

Providers of assisted living services must be licensed by the MDH. Three types of licenses are available which include:

- **Class A Professional Home Care Agency License:** may provide home care services that include nursing, home health aide, therapies, supplies and equipment.

- **Assisted Living Home Care Provider License:** may provide assisted living home care services solely to recipients of registered Housing with Services Establishments that provide sleeping accommodations to one or more adult recipients, at least 80% of the recipients are age 55 or older, and furnishes or arranges for one or more regularly scheduled health-related services or two or more regularly scheduled supportive services for the recipients.

Settings that may register as Housing with Services Establishments include corporate foster care, board and lodge, and residential centers (apartment buildings).

- **Class E Assisted Living Program License:** may provide assisted living services to recipients of a residential center (a residential center means a building or complex of contiguous or adjacent buildings in which clients rent or own distinct living units).

**The following is a list of licensing requirements for the settings (residential centers or registered Housing with Service Establishments) that assisted livings services may be provided in:**

- For recipients not in registered Housing with Services Establishments, assisted living services may be provided in a residential center (apartment building) in the individual’s own unit or apartment. The service may or may not include 24-hour supervision. The provider must hold either a Class A professional home care agency license or a Class E assisted living program license.
For recipients in registered Housing with Services Establishments (80% of recipients over age 55), the provider must hold a Class A professional home care agency license (less than 24-hour supervision), assisted living home care provider license (less than 24-hour supervision), or Class E assisted living program license (may or may not provide 24-hour supervision).

Class A or assisted living home care licensed providers who provide 24-hour supervision are considered Assisted Living Plus providers. For size and location of setting requirements, contact the MDH.

**Assisted Living Plus (aa)**


Assisted Living Plus services are assisted living services with additional requirements. Providers must provide 24-hour supervision and must be registered with the MDH as Housing with Services Establishments. Assisted Living Plus includes all of the individualized assisted living services but must also meet the following criteria:

- Can only be provided in a registered Housing with Services Establishments (80% of recipients over age 55);
- Must be furnished by a provider who holds either a Class A professional home care agency license or an assisted living home care provider license;
- Must include 24-hour, onsite supervision (24-hour supervision means a service which includes ongoing awareness of recipient’s needs and activities which is provided by an employee of the assisted living provider who is not a recipient of services, and whose primary job responsibility is to provide supervision to recipients of the setting). The vendor must provide a means for recipients to summon assistance and the responsible employee must be available to respond in person to the request within a reasonable amount of time.)

Class E, assisted living program licensed providers, may not provide Assisted Living Plus services.

**Provider Standards:**

Class A home care license (Medicare certified or non-Medicare certified) or assisted living home care provider license (available only to a setting registered as a Housing with Services Establishments). All home care licenses are issued by the MDH under Minnesota Rules, Chapters 4668 and 4669. Certain settings may be required to register with the MDH as Housing with Services Establishments. For size and location of setting requirements, contact the MDH.

**Assistive Technology**

Available through: MR/RC (billing code X5671-per item). See [Equipment and Supplies chapter](#) (Ch.23) for examples of MA covered and non-covered items.
Assistive technology refers to the provision of a device or equipment or combination of methods that improve a recipient’s ability to perform activities of daily living, control or access his/her environment, or communicate in his/her community. When specified as necessary to meet a recipient’s needs in the individual service plan (ISP). This service may cover an evaluation of a recipient’s need for an assistive device and, if appropriate, subsequent selection and acquisition of an assistive device, equipment rental during a trial period, procurement, customization, and training and technical assistance to recipients, caregivers and staff to enable a recipient to benefit from the assistive device. This service may also cover maintenance, repair of devices, and rental of equipment during periods of repair.

Items and services reimbursed with waiver funds are those that are not available or have been denied through the Medicaid state plan and exclude items that are not of direct, specific and exclusive benefit to the recipient due to his/her disability. There will be coordination with other services provided to the recipient, such as those through the educational system. The ISP must assure that there is no duplication with other services provided to the recipient, regardless of funding. Items purchased will reflect consideration of all potential methods, devices and equipment to assure the most effective, appropriate, and prudent choice is made. All items must meet applicable standards of manufacture, design and installation. The provision of this service must meet recipient needs in activities of daily living and/or functional communication and address the lack of control over one’s environment that often results in challenging behaviors, thus preventing institutionalization.

Provider Standards:

The service planning team will identify the recipient(s) or entity experienced in the area of assistive technology and its application for recipients with physical disabilities and/or communication deficits and mental retardation or related conditions as qualified to provide the following activities ensuring that:

- An evaluation of the recipient’s need for an assessment of potential for successful utilization of assistive devices occurs;
- The appropriate, prudent and effective device is selected from available options;
- The appropriate device is procured;
- That training and technical assistance to the recipient, caregiver and staff for the proper utilization of the device occurs; and
- That appropriate evaluation methods are developed to assure that the intended outcome(s) of the technology is achieved.

Behavioral Programming

Available through: TBI (X5583-30 minutes, by a professional (bb); X5570-30 minutes, by an analyst; X5582-15 minutes, by a specialist; X5572-15 minutes, by an aide).

Behavioral programming consists of individually designed strategies to decrease the recipient's severe maladaptive behaviors that interfere with their ability to remain in the community. Behavioral programming includes: a complete assessment of the maladaptive behaviors, development of a
structured behavioral intervention plan, implementation of the plan, on-going training and supervision to caregivers and behavioral aides, and periodic reassessment of the plan.

Provider Standards:

Licensed psychologists, clinical social workers, behavioral analysts, and behavioral specialists, behavioral aides may provide the different levels of behavioral programming as follows:

- **A psychologist or a clinical social worker** is responsible for conducting a diagnostic assessment of maladaptive behaviors; developing and implementing the behavioral treatment plan; providing intervention with interpretation of results of services; in-person or telephone consultation; and training and supervision of behavioral staff.
  - **A psychologist** must be licensed under Minnesota Statutes, sections 148.88 to 148.98, and have stated to the board of psychology, competencies in areas related to the diagnosis and treatment of brain injury.
  - **A clinical social worker** must be licensed as an independent clinical social worker under Minnesota Statutes, section 148B.21, subdivision 6.

- **A behavioral analyst** is responsible for designing and overseeing the implementation of behavioral programming in coordination with the psychologist or clinical social worker; providing ongoing analysis in interpretation of the behavioral program data; consulting as needed (e.g., on-call) with other individuals involved with the recipient; participating in progress review meetings; and coordinating with the psychologist or clinical social worker the scheduling, training, and supervision of behavioral staff.
  - A behavioral analyst must have a baccalaureate degree in a social services discipline and three years experience working with persons with behavioral deficits. Two years experience as a behavior analyst may substitute for the above education requirements.

- **A behavioral specialist** must acquire the comprehensive knowledge about the recipient's behavioral plan that is necessary to provide ongoing support for direct care staff in executing the plan. A behavioral specialist is usually associated with the recipient's residential or day program as an "in-house" expert.
  - A behavioral specialist must have an associate’s degree in a social services discipline or two years experience working with persons with behavioral deficits, and a determination, by the psychologist, clinical social worker, or behavioral analyst, that the individual has the skills required to provide behavior modification intervention to the recipient.

- **A behavioral aide** is a member of the direct care staff who is responsible for day-to-day administration of the behavioral plan. A behavioral aide is usually employed by the recipient's residential or day program.
A behavioral aide must have a minimum of four hours of training in understanding the cognitive and behavioral effects of brain injuries, 20 hours of instruction in behavior modification techniques, and a determination, by the psychologist, clinical social worker, or behavioral analyst, that the individual has the skills required to provide behavior modification intervention to the recipient.

### Caregiver Training and Education

Caregiver training and education is a service that provides training and education to a parent or primary caregiver when the primary caregiver is not employed by a corporation to provide supervision and care to a recipient. The requested areas of training and education will be documented as well as potential sources of training and identification of methods by which the caregiver will receive information about training and educational opportunities.

Caregiver training and education may be provided by an individual, agency, or educational facility. The case manager determines which training will be provided to the unpaid caregivers. Examples of caregiver training and education topics are: developmental disabilities, community integration, parenting skills, family dynamics, stress management, intervention strategies, and mental health that are related to the needs of the recipient or the caregiver’s ability to provide care and support to the recipient.

Payment is made for enrollment fees, materials, and any mileage, hotel and meal expenses related to attendance by the primary caregiver. The authorization of expenses must be approved by the case manager. Documentation of expenses such as the course syllabus, workshop description, or training objectives and receipts for any fees and expenses must be submitted to the local county social service agency prior to payment. Payment may be made directly to the primary caregiver by the local county social service agency and the local county social service agency, as an enrolled provider, will submit claims for this service to DHS.

### Provider Standards:

Training and education of caregivers must be provided by health care professionals, such as a public health nurse, registered nurse, licensed practical nurse, or vocational/technical college offering home health aide and certified nursing assistant training.

**EW & AC Program:** Health care professionals, such as public health nurses, registered nurses, licensed practical nurses, physicians, social workers, rehabilitation therapists, gerontologists, pharmacists, vocational and technical colleges offering home health aide and certified nursing assistant training. Training and education of caregivers must be provided by health care professionals such as public health nurses, registered nurses, licensed practical nurses, physicians, social workers, rehabilitation therapists, gerontologists, or pharmacists who have at least one year of experience in providing home care or long term care service to the elderly or at least one year of experience providing training or education to caregivers of elder persons. Physical cares requiring a
specific technique for the safety of both the caregiver and care receiver must be taught by a professional specializing in such techniques such as public health nurses, registered nurses, and licensed practical nurses. Training and education of caregivers may also be provided by vocational and certified nursing assistant training or provided by care or support related organizations (e.g. Alzheimer's Association) when it is determined by the case manager that the content of the training or conference directly applies to the care and well being of the recipient.

**Case Management**


All recipients receiving program services are required to have a case manager assigned when their plans of care are developed. The case manager is responsible for: Assisting the recipient in locating and gaining access to necessary waiver services as well as medical, social, educational, or other needed services, regardless of the funding source; coordinating the plan of care; monitoring services so the recipient's health and safety are assured; and conducting reassessments.

**Provider Standards:**

Case management services may be provided by a public health nurse, registered nurse, or social worker employed by the local agency. If the case manager is not a county employee, then the provider of services will be required to execute a contract with the agency in order to provide case management. Case Managers, with the exception of county employees, may not have a financial interest in the provision of services.

**Case Management Access/Conversion**

Available through: MR/RC (billing code X5455-one time, case management access). AC (billing code X5477-case management conversion). AC case management conversion is available when the AC recipient is not eligible for MA. It is used to provide case management activities while the recipient is admitted to a nursing facility and it is anticipated that the recipient will return to the community with AC services.

**Case Management Aide/Paraprofessional**

Available through: CAC, CADI, TBI, EW & AC (billing code X5491-15 minutes).

Case management aides provide assistance to the case manager in carrying out administrative activities of the case management function. The case management aide may not assume responsibilities requiring professional judgment including assessments, reassessments, and care plan or community support plan development. The case manager is responsible for providing oversight of tasks delegated to case management aides.
Provider Standards:

The case management aide must be a high school graduate with one year of experience as case aide or in a closely related field. One year of education beyond high school (e.g., business school, college) may be substituted for the experience. The case management aide/paraprofessional must understand, respect, and maintain confidentiality in regard to all details of the case. The case management aide is employed by the county and receives oversight from the case manager.

Cash Payments

Available through: AC only (billing code X5526 - grant). The county bills DHS and gives the cash payment to the recipient. The payment may be in the form of cash to the recipient, a voucher for services, or direct county payment to the vendor. The service provider receives payment from the recipient.

Counties must obtain approval from DHS before using cash payments. Providers interested in offering this service should contact the county. Providers may furnish services without enrolling with DHS. The recipient controls the selection, training, supervision and dismissal of providers for services paid by cash payments. The county assists the recipient in this process when necessary. Limit is 80% of client’s case mix cap.

Chore Services

Available through: TBI, MR/RC, EW & AC (billing code X5268-30 minutes).

Chore services are used to maintain the recipient’s home in a clean, sanitary, and safe environment. This includes heavy household chores such as washing floors, windows, and walls, cutting grass, putting up and taking down storms and screens, fixing loose rugs and tiles, basic home maintenance, moving heavy items in order to provide safe access inside the home for the recipient and shoveling snow to provide access and egress.

This service will be provided only in cases where neither the recipient nor anyone else in the household is capable of performing or financially providing it and where no other relative, caretaker, landlord, county agency, community volunteer/agency or third party payer is capable of or responsible for its provision. For MR/RC, chore services may be provided when the individual or his/her primary caregiver is not capable of performing the household tasks or when the provision of the chore services allows the caregiver to provide other needed supports to the recipient with a disability. Other sources of funding (e.g., CSSA/Title XX) or in the case of rental property, the responsibility of the landlord pursuant to the lease agreement, will be investigated prior to any authorization of service.

EW and AC Programs: Chore service may also include customary service charges made for the delivery of grocery store products when those products represent the majority of the consumer’s total grocery needs for a minimum seven day period. The payment of grocery delivery service charged may be funded by the Elderly Waiver if all of the following conditions are met:
• The amount of the service charge is common and customary within the recipient’s community;
• The products delivered represent the majority of the consumers total grocery needs for a minimum seven day period;
• Payment of a grocery deliver fee is the most cost effective method available to procure consumer required grocery store products; and
• Any assistance the person may require ordering, receiving, or storing the groceries is available to them.

Provider Standards:

It is the responsibility of the county agency to ensure that the services provided meet the minimum standards including that the chore services provider is approved by the county, who will also monitor the service, ensuring the quality of services provided by a private vendor is at least equal to that which county chore services would provide. Local agencies are responsible to assure that the chore services meet the recipient’s health and safety and are cost-effective and are directed at the outcomes desired by the recipient. Provider qualifications necessary to meet an individual’s needs and references will be specified in the recipient’s individual care plan.

Cognitive Therapy

Available as an extended MA service through: TBI (billing code X5584-30 minutes—by Professional, Extended (bb); X5574-15 minutes, by a BA/BS personnel, extended).

Cognitive therapy is specifically designed to improve cognitive functions such as attention, concentration, information processing skills, learning, memory, planning, problem solving, executive functions (processes by which a person plans, prioritizes, organizes, sets goals, executes strategies, and monitors personal behavior), self-control, and visual-spatial deficits. Cognitive therapy may be provided to the recipient on an outpatient basis or in the community as specified in the approved plan of care.

Provider Standards:

Cognitive therapy may be provided by baccalaureate degreed individuals under the TBI waiver, and by a licensed psychologist, occupational therapist, or speech-language pathologist.

Companion Services

Available through: TBI, EW & AC (billing code X5261-30 minutes).

Companion services consist of non-medical care (e.g., supervision and socialization) provided to a functionally impaired adult. A companion may assist the recipient with such tasks as meal preparation, laundry and shopping but does not perform these activities as discrete services. A companion may also perform light housekeeping tasks that are incidental to the care and supervision of the individual and also may accompany the individual into the community. Companion services
are provided in accordance with a therapeutic goal in the plan of care (e.g., not diversional in nature).

**Provider Standards:**

A companion must be able to read, write, and follow written and oral instructions. A companion must have had experience and/or training in homemaking skills, and/or in care of individuals with disabilities or brain injuries. He or she must have the ability to converse effectively on the telephone, to work under intermittent supervision, and to manage emergency situations effectively. A companion must understand, respect, and maintain confidentiality in regard to case details. To receive reimbursement under the waiver, a companion cannot be the recipient's legal guardian or related to the recipient as a spouse or other relative.

**Consumer-Directed Community Supports (CDCS)**

Available through: MR/RC (X5503-hourly; X5504-daily; X5506-monthly).

CDCS services provide support, care and assistance to recipients with disabilities. These services prevent institutionalization and allows recipient to live an inclusive community life. They are designed to build, strengthen or maintain informal networks of community support for the recipient.

When paying the legal representative to provide supports under CDCS, the recipient’s support plan should include, but is not limited to:

- The recipient’s preference for the support provider;
- The role of the legal representative as a paid provider under CDCS, must be clearly outlined and the specific duties identified. The duties under CDCS must also be clearly differentiated from those duties provided as a legal representative;
- Identification of conflict of interest, if any, and resolutions; and
- The health, safety, and welfare of the recipient.

CDCS services include the following specific activities at the request and direction of the recipient or his/her legal representative:

- Provision of services and supports which assist the recipient, family, or friends to identify and access formal and informal support systems, develop a meaningful recipient support plan, or increase and/or maintain the capacity to direct formal and informal resources.
- Completion of activities that assist the recipient, his/her family, or his/her friends to determine his/her own future.
- Development of person-centered support plans that provide the direction, assistance and support to allow the recipient with a disability to live in the community, establish meaningful community associations, and make valued contributions to his/her community.
- Ongoing consultation, community support, training, problem solving, and technical assistance to assure successful implementation of his/her person-centered plan.
- Development and implementation of community support strategies that aid and strengthen the involvement of community members who assist the recipient to live in the community.
The recipient, his/her legal representative, and the county agency will assure that recipient-directed community supports are not duplicative of any other service provided to the recipient. The legal representative is the person who has the legal authority to make informed consent decisions on behalf of an adult recipient. Parents of minors, professional guardians and professional conservators are excluded from receiving payment through CDCS. The exclusion also applies to county case managers who act as the legal representative on behalf of the State and to the recipients with MR/RC who is his/her own guardian. Components of the CDCS will be documented as necessary to prevent the recipient’s institutionalization in the individual service plan/personal support plan. Additionally, the county agency must document how the community support services enable the recipient to lead an inclusive community life, build a viable network of support, and result in outcomes specified by the recipient or his/her legal guardian.

**Legal Representative Screening Team Responsibilities:**

If a person has a legal representative, the representative is required to be a member of the screening team for a person with developmental disabilities. In general, members of the screening team have not been able to have a “service provider interest” with the individual. Under CDCS, the legal representative is not considered to have a direct or indirect service provider interest. This allows the legal representative to continue to participate on the screening team, regardless of becoming a paid provider of supports to the recipient.

**Payment Parameters:**

Minnesota will cover CDCS services in areas of the state in which local agencies have memorandums of understanding with the state agency to demonstrate the feasibility and effectiveness of CDCS. Local agencies offering CDCS services will:

- Provide recipient education and assistance in areas of self-determination and person-centered planning,
- Incorporate practices to develop and implement CDCS;
- Support options in their local written procedures and criteria for the allocation of home and community based waiver resources;
- Establish mechanisms which allow recipients to exercise control and responsibility over their supports; and
- Refine outcome-based quality assurance methods.

Local agencies’ written procedures and criteria will specify their responsibilities to provide information about CDCS options, to assist recipients in accessing and developing the desired support(s), and to assist in securing administrative assistance to implement the support(s).

Authorization of resources for the purposes of purchasing CDCS services will be made on the local level based upon factors outlined in the agency’s written procedures and criteria. These factors may include the recipient’s functional skills, his/her environment, the supports available to the recipient, and the specialized support needs of the recipient. Costs associated with CDCS will be managed within a county’s unique allowable average to provide the flexibility to meet the preferences and needs of recipients in the most effective and efficient manner.
The Medicaid agency will pay providers through the use of a limited fiscal agent who function to pay waiver claims to implement self-determination initiatives. Providers may voluntarily reassign their right to direct payments to county social service agencies to implement self-determination initiatives.

**Provider Standards:**

CDCS services will be provided by entities or individuals that meet the unique needs and preferences of the recipient as specified in the recipient’s individual service plan or personal support plan. The service planning team will document in the individual service plan or personal support plan the specific training, experience, and/or education standards required to meet the unique needs and characteristics of the recipient. Local agencies are responsible to work with the recipient and his/her legal guardian to assure the CDCS services meet the recipient’s health and safety needs, personal preferences, and are directed at the desired personal outcomes. Local social service agencies must verify that the provider has met the identified standards and must monitor the provision of CDCS.

**Consumer Training and Education**

Available through: MR/RC (billing code X5502-Unit/course/item, etc.) (cc)

Consumer training and education is a service designed to help a recipient with a disability develop his/her self-advocacy skills, exercise his/her civil rights, and acquire skills that enable him/her to exercise control and responsibility over the supports he/she receives. Areas of training and education that achieve these outcomes will be documented as necessary in the recipient’s individual service plan or personal support plan. Local agencies will assure that the recipient and his/her legal guardian receives necessary information on training and educational opportunities. Documentation of the outcomes and benefits of the recipient’s participation in specific education and training will occur in the individual service plan or personal support plan.

Consumer training and education will be provided by individuals, agencies or educational facilities which have expertise in areas such as consumer empowerment, CDCS, self-advocacy, community inclusion, relationship building, problem solving and decision-making. MA covers enrollment fees, materials, transportation, hotel and/or meal expenses related to participation in the consumer training and education. It can include person-centered planning assistance from individuals or agencies other than county case managers. Resources to allow a recipient to attend a needed training or educational experience may be prior authorized by the local agency. The local agency, as an enrolled MHCP provider, will submit claims for this service to DHS. Payment may be directed to the recipient by the local agency to allow him/her to receive the needed training or education. Documentation of expenses may include the course syllabus, workshop description, or training objectives. Receipts for allowable fees and expenses must be submitted to the local agency to verify accurate payment.

**Crisis Respite**

Available through: MR/RC (X5685-15 minutes specialized; X5664-daily; X5665-hourly).
Crisis respite services are specialized services that provide short-term care and intervention to an individual due to the need for relief and support of the caregiver and protection of the recipient or others living with the recipient. Crisis-respite services will include the following recipient specific activities:

- Assessment to determine the precipitating factors contributing to the crisis;
- Development of a provider intervention plan in coordination with the service planning team;
- Consultation and staff training to the provider(s) and/or caregiver(s) as necessary to assure successful implementation of the recipient specific intervention plan;
- Development and implementation of a transition plan to aid the recipient in returning home if out of home crisis-respite was provided;
- On-going technical assistance to the caregiver or provider in the implementation of the intervention plan developed for the recipient; and
- Provision of recommendations for revisions to the 24-hour plan of care (individual service plan) to prevent or minimize future crisis situations in order to increase the likelihood of maintaining the recipient in the community.

Crisis respite services provide specific intervention strategies directed towards enabling the recipient to remain in the community. These services are a necessary service component of the 24-hour plan of care that is developed and monitored by the case manager and, as such, do not duplicate those services provided through case management.

Crisis respite services can either be provided to the recipient in his or her home or, when necessary for the relief of the caregiver and the protection of the recipient or others living in the home, in a specialized licensed foster care facility developed for the purpose of providing short-term respite and crisis intervention. Payment for out-of-home crisis respite will include payment for room and board costs when the service is provided in a licensed foster care facility developed for the provision of crisis-respite that is not a private residence.

The following criteria must be met for a recipient to receive crisis-respite services:

- The caregiver and service providers are not capable of providing the necessary intervention and protection of the recipient or others living with the recipient;
- The crisis-respite service(s) will enable the recipient to avoid institutional placement;
- The use of out-of-home crisis respite will not exceed 21 days except when authorized as part of an approved regional plan or by the Commissioner’s designee upon evidence of need, assurances that the extension will not result in the recipient’s inability to return home or to an alternative home in the community, and that the continued use of the crisis respite service is a cost-effective alternative to institutionalization; and
- The recipient has been screened and authorized as eligible to receive home and community-based services. Unlike other waiver services, the crisis respite service must be immediately available to a recipient as an alternative to institutional placement. Because of this, the determination of eligibility and modifications to the plan of care may occur within five working days of receiving crisis respite services. However, no MA payment will be made if the screening process determines that the recipient is not eligible for home and community-
based services. The screening process is the same and uses the same instrument as used for all evaluations of eligibility for ICF/MR or home and community-based services.

All local county agencies and providers of crisis services seeking MA home and community-based reimbursement for crisis respite services must have an annually approved provider agreement. The provider agreement specifies local agencies’ responsibilities, provider responsibilities, the services to be provided, the network of specialized service providers to be utilized the annual projected costs of the crisis respite services, the administrative responsibilities of the participating agencies, how the utilization and effectiveness will be monitored, and how the overall MA cost-effectiveness of the service will be assured.

Payment Parameters:

The MR/RC Waiver will pay a provider of residential services licensed under Minnesota Statutes, Chapter 245B, when a recipient receives out of home crisis respite services and the services are authorized as necessary in the recipient’s plan of care to maintain community placement for the recipients. The provider is reimbursed for services rendered, such as 1) consultation with the crisis respite provider related to the assessment of precipitating factors leading to the crisis and development of the intervention plan; 2) planning for the recipient’s transition home; 3) provider staff training necessary to implement the intervention plan; and 4) other allowable supportive living services and costs necessary to assure continued community placement. Only those allowable services and costs that are within the service parameters of the supported living services (SLS) definitions as described in the approved waiver plan will be reimbursed. Payment to the provider may not exceed 21 days while the recipient is receiving out of home crisis respite services.

Crisis respite services do not duplicate other services provided to the recipient, as they will only be provided when the service provider is not capable of providing the necessary care and intervention and the crisis respite services have been determined necessary to prevent costly institutional placement. If at any point, the residential provider states they will no longer continue to provide services to the recipient, no payment will be made to the residential provider effective as of the date the recipient entered the out of home crisis respite service. If the residential provider refuses to provide services to the recipient after the crisis respite service has been completed, any and all payments made to that residential provider for that recipient during the out of home crisis respite service must be paid back to the State by the residential provider.

Provider Standards:

Crisis respite services will be provided by entities licensed under Minnesota Statutes, Chapter 245B, residential habilitation, and, if out of home crisis intervention, will be provided in a location licensed under Minnesota Rule, parts 9545.0010 - 9545.0260 or Minnesota Rule, parts 9555.5105 - 9555.6265 (Child and Adult Foster Care licensing rules). These licensing standards are the same as those required for providers of residential habilitation services and have been previously approved as part of Minnesota’s Waiver Plan. The service planning team has the ability to require additional provider qualifications when determined necessary for the crisis-respite provider to appropriately meet individual recipient needs. Additional provider qualifications necessary to meet a recipient’s unique needs will be specified in the recipient’s plan of care.
DD Screening

Available through: MR/RC (X5400-per screening).

Day Training and Habilitation (see detailed description under Habilitation Services section)

Available through: MR/RC (X5679-Partial Day; X5680-Full Day; X5681-Transportation; DT&H Pilot Rates (X5296-60 minutes-Rate A; X5297-60 minutes-Rate B; X5298-60 minutes-Rate C; X5299-60 minutes-Rate D).

Day training and habilitation (DT&H) provides training, supervision, and assistance to help a recipient develop and maintain vocational and daily life skills and become more involved in the community. These services are coordinated with residential services.

Rates are provider specific and are negotiated between the provider and county.

Discretionary Services

Available through: AC (X5527—the county bills the State). The service provider receives payment from the county.

Counties must obtain approval from DHS before using discretionary services. Providers interested in offering these services should contact the county. Providers may furnish these services without enrolling with DHS. Discretionary services are home and community-based services paid by the county to a provider that are not provided elsewhere in AC statute. Discretionary services are administered similar to AC services that are defined in statute; the most significant difference is that the county, not the state, defines the discretionary service and the provider qualifications required to provide the service.

Provider standards:

Set by the county.

Environmental Modifications (see detailed description under Modifications and Adaptations section)

Available through: MR/RC (X5419-per item). Examples of covered and non-covered items and limitations can be found in Equipment and Supplies chapter (Ch. 23).

Environmental modifications are equipment and physical adaptations to a recipient’s home and/or vehicle necessary to help the recipient have greater independence. This service includes only modifications to the home or vehicle that are of direct and specific benefit to the recipient due to his or her disability.
Extended Personal Care Attendant (see Personal Care Attendant Services - Extended for description)

Family Counseling and Training:

Available through: CADI and TBI (X5460-15 minutes); CAC (billing code X5676-15 minutes-Family Counseling; billing code X5677-15 minutes-Family Training).

Family counseling and training includes services for the recipient as well as the family with whom he/she lives or who routinely provide care. Family is defined to be the persons who live with or provide care to a recipient and may include spouse, children, friends, relatives, foster family, or in-laws. Family does not include individuals who are employed to care for the recipient.

Counseling may include helping the recipient and/or his or her family members with crisis management, coping strategies, stress reduction, etc.

Training is for the purpose of increasing the recipient's or family member's capabilities to maintain and care for the recipient in the community. It includes use of equipment and treatment regimes as specified in the care plan. Periodic training updates may be necessary to safely maintain the recipient in the community.

Provider Standards:

All vendors who provide training services must be Medicare certified and/or enrolled as an MA provider and qualified as a/an:

- Physician currently licensed to practice in Minnesota;
- Registered nurse currently licensed in Minnesota;
- Social worker who is a graduate of a school of social work accredited by the Council on Social Work Education and must meet the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota;
- Physical therapist who is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association;
- Occupational therapist currently registered by the American Occupational Therapy Association;
- Respiratory therapist who is a graduate of a program in respiratory therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Respiratory Therapy Association;
- Medical equipment supplier enrolled as an MA provider;
- Speech-language pathologist with a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association;
- Nutritionist with a minimum of a bachelor’s degree who is registered by the Commission on Dietetic Registration;
• Mental health professionals who is licensed and/or qualified according to the Minnesota Comprehensive Adult or Children’s Mental Health Acts (Minnesota Statutes, sections 245.462 or 245.4871). Mental health professionals include:
  - Psychiatrists
  - Psychologists
  - Psychiatric nurses
  - Clinical social workers
  - Marriage and family therapists
  - Person with a master’s degree in an allied field with at least 4,000 hours of post-master’s supervised experience

• Independent practitioner who provides counseling services and who has been determined by the lead agency to have:
  - General knowledge of disabilities and chronic illnesses that may affect individual or family functioning.
  - Skills in mental health assessment, including client interviewing and screening.
  - Skills in mental health management including treatment planning, general knowledge of social services, record keeping, reporting requirements, confidentiality rules, and any federal or state regulations which apply to mental health services.
  - Skills in individual or group counseling, including crisis intervention.
  - Proof that:
    - The individual possess at least a bachelor’s degree with a major in social work, nursing, sociology, human services, or psychology and has successfully completed 960 hours of experience as a counselor supervised by a licensed psychiatrist or psychologist. The experience can be either as a student, volunteer, or employee.
    - The individual has successfully completed two years of supervised experience as a counselor or therapist.

Counseling services may be provided by an MA enrolled mental health professional.

**Foster Care**

Available through: CADI (kk), TBI (kk), CAC (X5449-daily-TBI (aa) and CAC (dd)); X5450-monthly-CADI, CAC (dd) and TBI (aa); EW & AC (aa)(X5450-monthly-family adult foster care; X5363-monthly-corporate adult foster care).

**Adult foster care** is available to a recipient 18 years of age and older. Adult foster care is defined as a licensed, adult-appropriate, sheltered living arrangement for up to four functionally impaired adults in a family-like environment. Adult foster homes provide food, lodging, protection, and household services. They may also provide living-skills assistance or training, medication assistance, assistance safeguarding cash resources, care giving, homemaking, oversight and supervision, and transportation, etc.
Child foster care is available to CADI, TBI, and CAC recipients under the age of 18 years. Child foster care is defined as the provision of ongoing residential care and supportive services to enable the child to be cared for in a setting other than with his/her natural family unit.

Provider Standards for Adult Foster Care:

Providers of adult foster care must be licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 or certified as an adult foster care provider by the county. For EW only: a relative may be certified under a hardship waiver by the county to be an adult foster care provider. For EW and AC only: Adult foster care providers may be licensed for up to five adults per home if all foster care recipients age 55 or older, have no serious and persistent mental illness nor any developmental disability. Cost of room and board (shelter, food, utilities, household supplies, etc.) is covered by other resources, such as Social Security Disability Insurance (SSDI), General Assistance (GA), or Supplemental Security Income (SSI). Additional payment for room and board, beyond the recipient’s contribution, may be subsidized by Group Residential Housing (GRH).

Provider Standards for Child Foster Care:

Providers of family foster care are licensed under Minnesota Statutes, section 245A. Cost of room and board in the base foster care rate is covered by other resources such as SSI. In addition to the base rate, a difficulty of care rate may be established by the county of financial responsibility. The difficulty of care may be provided under Title IV-E.

Waiver funds may not be used to reimburse any room and board expenses or duplicate services paid by other sources. Program services beyond room and board, and for children beyond difficulty of care, may be covered under the waivers. These include care giving services, homemaking, oversight and supervision of the recipient, behavioral staff, etc.

Habilitation (In-Home Family Support Services, Supported Living Services, Day Training and Habilitation Services)

Available through: MR/RC (In-Home Family Support- X5417-30 minutes, X5418-day; Supported Living-Adult- X5415-30 minutes, X5416-day, X5398-monthly & bi-monthly; Supported Living-Child- X5413-30 minutes, X5414-day, X5399-monthly & bi-monthly; Day Training and Habilitation- X5679-partial day, X5680-full day, X5681-transportation; DT&H pilot rates- X5296-60 minutes-Rate A, X5297-60 minutes-Rate B, X5298-60 minutes-Rate C, X5299-60 minutes-Rate D).

Habilitation services are directed towards increasing and maintaining the physical, intellectual, emotional, and social functioning of recipients with mental retardation or related conditions through the delivery of health and social services in order to avoid institutionalization. Habilitation services include therapeutic activities, monitoring, supervision, training, or assistance to a recipient in the following areas: self-care, sensory/motor development, interpersonal skills, communication, reduction/elimination of maladaptive behavior, community living and mobility, health care, leisure and recreation, money management and household chores.
Habilitation services will be provided either directly by or under the supervision of a qualified mental retardation professional as defined in 42 CFR 442.401. In addition to services provided by direct care staff, supportive services, in the areas of behavior management, medical, and therapeutic services, will be provided by professionals within the scope of their practice.

Respite care and homemaker services may also be provided for recipients needing habilitation services. The following is a description of the types of habilitation services to be offered.

**Residential Habilitation Services:**

These services are provided to individuals who cannot be maintained at home or who need outside support to remain in their homes. Recipient room and board costs for recipients receiving supported living services (SLS) will not be paid through MA. In Minnesota, room and board payments for adult SLS recipients are made through a combination of county and Title IV-E funds. Room and board payments made through these sources are for the usual costs related to the recipient’s full nutritional regimen, shelter, and furnishings as well as the usual costs related to property administration, maintenance, upkeep, and improvements. When there is more than one recipient benefiting from room and board provided at the same facility, the room and board costs are apportioned among all beneficiaries to determine the payment amount for each recipient. For recipients living in their family home and receiving in-home family support services there are no room and board payments available to families from any sources including the waiver.

**Changes in Supported Living Services for adults and children:** Effective July 1, 2001, SLS provided in the following living arrangements are not reimbursable through the MR/RC waiver:

- Services provided in an institution or in a living setting on the same property as an institution. Institution means a nursing facility, hospital, intermediate care facility, or institute for mental disease.
- Services are only reimbursable at one home when provided in single- family homes or multiplex homes on adjoining properties when the homes are owned or leased by a single license holder. A multiplex is considered a home for the purposes of this language. Examples include, but are not limited to, apartment complexes, town homes, twin homes, and condominiums.

Minnesota’s home and community-based waivers will continue to pay for costs for modifications or adaptations to a licensed facility or home where the waiver recipient resides which are required to ensure the health and safety of the recipient or to meet the requirements of the applicable life safety code. Waiver funds will not be used to reimburse activities or supervision for which payment is available by sources other than MA.

- **In-Home Family Support Services:** These are habilitation services provided to recipients with mental retardation or related conditions and their families, including extended family members who are not providing licensed foster care, in the family’s home, and in the community, to enable the recipient to remain in or return to the home. In-home family support services include training of the recipient and training of the family to increase their capabilities to care for and maintain the recipient in their home. Services will be provided by
individuals or agencies approved by the state for such purposes.

- **Supported Living Services for Children:** This program involves the provision of habilitation services to children and adolescents with mental retardation or related conditions who require daily staff intervention due to severe behavior problems, medical conditions, physical deficits, and/or lack of adequate survival skills which result in a family’s inability to maintain them in their home. Services will be provided outside of the biological or adoptive homes in family-style settings for up to four recipients and in the community.

- **Supported Living Services for Adults:** This program offers habilitation services to adults with mental retardation or related conditions who require daily staff intervention due to behavior problems, medical conditions, physical deficits, and/or lack of adequate survival skills. Daily staff intervention means direct care or professional staff providing on-site supervision, training or assistance to a recipient in the following areas: self-care, sensory/motor development, interpersonal skills, communication, reduction/elimination of maladaptive behavior, community living and mobility, health care, leisure and recreation, money management and household chores. Services will be provided in a recipient’s own place or residence, specialized adult foster homes, and group homes for up to four persons and under restricted conditions specified by Minnesota Statute (section 252.28, subdivision 3, item 4) and rule for up to six persons and in the community.

**Day Habilitation**

This service will only be offered as a waiver service to individuals who receive at least one residential service offered under this waiver request. Residential services include all residential habilitation services as well as respite and homemaker services. Day habilitation services are directed at the development and maintenance of life skills and community integration.

The services include supervision, training, and assistance in the areas of self-care, communication, socialization, use of leisure and recreation time, and behavior management as well as training in community survival skills, money management, and therapeutic activities designed to increase an individual’s adaptive living skills.

Day habilitation services will typically be provided away from an individual’s place of residence. Exceptions will be authorized by the state Medicaid agency based on circumstances such as need for alternatives to day habilitation services for older recipients or recipients with overriding medical conditions. The hours or service per day will be based upon recipient’s individual needs and functioning. All day habilitation services will be coordinated with the recipient’s residential habilitation services by the case manager.

Non-medical transportation services are also provided by day habilitation providers to enable individuals to participate in these services. This is particularly critical in Minnesota where people are dispersed geographically and may need to travel significant distances between their residential and day program sites.
Habilitation services may not include special education and related services as defined in the Education of the Handicapped Act (20 U.S.C. 1401(6), (17)) which otherwise are available through a local educational agency or vocational services funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended. A finding that such services are not otherwise available through a program funded under Section 110 of the Rehabilitation Act of 1973 must be based on written documentation that the individual; (1) is not considered an appropriate referral to the Division of Rehabilitation Services because the individual satisfies on or more of the Screen-Out Criteria, or present an unfavorable Applicant Profile as described in Section 26520.025 of the social Security Administration Program Operations Manual System; or (2) has been referred to the Division of Rehabilitation Services, but was found to be ineligible for vocational services under Section 110 of Rehabilitation Act; or (3) has been a recipient of section 110 services provided by the Division of Rehabilitation Services, but is no longer eligible for such services; or (4) is a current recipient of the Division of Rehabilitation Services, but the activities that are provided under the definition of supported employment services are not typically available as Section 110.

**Billing for Business Supported Employment Through a DT&H**

When a Day Training and Habilitation vendor enters into an agreement with a business whereby the business agrees to provide direct support to individuals while those individuals work at the business and all the criteria (Minnesota Statutes, sections [252.45](#) and [252.451](#)) are met, the vendor must bill with the following procedure codes:

- X5656 - Day program, business supported employment, full day
- X5657 - Day program, business supported employment, partial day

**Home Delivered Meals**

Available through: CADI, TBI, EW & AC (X5264-one meal per day).

A home delivered meal is an appropriate, nutritionally balanced meal that meets one-third of the current daily recommended dietary allowance (RDA) served in the home of a waiver recipient. For AC and EW only: A home delivered meal may also be delivered to the recipient in a common dining space which is separate from their apartment only if it is located in the building in which they reside. The recipient has a choice of delivery sites and may not be required to accept their home delivered meal in a common dining space (even though one may exist in the building in which they reside) but may request their meal be delivered to their apartment.

This service is essential to preventing institutionalization because of the absence of proper nutrition in an individual with a disabling condition presents severe risks to health and an accompanying risk of institutionalization.

Home delivered meals may be provided to recipients who are unable to prepare their own meals and for whom there are no other persons available to do so, or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal.
All home delivered meals provided must contain at least 1/3 of the current Recommended Dietary Allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council. Modified diets, where appropriate, will be provided to meet the recipient's individual requirements. Menu plans will be reviewed and approved by a Registered Dietician.

**Provider standards:**

Hospitals, schools, restaurants or any agency providing home delivered meals must comply with all state and local health laws and ordinances concerning preparation, handling and serving of food as defined under Minnesota Rules, parts 4626.0010 to 4626.1870. Insulated hot and cold containers must be used on delivery routes to assure that food reaches the recipient at appropriate temperatures.

A contract for the delivery of one home delivered meal per day may be developed with a qualified home delivered meal provider. The provider must meet the provider qualifications above, must be enrolled MHCP home delivered meal provider, and must submit home delivered meal claims to DHS. If the payment for the home delivered meal is made to the Assisted Living or Assisted Living Plus (AL/AL+) provider, who, prior to contracting for the home delivered meal was paid for the preparation cost of the same meal, counties must adjust the AL/AL+ service payment to reflect the shift of preparation costs from the AL/AL+ payment to the home delivered meal payment.

**Determining payment rates for home delivered meal providers:** The waiver will not supplant other funding sources for all waiver and programs.

**EW and AC specific funding requirements:** Providers of home delivered meals may have multiple funding sources to support their business. To assure the AC or EW programs are not supplanting other funds, understanding the funding source(s) and funding amounts each HDM provider receives is critical in developing provider contracts. In particular, funding distributed to HDM providers through contractual agreements with Area Agencies on Aging (AAA’s) should not be supplanted by EW or AC funding.

- **Title IIIC Funding:** Home delivered meal providers who contract with Area Agencies on Aging (AAA’s) for funding to support their program may be receiving funds available from Title IIIC of the Older Americans Act, USDA funding, or state grants. These funds are all distributed by AAA’s through a contractual agreement with the provider. Specific revenue sources may be defined, including all other grants and anticipated client contributions in these contracts. Counties may find these contracts helpful in identifying provider revenue resources in determining the portion of the meal cost met by other revenue sources.

- **No Receipt of Title IIIC Funding:** Although some HDM providers do not receive any Title IIIC funding, USDA funding, or state grants funding, they may receive funding from other sources such as grants from organizations (such as United Way) and grants from local government or revenue from client contributions. Information about providers’ other funding sources is essential to assure waiver and AC funds are not supplanting other funds and negotiated rates do not exceed the cost of the home delivered meal.

Neither AC nor EW clients may be required to make a contribution to their meal cost or be asked to pay for a portion of their meal cost.
Home Health Services

The following extended home health services are used only after exceeding either the amount, duration, or scope of the home care services available to all MA recipients, except for individuals on the AC program. The AC services listed below are not extended services, as there would have been no equivalent home health services billable against MA before accessing these home health services through AC.

CADI, TBIW, CAC, EW (Home Health Aide, Extended: X5650-15 minutes)
AC (Home Health Aide: X5661-daily; X5660-15 minutes)

AC (LPN, Home Health: X5662-15 minutes; LPN, Shared Home Health 1:2: X5662-52 modifier-Y for shared care-15 minutes)

CADI, TBIW, CAC (LPN, Complex Home Health, Extended (II): X5437-15 minutes)

CADI, TBIW, CAC (Occupational Therapy, Extended Home Health: X5429-15 minutes)

CADI, TBIW, CAC (Physical Therapy, Extended Home Health: X5426-15 minutes)

AC only (RN, Home Health: X5663-15 minutes; RN, Shared Home Health 1:2: X5663-52 modifier-Y for shared care-15 minutes)

CADI, TBIW, CAC (RN, Complex Home Health, Extended (II): X5434-15 minutes)

CAC (RN, Supervision of Independent Private Duty Nurse [PDN]: X5441-15 minutes)

CADI, TBIW, CAC (Respiratory Therapy, Extended Home Health: X5430-15 minutes)

CADI, TBIW, CAC (Speech Therapy, Extended Home Health: X5427-15 minutes)

AC (RN, Supervision of a PCA: X5289-15 minutes)

Home health services include care by home health aides, registered nurses, licensed practical nurses, and occupational, physical, respiratory, and speech therapy. For EW and AC: therapies are not available as extended services.

Provider Standards:

A Home Health Agency (HHA) must be enrolled as an MHCP provider, have a Class A home care license issued by the MDH, and be Medicare certified to provide home health.
Notice to Interested Nurses:

Independent (self-employed) PDNs must enroll as providers of MA services with DHS. RNs and LPNs interested in providing private duty nursing without being an employee of a home care agency are encouraged to contact the DHS Provider Enrollment to request an application. Independent PDNs should also contact county social service agencies to inform waiver case managers of their availability to provide PDN services. LPNs providing independent private duty nursing are required to hold a Class A home care license through the MDH. RNs are exempt from this requirement.

Nursing agencies, independent PDNs and county case managers are to use the same procedure codes and rates for independent PDNs that are used for PDNs employed by agencies.

Homemaker Services

Available through: CAC, CADI, MR/RC, TBI, EW & AC (X5655-15 minutes-Homemaker-all program types); EW & AC only (X5479-daily).

Homemaker services are those residential services that provide general household activities by a trained homemaker when the individual (beneficiary), family member(s), or primary caregiver regularly responsible for these activities is temporarily absent, or unable to manage the home and care for himself/herself or others in the home. Homemaker Services will be directed toward enabling an individual to remain in the community and thus avoid institutionalization. Homemaker services include meal preparation, routine household care, shopping and errands, assisting with daily activities, arranging transportation, providing emotional support and social stimulation, and monitoring safety and well being.

Provider Standards:

A homemaker must have a minimum of 24 hours of training during the first year, and six hours training annually thereafter. Such training will include courses in homemaking skills, child and personal care, human growth and development, the aging process, nutrition, home management, and training in working with recipients who have mental retardation, mental illness, chemical dependency, physical handicaps, and family malfunction.

A homemaker may only provide services in the individual service plan.

For the MR/RC Waiver, local county social service agencies may grant a variance to the requirement that homemaker providers meet certification requirements in Minnesota Rule, part 9525.1200 governing provision of homemaker services, when the individual service plan specifically states that the homemaker is only providing light housekeeping and is not responsible for training to the recipient or for monitoring the well being of the recipient. The provider of homemaker services must have the ability to perform the duties expected and be a cost effective alternative to certified homemaker providers.
Housing Access Coordination

Available through: MR/RC (X5666-hourly; X5667-per occurrence).

The purpose of this service is to help recipients make choices about where to live, the type of home the recipient wishes to have, and who will be a roommate(s), if any. This service helps the recipient to identify affordable, accessible housing and assures that housing needs are provided for separately from other service needs. It may also include assistance in identifying options and making choices, planning for ongoing maintenance and/or repair of the home, and identification of financial resources such as eligibility for housing subsidies and other benefits.

Independent Living Skills

Available through: CADI (X5590-30 minutes), TBI (X5590-30 minutes-Independent Living Skills, Counseling; X5591-30 minutes-Independent Living Skills, Maintenance).

Independent living skills (ILS) services are directed at the development and maintenance of community living skills and community integration. Services may include supervision, training, or assistance to the recipient with self-care, communication skills, socialization, sensory/motor development, reduction or elimination of maladaptive behavior, community living and mobility.

Provider Standards:

ILS services may be provided by employees of a: (1) Home health agency that is enrolled as an MA provider; (2) Rehabilitation agency or comprehensive outpatient rehabilitation facility that is enrolled as an MA provider; (3) Mental health community support program covered under the Minnesota Comprehensive Adult or Children’s Mental Health Acts (Minnesota Statutes, sections 245.461 to 245.486 or 245.487 to 245.4888).

The local agency must determine that the provider of ILS services meets all of the following qualifications:

- Has general knowledge of disabilities and chronic illnesses which an individual’s ability to live independently in the community;
- Has the ability to do a needs assessment of the skills a recipient with a disability must develop in order to live independently in the community;
- Has knowledge of ILS management including service planning, general knowledge of social services, record keeping, reporting requirement, and confidentiality;
- Has the ability to provide assistance, supervision, in the area of independent living; and
- Provides proof that the recipient has received a minimum of:
  - Five hours of classroom training in recognizing the symptoms and effects of certain disabilities and health conditions.
  - 20 hours of classroom instruction in providing supervision of, training to, and assistance with independent living skills services.
A determination by the individual's supervisor that the individual has the skills required to provide the independent living skills services stated in the care plan.

Independent Living Skills Therapies

Available through: TBI (X5592-30 minutes-ILS Therapies, Individual; X5593-30 minutes-ILS Therapies, Group).

Individual living skills therapies include therapeutic recreation, music and art therapies. These may be provided to the recipient on an individual basis or in a group.

Provider Standards:

Providers of independent living skills therapies must meet requirements of their certifying agency as listed below a qualified:

- A therapeutic recreation specialist must be a graduate of an accredited baccalaureate program, and be certified as a Certified Therapeutic Recreation Specialist;
- A music therapist must be a graduate from an institution accredited by the National Association for Music Therapy or the American Association for Music Therapy, and be certified as a Music Therapist - Board Certified; or
- An art therapist must be a graduate of a master's program in art therapy or a graduate of a related degree, and be registered by the National Association for Art Therapists.

In-Home Family Support (see Habilitation section)

Live-In Personal Care Giver Expenses (also called Caregiver Living Expenses)

Available through: MR/RC (X5505-day).

Live-in personal caregiver expenses cover certain expenses of a live-in personal caregiver residing with a MR/RC Waiver recipient. The live-in personal caregiver is required to provide a waiver service that meets a physical, social, or emotional need of the recipient. Coverage of expenses is not available in situations in which the recipient lives in the caregiver’s home or a residence owned or leased by the provider of MA services.

This service provides payment for rent and food that may be reasonably attributed to a live-in personal caregiver. The live-in personal caregiver also provides one of the following waiver services: residential habilitative services, personal support services, extended personal care attendant services, or recipient-directed community supports.

Mental Health – Psychological Testing/Explanation of Findings

Available as an extended MA service through: TBI (X5594-30 minutes-Mental Health Psychological Testing, Extended; X5595-30 minutes-Mental Health Explanation of Findings, Extended).
Psychological testing is the use of tests of other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning. Explanation of findings is the analysis and explanation of a diagnostic assessment, psychological test, treatment program, or other accumulated data and recommendations to the recipient's family, primary caregiver, or other responsible persons.

**Provider Standards:**

Providers of extended psychological testing and extended explanation of findings must the same qualifications as mental health providers enrolled as an MHCP provider.

**Modifications and Adaptations**

Home and vehicle modifications are available through: CADI, TBI, CAC, MR/RC, EW & AC. Adaptive equipment is available through: CADI and MR/RC (X5419-up to DHS maximum allowed under each waiver type and under cap-TBIW (dd); X5419-per item-CAC & MR/RC). For EW and AC only: Environmental modifications and adaptations to a home or vehicle or adaptive equipment are limited to a combined total of $4,634 (effective for state fiscal year 03) per recipient per waiver year. For more clarification on covered and non-covered items, see end of this chapter and chapter 23.

Modifications include adaptations to the home or vehicle which are necessary to ensure the health, welfare and safety of the individual or which enable the recipient to function with greater independence.

Modifications may be completed prior to the recipient’s discharge from an institution. Counties must wait to claim the expense after the discharge occurs. If the recipient is not discharged from the institution, the county can claim the expense by submitting the appropriate DHS form (Notification of RSC or Modifications Provided to Person Not Discharged from Institution form).

Purchase agreements are allowed as an alternative to a contract for providers of environmental modifications.

**Home/residence modifications:**

Home/residence modifications include minor physical adaptations to the home which are necessary to ensure the health, welfare and safety of the individual or which enable the recipient to function with greater independence in the home. Adaptations and modifications may be made to the recipient’s “residence” which includes the recipient’s own home, family residence, family foster home, or where necessary for the recipient to be included in his or her family’s activities.

Examples of minor physical adaptations or modifications to the home/residence may include but are not limited to:

- The installation of wheelchair ramps
- Widening of doorways
• Modifications to the bathroom or kitchen facilities
• Shatterproof windows
• Alternative warning systems (blinking lights, tactile alarms)
• Lifting devices (stair climbers)
• Handrails and grab-bars
• Specialized electric and plumbing systems necessary to accommodate medical equipment

Vehicle modifications:

Modifications to vehicles include modifications and adaptations that allow the individual to function with greater independence in the community. “Vehicle” refers to the recipient’s own vehicle, family vehicle or a foster home vehicle. The vehicle is to be the recipient’s primary mode of transportation to participate in the community. Such modifications may include:

• Wheelchair lifts or ramps
• Adapted controls
• Adapted seating
• Door widening
• Door handle replacements
• Wheelchair securing devices

Adaptive equipment:

Adaptive equipment includes:

• Adaptive furniture
• Utensils

Exclusions to Modifications and Adaptations:

Improvements to the home that are of general utility and are not of direct medical or remedial benefit to the recipient are excluded. For example:

• Carpeting
• Central air conditioning
• Roof repair
• Adding total square footage to the home
• Estimates, bids, mileage and other expenses to provide the estimate or bid
• A consultant or planner to evaluate the recipient’s living environment

Example: the waiver may pay for an enlarged basic entrance door to accommodate a wheelchair and medical equipment; however, if the recipient or family chooses to upgrade the door for design features, type of wood, etc., the upgrade could not be paid by waiver funds.
An evaluation regarding which adaptations and modifications are most appropriate for a recipient, may be provided by a therapist.

**Authorization Criteria:**

The item is:

- Not able to be funded through any other source. (See Order of Payers section.)
- Necessary to avoid the recipient’s institutionalization. (e.g., widening of a doorway to allow access to a bathroom);
- For the sole utility of the recipient. (e.g., installation of a wheelchair-accessible shower). (Individuals in the residence may use the modified shower.);
- Determined by prevailing community standards or customary practice and usage to be:
  - Medically necessary: appropriate and effective for the recipient’s medical needs, health and safety (e.g., purchase of a room air conditioner may be necessary for some individuals with acute respiratory difficulties);
  - Remedially necessary: appropriate to assist a recipient in increased independence and integration in their environment/community;
  - Appropriate and effective for the medical needs, diagnosis, and condition of the recipient (e.g., installing an alarm system to alert caregivers when a confused/vulnerable client is attempting to wander outside of the home);
  - Of an acceptable quality (e.g., use of an individual who has the proper credentials and experience to provide the modification, such as an electrician to upgrade wiring to accommodate medical equipment such as ventilators);
  - Timely: the accommodation is provided at the time it is needed (e.g., safe egress from the residence at the time the individual moves in);
  - The most cost-effective health service available to meet the medical needs of the recipient. (e.g., use of treated wood for ramp construction versus a higher grade of lumber); and

- An effective and appropriate use of MA waiver funds. When cost-effective, waiver funding is available for the following modifications:
  - Individual evaluation or assessment
  - Purchase or rental
  - Installation
  - Maintenance and repairs

**Authorization Procedures**

Review and authorization must occur prior to the purchase and the description of the minor environmental adaptation or modification is to be included in the recipient’s file/plan of care:

- It is recommended that local agencies consider bids from a minimum of two contractors/vendors;
• All services must be provided in accordance with applicable state and local building codes; and
• If it is determined by the county agency that all of the criteria are met and the bid for the work is reasonable, the local agency enters a line item and amount on the recipient’s service agreement using procedure code X5419.

If the local agency determines that the item requested does not meet the authorization criteria, documentation regarding the determination and rationale is to be kept on record at the local agency. Recipients must be notified of determinations and given information regarding appeal procedures.

The annual limit on modifications for CAC, CADI, and TBI waivers has been removed, but the cost of adaptations and modifications for other waiver types must be included in the recipient’s waiver cap. Costs may be averaged over the span of a service agreement (up to 12 months) provided the recipient is expected to remain on the waiver for the full span of the service agreement. However, should the cost of an item be spanned beyond the month the cost was authorized and incurred and the recipient exits the waiver program, the waiver cannot pay for any service or time billed after the individual’s exit date (e.g., the date the recipient is no longer waiver eligible).

**County Contract or Purchase Agreement:**

Counties must contract with or secure agreements with qualified providers of modifications and supplies. Home modifications must be provided in accordance with applicable state or local building codes.

**Provider Standards:**

A provider of modification services must meet all professional standards, including licensure and certification, and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services which they provide. Modifications must be provided in accordance with applicable state or local building codes. If the vendor does not have a waiver service contract with the county, the county may use the written contract for the specific work project. Billing for the completed work then is submitted under the county’s provider number who, in turn, pays the contractor.

**Night Supervision Services**

Available through: TBI (X5606-15 minutes).

Night supervision services provide overnight assistance and monitoring of the individual in his or her home for a period of no more than 12 hours. Providers of night supervision must have the ability to provide a consistent approach when interacting with the individual. This may include understanding and carrying out the individual's behavior program, reinforcing independent living skills, assisting with incidental daily activities.
Provider Standards:

Night supervision providers must be at least 18 years old and have received a high school diploma. They must have had experience and/or a minimum of eight hours training in caring for individuals with traumatic brain injury. They must have the ability to understand the recipient’s programs and provide intervention when necessary. They must have good physical and mental health and maturity of attitudes towards work assignment. They must have the ability to converse on the telephone, work under intermittent supervision, handle emergencies that may arise in connection with the assignment, and work under stress in a crisis situation. They must understand, respect and maintain confidentiality.

Nutrition Services


Nutrition counseling is one or more individual sessions in which a qualified professional provides advice or guidance in solving a recipient's diet related health problems. Examples include planning diabetic meal patterns to meet a recipient’s needs, therapeutic diet instructions (low sodium, low cholesterol and fat, combination diets, etc.), suggestions for recipients who are chronically underweight, have had severe weight loss, have difficulty chewing of swallowing, weight reduction diets, etc.

Nutrition education is an individual or group-event that provides formal or informal opportunities for individuals to acquire knowledge, experience and skills about foods and nutrition. Examples of nutrition topics are wise food choices at grocery shopping, food selection and preparation, methods for therapeutic diets, menu planning, food safety storage tips, cooking for one or two, tips for eating well on a limited budget.

Provider Standards:

Nutritional services must be provided by a registered dietitian, qualified dietitian, or registered nurse.

Personal Care Assistant (PCA)

Available through: AC program (X5653-15 minutes-PCA, Shared 1:1, X5357-15 minutes-PCA, Shared 1:2, X5358-15 minutes-PCA, Shared 1:3, X5652-day, X5289-15 minutes-RN Supervision of the PCA).

PCA services for waiver recipients, funded through the MA home care program, are accessed by having the case manager list this service (using X5645) on the waiver service agreement.

PCA services include assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may also include meal preparation and such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the cares provided and essential to the health and welfare of the recipient.
Personal Care Assistant, Extended

PCA services through straight MA must be accessed to its full limitation before this service can be covered as an extended service through a waiver. Available through: CADI, TBI, CAC, MR/RC, and EW (PCA-Extended (ee)-all: X5581-15 minutes-Extended 1:1, X5359-15 minutes-Extended 1:2, X5360-15 minutes-Extended 1:3).

PCA services include assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may also include meal preparation and such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the cares provided and essential to the health and welfare of the recipient.

Provider Standards:

A PCA is an employee of personal care provider organization. A PCA must be able to show successful completion of one or more of the following a/an:

- Nursing assistant training program or its equivalent, for which competency is determined by the State Board of Technical Colleges;
- Homemaker/home health aide pre-service training using a curriculum recommended by the Minnesota Department of Health;
- Accredited educational program for registered nurses or licensed practical nurses;
- Training program that provides the assistant with skills required to perform personal care assistant services; or
- Determination by the supervising RN that the assistant has the skills required through training and experience, to perform personal care services.

Relatives may provide personal care assistant services through a Relative Hardship Waiver if they meet one of the qualifications above and meet financial hardship criteria and are an employee of a personal care provider organization. The supervising nurse of the provider organization must submit a Relative Hardship Waiver request to DHS for approval. Requests must be submitted to the designated health plan if the waiver recipient is enrolled in a Prepaid Medical Assistance Program (PMAP). Please see Home Care chapter 24 in the MHCP manual for information on criteria related to the Relative Hardship Waiver and how this service may be accessed.

Personal Support

Available through: MR/RC (X5672-daily; X5673-hourly).

Personal support services include non-medical care, supervision and assisting a recipient in their home or in the community to achieve increased independence, productivity, and inclusion in the community. Personal support services may provide supervision and assistance to a recipient in accessing community services and participating in community activities. This service is provided in accordance with outcomes identified in the Individual Service Plan but when training is determined not to be necessary for those goals. The case manager will assure that there is coordination with
other services, the personal support services do not duplicate other services provided to the recipient, and the provision of personal support services is monitored.

Provider Standards:

Minimal standards include training in first aid, vulnerable adult law, medication administration, if applicable as a responsibility of personal support in the plan of care, and providers are not disqualified as a result of a background study. The service planning team will document in the Individual Service Plan or contractual agreement any further training experience and/or supervision standards specific to the needs of the recipient. The local county social service agency must verify that the provider has met the standards identified.

Prescription Drugs, Extended

Available through: CAC (X5431-Per Item-Prescription Drugs, Extended).

Prevocational Services

Available through: CADI & TBI (X5507-30 minutes (ff); X5508-full day (gg)).

Prevocational services are designed to prepare individuals for paid or unpaid employment but are not job-task oriented. Services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Prevocational services are provided to recipients who are not expected to be able to join the general work force or participate in transitional sheltered workshop services within one year (excluding supported employment programs).

Individuals may be compensated at a rate not to exceed 50% of the minimum wage. The waiver does not directly pay any compensation to a recipient. Compensation may be provided to the recipient by the prevocational service vendor or other source. All prevocational services are included in the individual’s plan of care and reflect goals directed at assisting the recipient toward greater independence.

Prevocational services may only be provided when they are not otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973 as amended in 1998 or section 602 (16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)). Local agencies are responsible to obtain necessary information to make a determination regarding other funding sources and maintain documentation of findings in the case record.

Provider Standards:

Eligible Providers: Rehabilitative agencies, comprehensive outpatient rehabilitation facilities, adult day care centers or programs, vocational rehabilitation service providers, training and habilitation service providers, and community mental health centers.

License: Adult day care centers must be licensed under Minnesota Rules, part 9555.9600 to 9555.9730. Adult day care programs are established under Minnesota Statues, section 245A.
Providers of training and habilitation services are licensed under Minnesota Statutes, section 245B and Minnesota Rules parts 9525.1580 and 9525.1600.

**Certification:** Vocational rehabilitation services providers that are so certified by the Commission of Accredited Rehabilitation Facilities (CARF).

**Other Standards:** Rehabilitation agencies must meet the standards under Minnesota Rules, parts 9505.0385 to 9505.0386. Comprehensive outpatient rehabilitation facilities must meet the standards under Minnesota Rules, parts 9505.0386 to 9505.0390. Community mental health centers are defined under Minnesota Statutes, section 245.62 and must meet standards under Minnesota Rules, part 9505.0260 and parts 9520.0750 to 9520.0870.

## Relocation Service Coordination

Relocation Service Coordination (RSC) is a new MA benefit designed to assist recipients with transition from institutions to the community. RSC is billed directly to MA while the individual is still in the institution, for up to 180 consecutive days prior to discharge. The cost for RSC will not come out of the recipient’s waiver limit. See [Bulletin #01-56-23](#), OPTIONS SERIES: Implementation of Relocation Service Coordination, for more information on the service and billing procedures. This service replaces conversion case management (CAC-X5424 and CADI & TBI-X5455).

## Residential Care Services

Available through: CADI (kk) (X5291-monthly (aa)). TBI (kk) (X5291-monthly (aa), X5605-daily (aa)). EW & AC (X5291-monthly).

Residential care services are provided to individuals living in a residential care home. Residential care homes are currently licensed as board and lodging establishments and are registered with the State Department of Health as providing specialized services. Residential care services are defined as "supportive services" and "health related services."

Supportive/residential care services provides up to 24-hour supervision and oversight. Supportive services include providing:

- Transportation when provided by the residential care home only;
- Socialization when socialization is part of the plan of care, has specific goals and outcomes established and is not diversional or recreational in nature;
- Assistance in setting up recipient’s meetings and appointments;
- Assistance in arranging recipient’s medical and social services;
- Assistance with personal laundry such as carrying the recipient's laundry to the laundry room (assistance with personal laundry does not include any laundry that is included in the room and board rate - e.g., bed linens, towels, etc.); and
- Meal preparation.

Health related services are limited to minimal assistance with dressing, grooming and bathing and to providing reminders to recipients to take medications that are self-administered or providing storage for medications, if requested.
The care plan must indicate what services the residential care provider will furnish and these services cannot be duplicated by other State Plan or waiver services. Recipients receiving residential services are not eligible to receive homemaking services in addition to residential care services. Service direction must be provided by the recipient or residential care home staff with oversight from the case manager.

Costs for room and board in a residential care home will be covered by other resources such as Social Security Disability Insurance, General Assistance, Group Residential Housing, or Supplemental Security Income. Waiver funds cannot be used to pay for or supplement for room and board costs.

Residential care room and board expenditures are covered through group residential housing established in Minnesota Statute 256I.03, subdivision 2, as follows: "Group residential housing rate means a monthly rate set for shelter, food, utilities, household supplies, and other costs necessary to provide room and board for individuals eligible for General Assistance or supplemental aid". For a waiver recipient, this room and board rate is limited to the current GRH rate. Exceptions to this limit may be approved by the State for additional room and board charges (following the above definition) that are directly related to the recipient’s disability.

Provider Standards:

The state agency requires that the residential care service providers meet standards of licensure, certification or registration where they exist either in state law or administrative rule. Current standards for residential care services are in Minnesota Statutes, section 157.17. The residential care home must meet the appropriate local building codes.

Residential care homes are licensed by the MDH as board and lodging establishments. In addition, if the residential care home is providing residential care services to their recipients, they must be registered to provide specialized services under Minnesota Statute 157.17. Residential services must be provided management of the residential care home. For staff providing assistance with grooming, bathing, or providing medication reminders or storage of medication, eight hours of training and orientation of staff by a registered nurse is required. If medications are to be stored, a registered nurse must provide supervision of this process.

Staff providing supervision, oversight and supportive services must be able to read and write and follow written and oral instructions. They must have had experience and/or training in caring for individuals with handicapping conditions. They must have good physical and mental health, and maturity of attitudes towards work assignment. They must have the ability to converse on the telephone, to work under intermittent supervision, to deal with minor emergencies arising in connection with the assignment, and work under stress in a crisis situation. They must understand, respect and maintain confidentiality. They must have a valid State driver's license, if they provide transportation to recipients.
Respite Care

Available through: CADI, TBI, CAC, MR/RC, EW & AC (X5480-30 minutes-Respite Care in-home for CADI, TBI, MR/RC, EW & AC; X5481-daily-Respite Care in-home for CAC, MR/RC, EW & AC; X5484-30 minutes-Respite Care out-of-home for MR/RC, EW & AC; X5485 (hh)-daily-Respite Care out-of-home for CADI, CAC, TBI, MR/RC, EW & AC; X5485 (hh)-daily-Respite Care out-of-home in certified facility for EW & AC; X5485-daily-Respite Care in hospital for EW & AC). For EW & AC only: Respite care is limited to 30 consecutive days per respite stay in accordance with the plan of care.

Respite care services may be provided on a short-term basis to provide for the relief of the unpaid caregiver. Respite care may include day and overnight services. Respite Care is not provided for recipients residing in corporate foster care settings.

Provider Standards:

Respite care may be provided in either an out-of-home setting or in the recipient's own home; consequently, two standards apply.

For CADI, TBI, CAC, EW, and AC, out-of-home respite care must be provided in a facility approved by the local county agency such as a hospital, nursing facility, foster home, camp, or community residential facility. (Respite Care in a camp setting is not available for CAC.) When respite care is provided in a non-MA certified facility, that facility must meet applicable state licensure standards.

EW and AC Programs: out-of-home respite may be provided in a currently registered housing with services establishment when services are delivered by a licensed home care agency or in a private unlicensed home when it is determined by the case manager that the service and setting can safely meet the recipient’s needs. The case manager must take into account the accessibility and condition of the physical plant, ability and skill level of the caregiver, and the recipient’s needs and preferences. The unlicensed home and caregiver cannot otherwise be in the business or routine practice of providing respite services.

For CADI, TBI, CAC, EW and AC, in-home respite care providers must be individuals who meet the state qualifications of registered or licensed practical nurses, home health aides, or personal care assistants who have been specifically trained to provide care to the recipient. Respite care workers must have had first-aid training and cardiopulmonary resuscitation training. A respite care worker who is a home health aide or personal care assistant must be under the supervision of a registered nurse. The registered nurse must assure that the respite care worker is able to read and follow instructions, able to write clear messages, and has the level of skill required by the recipient's needs.

Specialist Services

Available through: MR/RC (X5674-hourly).
Specialist services provide assessments, program development, training and supervision of staff and caregivers, monitoring of recipient specific program implementation, and evaluation of service outcomes in areas specific to the needs of the recipient to assure competency by staff and caregivers in service provision. Specialist services include services unavailable through regular MA, which exceed the scope and duration of available services, including Medicaid state plan option services, will not duplicate other services that are provided to the individual, will be cost efficient, and will be documented in the Individual Service Plan as necessary to meet the needs of the recipient. They may be directed solely to one area of recipient need or may be authorized as a QMRP function as long as the QMRP function does not duplicate that provided as part of an habilitation service to the recipient. This service will be utilized for recipients whose needs in the areas of behavior management, augmentative communication, personal health, functional motor skills, social skills, leisure and recreational skills, or independent living skills require specialized services.

**Qualification standards:** Specialist services will be provided by individuals who meet QMRP standards, have demonstrated expertise in the recipient’s areas of need, meet standards in Minnesota Rule, part 9525.1850, and are not disqualified as a result of background study. The service planning team will: 1) identify the specific experience and skills required of the specialist to meet the needs of the recipient, 2) identify the qualifications of that individual and document those qualifications in the Individual Service Plan or contractual agreement, and 3) monitor and evaluate the specialist services provided based upon the identified outcomes to be accomplished.

**Structured Day Program**

Available through: TBI (X5599-30 minutes; X5600-daily).

Structured day program (SDP) services are directed at the development and maintenance of community living skills. The services take place in a non-residential setting separate from the home in which the recipient lives. Services will normally be furnished 2 or more hours per day, for 1 or more days per week, on a regularly scheduled basis.

SDP services include supervision and specific training to allow recipients to attain their maximum potential. SDP services may include social skills training, sensory/motor development, reduction/elimination of maladaptive behavior. Services aimed at preparing the individual for community reintegration (e.g., teaching concepts such as compliance, attending, task completion, problem solving, safety, money management, etc.) are also included. Physical, occupational, speech, and cognitive rehabilitation therapy will be provided in addition to the SDP if needed. SDP does not include supported employment services or any other services funded through the Division of Rehabilitation Services.

SDP can potentially serve two types of individuals - those who will benefit from continued rehabilitation and those who need a very structured environment due to severe behavior problems preventing the individual from participating in adult day care or other day programs.
Provider Standards:

Regardless of the provider's background, to receive waiver reimbursement, the provider must develop specific programs for individuals with brain injury. The provider must submit an individualized plan of service outlining the components of the program and demonstrates knowledge of characteristic needs of the brain-injured recipient.

SDP services may be provided by a:

- Rehabilitation agency that is certified by Medicare to provide restorative and specialized maintenance therapy;
- Comprehensive outpatient rehabilitation facility that is a nonresidential facility established and operated exclusively to provide diagnostic, therapeutic, and restorative rehabilitation services;
- Provider of adult day care services must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730;
- Provider of day training and habilitation (DT&H) services (DT&H’s currently provide services to adults with mental retardation or related conditions) must be licensed under Minnesota Rules, parts 9525.1580 and 9525.1600;
- Provider of vocational rehabilitation services which is so certified by the Commission on Accredited Rehabilitation Facilities (CARF); or
- Community mental health centers as defined under Minnesota Statutes, section 245.62 and must meet standards under Minnesota Rules, part 9505.0260 and parts 9520.0750 to 9520.0870.

Supplies and Equipment

Available through: AC (X5651-per item).

Supplies and equipment include durable and non-durable medical supplies and equipment that are provided as a necessary adjunct to direct treatment of the recipient’s condition. This may also include grab bars, handrails, stair lifts or ramps, if these items are essential to keep the recipient in the community.

Provider standards:

Home health agencies, pharmacies, and medical suppliers may provide this service. Items which are not of direct or medical benefit to the recipient are not eligible for reimbursement. All items must meet applicable standards of manufacture, design and installation.

Purchase agreements are allowed as an alternative to a contract for providers of supplies and equipment.
Supplies and Equipment, Extended

Available as an extended MA service through: CAC, CADI, TBI, and EW (X5467-Per Item-Supplies and Equipment, Extended (dd)). See Chapter 23 for clarification on covered and non-covered items and regulations.

Supplies and equipment include durable and non-durable medical supplies and equipment, which provide a necessary adjunct to direct treatment of the recipient’s condition and which MA does not fund. Depending on the program, supplies and equipment may also include adapted furniture, devices, controls, or appliances that enable the recipient to increase his or her ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which he or she lives. This also includes items necessary for life support, ancillary supplies necessary for the proper functioning of such items.

CAC and CADI waivers include “specialized” supplies and equipment such as adaptive equipment and assistive technology. Adaptive equipment and assistive technology include any item or piece of equipment that is used to increase, maintain, or improve functional abilities of a recipient with a disability. This definition is broad and includes a range of devices from low technology to high technology items as well as software. Adaptive equipment through CADI waivers should now be billed to extended supplies and equipment rather than to modifications. Purchase agreements are allowed as an alternative to a contract for providers of supplies and equipment.

Authorization Criteria:

County case managers must ensure and document, in the recipient’s file/plan of care, prior to the purchase of the medical supply or equipment, that the item meets all of the following criteria:

- Not able to be funded through any other source. If an item is never covered by MA, it is not necessary to seek a written denial from MA. If an item may be covered by MA, the medical supplier must seek authorization from MA. (See order of payers);
- Necessary to avoid the recipient’s institutionalization;
- For the sole utility of the recipient;
- Determined by prevailing community standards or customary practice and usage to be:
  - Medically necessary: appropriate and effective for the recipient’s medical needs, health and safety;
  - Remedially necessary: appropriate to assist a recipient in increased independence and integration in their environment/community;
  - Appropriate and effective for the medical needs, diagnosis, and condition of the recipient;
  - Of an acceptable quality;
  - Timely (e.g., the accommodation is provided at the time it is needed);
  - The most cost-effective health service available to meet the medical needs of the recipient; and

- An effective and appropriate use of MA waiver funds.
When cost-effective, waiver funding is available for the following modifications:

- Individual evaluation or assessment
- Purchase or rental
- Installation
- Maintenance and repairs

Medical supplies and equipment are available through the MA state plan but with limitations. When an item is covered by MA, bill MA first to the extent of the limitations. If an item is never covered by MA, the case manager may decide to cover this item under the appropriate waiver if it meets criteria.

Once an item is purchased, it becomes the property of the recipient.

**Add-ons vs. Upgrades:**

An **add-on** is an MA non-covered service that the provider adds to an MA-covered service. In this case, the MA-covered item is billed to MA. The add-on may be billed to the waiver, or the recipient may choose to pay for the add-on.

Example: A recipient wants an MA non-covered basket added to an MA-covered walker. The supplier can bill MA for the walker and bills the recipient for the basket; or

The county case manager may determine that the basket is covered by the waiver program but the supplier still must bill MA for the MA-covered service.

For both fee-for-service and managed care recipients, the provider may receive payment for the covered service under MA and charge the recipient or waiver program for the add-on.

An **upgrade** is a non-covered MA service (and often a more desirable service) that substitutes for a covered service:

- The provider may choose to provide the upgrade and receive payment for the basic service as payment in full for the upgrade;
- The recipient may choose an upgraded service instead of an MA-covered service, even though MA will not pay for this item. The recipient is responsible for the entire cost of the upgraded item as long as the provider informed him/her that he/she is responsible before providing the service. In this case DHS recommends that the provider have the recipient sign a waiver acknowledging that the item is not covered by MA, and agrees to pay the entire cost for the upgraded item before the service is provided; or
- The waiver case manager may authorize an upgraded item to be covered under a waiver program, if determined to be medically necessary, and cover the entire cost of the item under the waiver program.

Example: A recipient wants a total electric bed, but does not meet the medical necessity criteria for MA to cover the bed. MA will only cover a semi-electric bed.
A case manager may elect to cover the entire cost of a total electric bed under a waiver services program.

If the supplier will not accept MA semi-electric bed payment, and the case manager does not approve the upgrade for payment under a waiver program, the recipient may still get the total electric bed, but is responsible for the entire charge for the bed as long as the provider informed him/her that he/she is responsible for payment before providing the service.

The supplier may not provide a total electric bed to the recipient, bill MA and charge the difference relating to the upgrade to the recipient, or to the waiver.

If the case manager decides to cover the total cost for an item through the recipient’s waiver, the item must be entered on the recipient’s SA. The case manager may need prior approval from DHS for some extended supplies depending on the cost of the item.

**County Contract or Purchase Agreement:**

Counties must contract with or secure purchase agreements with qualified providers of supplies and equipment.

For equipment or supplies provided on a routine basis by the same provider, local agencies may choose to develop contracts if the monthly amount paid to the provider by the waiver is less than $250. However, if the provider receives more than $250 (cumulatively) in waiver reimbursement each month, a contract with the local agency is required.

**Cost of Providing Supplies and Equipment Under a Recipient’s Waiver Cap:**

The cost of supplies and equipment must be included in the recipient’s waiver cap. Costs may be averaged over the span of a SA (up to 12 months) provided the recipient is expected to remain on the waiver for the full span of the SA. The waiver can only pay for these items when the recipient is eligible. For example: if the cost of an item spanned beyond the month that the cost was authorized and incurred, and the recipient exits the waiver program, the waiver cannot pay for any service or item billed after the individual’s exit date (the date the recipient is no longer waiver eligible).

**Doctor’s Orders for Medical Supplies and Equipment:**

When a doctor’s order is needed for MA/Medicare reimbursement, the medical supply and equipment provider is responsible to gather and send whatever documentation is needed to DHS before ordering/billing. Generally, doctor’s orders are not required for purchases through waiver funds. The provider is ultimately responsible to bill the appropriate payer (insurance, Medicare, MA, etc.) if the item is reimbursable through those payers, regardless of whether the county case manager has authorized waiver reimbursement through a SA or not. When other sources of payment are exhausted, the provider must submit copies of the denials from those payment sources to the case manager. If inappropriate billing shows up in an audit, the provider is responsible and risks payment recovery.
Incidental Maintenance on Adaptive Equipment and Supplies While Providing A Direct-Care Service:

MA only covers maintenance on a few items. Maintenance on adaptive equipment and supplies can be covered through all of the waivers if that service is not MA-reimbursable. For example, if a waiver provider does incidental maintenance on a recipient’s wheelchair during the course of providing direct care, they cannot bill for this through the waiver or MA as a separate service, as this is considered duplicate billing.

Long Term Care Facility/Providing Supplies and Equipment Before Discharge:

Providers cannot bill through a waiver for supplies and equipment before a recipient goes home from a nursing facility or leaves an ICF/MR to go to a community setting unless the correct living arrangement (LA) is coded in the recipient file at DHS. If the LA is correct, a provider could bill for assistive technology, adaptations/modifications, and extended medical supplies and equipment on the date of discharge, as long as the item(s) is/are provided after the time of the discharge.

Rental:

Rental contracts or supplies and equipment may only be approved when it is determined, for items that meet authorization criteria, as cost-effective. For example, the item is needed for a defined amount of time and rental is less expensive than purchase. All rental contracts should include a “rent to purchase” clause. The cost of renting a supply or equipment must not exceed the cost of purchase. The written contract should also be clear that the vendor is responsible for repairs over the duration of the rental agreement.

Once the rental fee equals the purchase price, the item is considered to be the recipient’s property (normally after 10-12 months’ rental).

Repair and Maintenance:

The waiver can pay for repair of equipment when the equipment meets the authorization criteria and the repair is a cost-effective alternative (e.g., is expected to last and without repair, the equipment would have to be purchased new at a great cost). A maintenance agreement may be purchased by the waiver for items that meet authorization criteria when the maintenance agreement is expected to be cost-effective.

For example, a maintenance agreement that covers evaluating an item but not actual repair may not be cost-effective. Consideration should also be given to other payment sources for repairs. MA covers the repair costs of certain items such as communication devices, wheelchairs, etc.

Shipping, Handling, and Installation:

Shipping and handling costs may be paid by a waiver if they are included in the price of the item, and the waiver is purchasing the item. Installation can be covered regardless of who purchased the item if the item meets waiver authorization criteria. If installation involves attaching an item to or
altering the existing physical structure of a home or vehicle, the costs are billed under minor environmental adaptations and modifications.

**Used Equipment:**

Used equipment may be purchased if the county determines that all authorization criteria are met and the item is considered of adequate quality, expected to be durable, and the cost is commensurate with the age and condition of the item (e.g., if a new item could be purchased at the similar cost, it may be worthwhile to purchase the new item).

**Provider Standards:**

Providers may be home health agencies, pharmacies, medical suppliers or other entities approved by the local agency. Items which are not of direct or medical benefit to the recipient, are not eligible for reimbursement. All items shall meet applicable standards of manufacture, design and installation.

Examples of MA non-covered items can be found in [Equipment and Supplies chapter](#) (Ch.23). All supplies covered by MA must be billed to MA. If providers are unsure if MA will cover the supply, they must first find the most appropriate HCPCS code by contacting the medical supplier. Either look in the MHCP Benefit Code Guide at [www.dhs.state.mn.us/provider/ref/codeguide.htm](http://www.dhs.state.mn.us/provider/ref/codeguide.htm) or call the Provider Help Desk with the HCPCS code to find out whether this item can be covered by MA. If an item is never covered by MA, the provider does not need to get a denial before it can be covered by a waiver.

Supplies and equipment paid for by the waiver must be provided by an MA enrolled provider when possible. In circumstances when there is no MA provider, the item or comparable item may be purchased from a non-MA provider. If a non-MA provider is used and there is an MA rate for the item, the amount paid for the item may not exceed the MA maximum allowable.

Reasonable standards should be used to assess if there is an available provider. For example, if a provider is a significant distance from the recipient but can ship the item, it may be reasonable to use that provider. However, if it is an item that needs to be routinely supplied or there is a need to have it provided closer to the recipient, it may be necessary to use a non-MA provider. In this case, the local agency must maintain documentation that the item could not be purchased from an MA provider.

When a supply or equipment item to be purchased by the waiver from an MA provider has a price established by MA, the provider must bill the MA amount. If there is not an established MA price and the item is being provided by an MA provider, the waiver purchase price is determined by using the manufacturer’s suggested retail price (not the provider’s list price) less 20%. In circumstances when there is not an MA provider for the particular supply or equipment item being sought, the 20% deduction does not apply.

**Supported Employment Services**

Available through: CADI, TBI & MR/RC (X5410-30 minutes-CADI & TBI (ff) and MR/RC; X5411-Partial Day-MR/RC; X5412-full day-CADI & TBIW (gg), and MR/RC).
Supported employment services consist of paid employment for recipients whom competitive employment at or above the minimum wage is unlikely and who because of their cognitive and/or physical limitations, require intensive ongoing support to perform in a work setting. Supported employment services provide ongoing training and support to the recipient while he/she is a paid employee working at an existing business or industry in the community. This provides the opportunity to work with people who do not have disabilities and who are not paid caregivers or service providers. Waiver funds may not be used to provide or subsidize compensation to the recipient or replace or duplicate funding available from any other source including section 110 of the Rehabilitation Act of 1973 as amended in 1998 or section 602 (16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)). Services may include: individualized assessment; individual and group counseling; job development; job placement activities which produce an appropriate job match for the individual and the employer; on-the-job training for work and related work skills required for job performance; ongoing supervision and monitoring of the recipient’s performance; long-term support services to assure job retention; training in related skills essential to obtaining and retaining employment such as the effective use of community resources; training in use of break and lunch areas; and, transportation between the individual’s home and work place when other forms of transportation are unavailable or inaccessible.

**Provider Standards:**

For MR/RC: Consolidated standards license for supported employment.
For CAC, CADI, and TBI Waivers:

**Provider type:** Rehabilitative agencies, comprehensive outpatient rehabilitation facilities, adult day care centers or programs, providers of vocational rehabilitation services, providers of training and habilitation services, and community mental health centers.

**License:** Adult day care centers must be licensed under Minnesota Rules, part 9555.9600 to 9555.9730. Adult day care programs are established under Minnesota Statutes, section 245A. Providers of training and habilitation services are licensed under Minnesota Statutes, section 245B and Minnesota Rules parts 9525.1580 and 9525.1600.

**Certification:** Vocational rehabilitation services providers that are so certified by the Commission of Accredited Rehabilitation Facilities (CARF).

**Other Standards:** Rehabilitation agencies must meet the standards under Minnesota Rules, parts 9505.0385 to 9505.0386. Comprehensive outpatient rehabilitation facilities must need the standards under Minnesota Rules, parts 9505.0386 to 9505.0390. Community mental health centers are defined under Minnesota Statutes, section 245.62 and must meet standards under Minnesota Rules, part 9505.0260 and parts 9520.0750 to 9520.0870.

**Supported Living Services (refer to the Habilitation Services section)**


The purpose of this service is to teach specific skills to a recipient who requires daily intervention. Daily intervention means providing ongoing supervision, training or assistance to help the recipient reach his/her individual goals in the following areas: self-care, sensory/motor development, interpersonal skills, communication, reduction and/or elimination of challenging behaviors,
community living, mobility, health care, leisure and recreation, money management and household chores.

**Transportation**

Available through: AC (X5265-one-way trip).

Transportation services are provided to enable AC recipients to gain access to services specified in their individual care plan. Whenever possible, family, neighbors, friends, or community agencies that can provide transportation without charge should be utilized.

**Provider standards:**

Providers of common carrier transportation include bus, taxicab, other commercial carrier, private automobile, or a county owned or leased vehicle. Only drivers or carriers that have a valid driver’s license and adequate insurance coverage including auto insurance required by Minnesota Statutes, chapter 65B, must be utilized.

Providers of special transportation, not excluded in Minnesota Statutes, section 174.30, must be certified by the Minnesota Department of Transportation under Minnesota Statutes, sections 174.29 to 174.30.

**Transportation**

Available through: CADI, TBI, CAC, MR/RC and EW. CAC, TBI, CADI only: X5601-Transportation, Extended (ee) -one-way trip; X5602-Transportation, Extended (commercial) (ee) – per mile; X5602-Transportation, Extended (Noncommercial vehicle) (ee) – per mile, X5603-Transportation, Extended-Extra Attendant. MR/RC only: X5601-Transportation, Extended (ff)-per trip.

Transportation service is offered to enable the recipient to gain access to waiver and other community services, activities, and resources specified in the individual care plan or community support plan. Whenever possible, family, neighbors, friends, or community agencies that can provide transportation without charge should be used.

MA only covers transportation to and from MA covered medical appointments (waiver programs do not cover this type of transportation).

**Provider Standards:**

Special transportation is available for recipients who are certified as eligible for special transportation through a Minnesota Healthcare Programs Certification of Need form (DHS-2910), and who qualify because of a physical or mental impairment and cannot use a common carrier. This form needs to be completed by one of the following four individuals: Attending Physician, Nurse Practitioner, Clinical Nurse Specialist, or Physician Assistant. A copy of DHS-2910 may be found at
the end of Transportation Services chapter (Ch. 21) of this manual, or by contacting DHS Forms Supply. Special transportation providers must be certified by the Minnesota Department of Transportation under Minnesota Statutes, sections 174.29 to 174.30.

Providers of common carrier transportation are bus, taxicab, other commercial carrier, private automobile, or a county owned or leased vehicle. All providers/drivers must have a valid driver’s license and adequate insurance coverage. Standards are defined under Minnesota Rules, parts 9505.0315, subpart 1, 9565.4200, subpart 2 and 9565.4300, subparts 2 to 4. Common carrier transportation is reimbursed by the county of financial responsibility; special transportation is billed directly to MA.

Transportation information specific to waivers (01-56-19 attachment E):

- Certified (through the Minnesota Department of Transportation) special transportation providers may bill MA for both a one-way trip and the commercial per mile rate. The same procedure can be used for special transportation providers through the waivers. However, the transportation provider cannot bill for transportation services provided for any one trip for an individual through both MA and a waiver.
- Transportation provided in other commercial vehicles (taxis, buses) is limited to the actual cost using the one-way trip code or the commercial per mile code.
- Transportation in noncommercial vehicles (private, county, etc.) is limited to the cost using the one-way trip code or the noncommercial per mile code.
- Counties may use the same procedures the county uses for contracting and/or for arranging for MA reimbursed transportation.
- Additional information on MA transportation from the Minnesota Health Care Programs Provider Manual can be found at: www.dhs.state.mn.us/provider/manual/chapter21.htm

Transportation During Prevocational and Supported Employment Services:

Transportation may be included in the prevocational service and supported employment rates. If it is included in the contract between the vendor and local agency, transportation may not be provided as a separate TBI or CADI line item on the SA (duplication cannot occur). Transportation that was included in the rate for adult day care, prevocational and supported employment may now be billed as a separate service through the CADI and TBI waivers. Contracts with providers should be updated to reflect this change.

Extended Transportation:

Extended transportation, when this is available through a waiver, cannot be used to pay for the transportation costs for a therapist to go to a recipient’s home for services such as OT, PT, RT, and ST. Extended transportation services are for the transportation needs of the recipient.

24-Hour Emergency Assistance:

Available through: MR/RC (X5668-hourly-service; X5669-daily-item).
24-hour emergency assistance is the provision of ready access to assistance for a recipient from a qualified provider. This service provides on-call counseling and problem solving and/or immediate response for assistance at the recipient’s home due to a health or personal emergency. This service includes provision of electronic personal emergency response systems.

This service may be authorized as an integral component of the recipient’s Individual Service Plan (24-hour plan of care). If the service is initiated in response to unexpected needs, the authorization of the service must be followed by review of the Individual Service Plan within five days of the first date of service initiation and amendment of the Individual Service Plan as necessary to meet the ongoing needs of the recipient. 24-hour emergency assistance may be furnished by the same vendor providing residential habilitation services, through a different vendor other than the vendor providing residential support or via other means, such as an organization supporting electronic personal emergency response systems. The Individual Service Plan will identify: the need for the availability of this service; a description of how the service will be provided; how the patterns of 24-hour emergency assistance usage will identify other services needs, thus prompting a reconvening of the service planning team; the specific qualifications necessary for the service provider to have in order to meet the recipient’s needs; and the person or entity that is responsible for the provision of such assistance. This service will not duplicate other services provided to the recipient.

24-hour emergency assistance is limited to those individuals who live in their own home, are not receiving 24-hour supervision, and would otherwise require extensive, routine supervision or who live with a family member or a primary caregiver who would otherwise require extensive supports in the absence of this service to secure help in the event of an emergency. By providing immediate access to assistance to recipients in their homes, 24-hour emergency assistance serves to prevent institutionalization.

Provider Standards:

Services must be provided by individuals, organizations or entities that meet the standards identified through the individual service planning process. Providers must have professional certification or licensure as appropriate based upon contractual agreements for the provision of this service. Outcomes of this service will be clearly identified in the contract and evaluated at least annually.

Footnotes

(aa) CADI and TBI: The maximum rate is limited to the monthly limit for each case mix level. All other waiver services must be included within the monthly limit. Counties should negotiate rates based on the level of service provided. For example, if 24-hour supervision is provided, the rate may be negotiated up to the monthly limit. If less than 24-hours of supervision are provided (Assisted Living or Residential Care), the rate should be negotiated at a lesser amount.

(bb) Master prepared professionals may be reimbursed at 80% of the maximum rate.
(cc) Caregiver and Consumer Training and Education are limited to $2,500 annually by the waiver plan.

(dd) Negotiated based on the recipient’s needs and county contract. (For TBI only: The maximum rate is limited to the monthly limit for each case mix level. All other waiver services must be included within the monthly limit.)

(ee) For shared PCA service (1:2 and 1:3), enter X5581 with “Y” in the shared care indicator field on the service agreement. X5359 and X5360 are used for billing purposes only.

(ff) The total number of units provided during one calendar day may not exceed the full day rate for the service.

(gg) Full day is equivalent to six or more hours of service provided during one calendar day. If the vendor also provides transportation, the time involved with transportation may be included in this amount.

(hh) For CADI and TBI only: Use the nursing facility’s per diem rate for recipient’s case mix classification for respite provided in nursing home.

(ii) For AC and EW only: Allowable rate is the nursing facility’s per diem rate for the client’s case mix classification.

(jj) The rates listed are only available to certified providers of special transportation services to transport recipients who meet MA criteria for needing special transportation. Transportation provided in other commercial vehicles (taxis, buses) is limited to the actual cost. Transportation provided in noncommercial vehicles (private, county, etc.) is limited to the MA (federal tax return) rate. Use the mileage procedure code for noncommercial vehicles. Destinations and mileage for transportation must be documented on the provider comment screen of the service agreement.

(kk) Unit of service is defined by the Individual Service Plan or contract.

(ll) Residential Services Location and Size Criteria for CADI and TBI Waivers:

Residential services which include assisted living, residential care and foster care have been amended to provide size and location safeguards. The following criteria do not apply to settings that have continuously provided services to waiver recipients prior to May 1, 2001:

- CADI and TBI recipients are not eligible for residential care, adult or child foster care services if they reside in a newly developed setting adjoined to or on the same contiguous property as a nursing facility, hospital, intermediate care facility, or institute for mental disease.
- The total number of individuals (unrelated to the principal care provider) living in a newly developed setting cannot exceed four.
Exception:

- **Emergency Situation**: In an emergency situation, DHS may authorize services in a setting serving up to six individuals for up to 24 months. An emergency situation occurs when the settings needed to avoid placing the recipient in a regional treatment center or a nursing facility. To receive authorization from DHS for an emergency situation, contact the Regional Resource Specialist.

- **Size of Settings for Residential Care**: The size restriction does not apply to recipients 55 or older or to settings that have continuously provided waiver services which began prior to May 1, 2001. This means that recipients age 54 and under can reside in any size board and lodge that has continuously provided waiver services prior to May 1, 2001, cannot reside in new board and lodges except in emergency situations (board and lodge licenses are for settings of five or more recipients). Recipients who are 55 years or older can reside in any size of setting.

- **Exceptions to Size of Settings for Adult Foster Care**: There are no exceptions to the size requirements for adult foster care. This means that the total number of recipients that may reside in adult foster care is limited to four except in emergency situations.

- **Exceptions to Size of Settings for Child Foster Care**: The size restriction does not apply to settings that have continuously provided waiver services that began prior to May 1, 2001. This means that children may reside in any size family foster care setting that has continuously provided waiver services prior to May 1, 2001. The total number of children that may reside in a family foster care setting developed after May 1, 2001, is limited to four except in emergency situations.

**Legal References**

- Minnesota Statutes, section 256B.0915
- Minnesota Statutes, section 256B.0916
- Minnesota Statutes, section 256B.092
- Minnesota Statutes, section 256B.49
- Minnesota Rules, parts 9525.0004 to 9525.0036
- Title XIX, 1915 (c) of Social Security Act
- 42 CFR 441.300-441.365

Private duty nursing (PDN) is now defined in two categories—complex and regular. Complex is nursing provided to recipients who are ventilator dependent or for whom a physician has certified that were it not for PDN the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care. Regular is nursing care provided to a recipient who does not meet the definition and criteria for Complex PDN.
Chapter 27
Long Term Care

Long term care (LTC) facilities provide medical and supportive services for residents who:

• Have lost some capacity for self care due to chronic illness or condition; and
• Are expected to need care for a temporary or prolonged period of time.

Questions on LTC facilities, policy and services can be directed to:

Long Term Care Policy Center
Minnesota Department of Human Services
444 Lafayette Road
St Paul, Minnesota 55155-3836
651/297-3583

Definitions

**Certified Bed:** A bed certified under Title XIX of the Social Security Act.

**Certified Nursing Facility (NF):** A facility or part of a facility which is licensed to provide nursing care for persons who are unable to care for themselves properly.

**Demand Bill:** A claim sent to Medicare that the resident's family or other interested party requests to receive a decision from Medicare regarding the status of a claim.

**Discharge:** Termination of placement in the NF that is documented in the discharge summary and signed by the physician.

**Facility with Distinct Part Certification:** Sections of the facility certified as psychiatric, NF, or ICF/MR; must admit and care for those MA recipients certified as requiring the same level of care as the bed certification.

**Intermediate Care Facility for Persons with Mental Retardation or Related Conditions (ICF/MR):** A facility licensed to serve persons who have mental retardation or related conditions, as a supervised living facility under MN Statutes, Ch. 144 and certified by the Minnesota Department of Health (MDH) as an intermediate care facility for the mentally retarded.

**LTC Facility:** A residential facility certified by the MDH as a skilled nursing facility or as an intermediate care facility, including an ICF/MR.
Leave Day: An overnight absence of more than 23 hours. After the first 23 hours, additional leave days are accumulated each time the clock passes midnight. Absence must be for hospital or therapeutic cause.

Reserved Bed: The same bed that a recipient occupied before leaving the facility for hospital leave or therapeutic leave, or an appropriately certified bed if the recipient’s physical condition upon returning to the facility prohibits access to the bed he/she occupied before the leave. Commonly referred to as bed hold.

Short-term Stay: Nursing facility admission expected to be less than 14 days.

Swing Bed: A hospital bed that has been granted a license under MS 144.562 and which has been certified to participate in the federal Medicare program under US code title 42, section 1395. Refer to the Swing Bed section of this chapter.

Transfer: Temporary disposition of a resident, for whom a bed is being held, to an inpatient hospital.

Eligible Providers

Psychiatric hospitals, skilled nursing facilities (SNF), nursing facilities (NF), boarding care homes (BCH), and intermediate care facilities for people with mental retardation or related conditions (ICF/MR) certified by Minnesota Department of Health (MDH), are eligible to provide LTC services. Swing bed hospital provider eligibility information is specified in the Swing Bed section of this chapter.

Facilities with distinct part certification must admit and care only for those MA recipients certified as requiring the same level of care as the bed certification.

Exemption: An SNF, ICF or ICF/MR that is operated, listed, and certified as a Christian Science sanatorium by the First Church of Christ Scientist, of Boston, Massachusetts, is not subject to the federal regulations for utilization control in order to receive MA payments for the cost of recipient care.

Eligible Recipients

LTC facilities provide services to elderly people, persons with disabilities, and persons with mental retardation and related conditions.

MA eligible recipients must reside in a certified bed that matches his or her certified level of care.

MA will cover the cost of care for a recipient who resides in a certified NF, certified BCH, or licensed ICF/MR if the following requirements are met:
Certified Nursing and Certified Boarding Care Facility:

- The care is ordered by a physician;
- The care is provided in compliance with MDH; and
- The care provided in an NF or BCH is required because of physical or mental limitations determined through the preadmission screening process completed by the county, prior to admission to the facility, with certain exceptions defined below.

Intermediate Care Facility for the Mentally Retarded:

- The recipient meets admission criteria as determined by the admission review team, based on the preliminary evaluation prior to admission;
- The recipient is in need of and receives active treatment or specialized services;
- The recipient’s active treatment program is integrated, coordinated and monitored by a qualified mental retardation professional.

Each ICF/MR provider agency is responsible to meet all federal, state and local requirements.

Swing Bed Hospital:

- Specifications are in the Swing Bed section of this chapter

Utilization Control

Physician Certification

A physician must certify the need for a certified NF, certified boarding care facility, or ICF/MR. A DHS-1503 form must be completed in the following instances:

- Upon initial admission or upon readmission following discharge;
- When a recipient transfers from one LTC facility to another;
- When a recipient transfers within a facility from a NF1 (SNF/NF) to a NF2 (Certified Boarding Care Home) level of care;
- When a recipient returns from an unauthorized leave exceeding 24 hours; and
- When a recipient returns from hospitalization, if their level of care changes.

Telephone orders cannot be used for physician certification purposes. Written orders signed and dated by a physician are permissible for this purpose, or a physician may sign and date the DHS-1503 form.

The DHS-1503 form must be completed by the:
• **Recipient**: Within 30 days prior to the admission date, or on the date of admission. Payment will begin on the date the physician signs and dates orders for admission or the DHS-1503, or the actual admission date, whichever is later.

• **Applicant**: Within two weeks from notification by the county that an MA application was taken. Payment may begin up to three months prior to the month the MA application was taken, based on the local agency’s eligibility determination.

**Physician Recertification for ICF/MR Recipients**

The Physician Recertification Form (DHS-1743) must be completed annually, and at least 30 days after the completion of form DHS-1503.

**Physician Visits for NF and Boarding Care Recipients**

Under state rule, a certified NF or boarding care resident must be examined by a physician within five days prior to or 72 days after admission. After the admitting examination, the resident must be seen at least every 30 days for the first 90 days after admission and at least every 60 days thereafter.

When a recipient on a 60-day schedule of visits is transferred to a hospital and returns to the same NF, it is not necessary to begin a new 30-day schedule of visits for 90 days. The next required routine physician visit would occur 60 days after the recipient returns from the hospital.

At the discretion of the physician and in accordance with facility policy, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, certified nurse practitioner, or clinical nurse specialist. The physician assistant, certified nurse practitioner, or clinical nurse specialist must not be an employee of the NF. Refer to the Physician Services chapter (Ch. 6) for supervision requirements for physician extenders.

Residents who would otherwise be on a 60-day visit schedule, but refuse to see their physician this often, may waive this requirement. Under state law, physicians must see nursing home residents at least every six months and boarding care home residents at least once per year. Each refusal must be documented in the recipient’s medical record and signed by the resident and the physician.

**Discharge and Transfer**

When a resident is discharged, he/she is terminated from a residential treatment period of care through the formal release or death of the resident. The record must contain a discharge summary signed by a physician and the facility must notify the county. Payment is not made for reserving a bed after discharge. If the resident returns to the facility, all admission record requirements must be completed.

When a resident is transferred, he/she is temporarily placed into an inpatient hospital (not including regional treatment centers or other LTC facilities) and the facility holds the bed for the resident. The medical record must indicate the resident was absent from the facility and upon return must be updated with any changes. A transfer does not prohibit a facility from thinning the medical record.
In addition, any transfer, discharge or relocation of residents must comply with all applicable federal or state laws, including the state Resident Relocation law, found in M.S. 144A.161.

**Resident Classification**

As of October 1, 2002, the new Minnesota case-mix system, known as the RUG III 34 model was adopted. This model uses an existing federally mandated assessment instrument for all nursing facility residents.

Facilities must conduct and electronically submit to the Department of Health a case-mix assessment for all residents.

The assessments used to determine a case-mix classification for reimbursement include the following:

- A new admission assessment, to be completed by the 14th day following admission;
- An annual assessment, to be completed within 365 days of the last comprehensive assessment;
- A significant change assessment, to be completed within 14 days of the identification of a significant change; and
- A second quarterly assessment, following either a new admission, annual, or significant change assessment. Each quarterly assessment must be completed within 92 days of the previous assessment.

Minnesota law requires the same assessment schedule as is required by the Omnibus Budget Reconciliation Act, 1987 (OBRA) regulations for nursing homes.

**Penalty for Late or Non-Submission of Resident Assessment**

A facility that fails to complete or submit an assessment for a case-mix classification within seven days of the time required, is subject to a reduced rate for that resident. The reduced rate will be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments, or on the day that the assessment was due, for all other assessments. The reduced rate continues in effect until the first day of the month following the date of submission of the resident’s assessment.

**Request for Reconsideration of Resident Classification**

The resident, resident’s representative, or the nursing facility or boarding care home may request that the Department of Health reconsider the assigned reimbursement classification. Residents or their representatives have the right to review the MDS and other documentation in the medical record. Facility staff should help explain the assessment process and discuss any MDS items in question. If the resident, resident’s representative, or facility staff wish to pursue a reconsideration, the request must be submitted in writing to the Minnesota Department of Health within 30 days of the day the resident or the resident’s representative receives the resident classification notice.
For additional information about Minnesota Case-Mix or to request a reconsideration, contact:

Minnesota Department of Human Services
Case Mix Review Section
P.O. Box 64938
St Paul, MN 55164-9938
651/215-8703

Medical/Social Evaluation (ICF/MR Only)

Each recipient must have a medical evaluation whenever a DHS-1503 is required. The minimum requirements of this evaluation are:

- Diagnosis, symptoms, complaints/complications, present medical/developmental findings, and medical/social family history;
  - Mental/physical functioning levels;
  - Prognosis;
  - Range of needs, objectives, and plans for continuing care;
  - The physician’s recommendation for admission;

- Alternatives to LTC available in the home, family, and community; and
- Results of a psychological evaluation performed within three months prior to admission (not required upon return from hospitalization).

In the situation where a recipient is readmitted from a hospital stay or unauthorized leave, it is required to document the review and any update of the evaluation.

Overall Plan of Care (ICF/MR Only)

Each recipient must have an individual plan of care developed by an interdisciplinary team with representation from the professions, disciplines or service areas specific to the individual needs and program design.

The plan must be based on the results of a comprehensive functional assessment as defined by federal regulations.

The plan must state the objectives needed to meet the individuals’ needs as identified by the comprehensive assessment and document a sequenced plan for meeting the objectives. The objectives must:

- Be stated separately, in terms of a single behavioral outcome.
- Be assigned projected completion dates.
- Be expressed in behavioral terms that provide measurable indices of performance.
- Be organized to reflect a developmental progression appropriate to the individual.
- Be assigned priorities.
The plan must describe relevant interventions to support the individual toward independence. The interventions must:

- Identify the location where program strategy information can be found.
- Include training in personal skills essential for privacy and independence, if the individual lacks them.
- Identify the need for mechanical supports to achieve proper body position, balance or alignments, when they are to be applied, and a schedule for the use of each support.
- Provide that individuals who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area.
- Include opportunities for individual choice and self-management.

The plan must be completed within 30 days after admission.

The plan must be reviewed by the QMRP as needed and when the individual:

- Has successfully completed an identified objective(s).
- Is regressing or losing skills already gained.
- Is failing to progress toward identified objectives after reasonable efforts have been made.
- Is being considered for training towards new objectives.

The plan must be reviewed and documented by the interdisciplinary team, per case management dictates.

**Utilization Review (ICF/MR Only)**

The initial utilization review date for a recipient must be established at the time of admission and documented on the DHS-1503. The initial utilization review date for an MA applicant must be established when notified of MA eligibility.

The Utilization Review Group documentation must indicate the recipient has been reviewed at least every six months, or more often if the group deems it necessary.

Each time a DHS-1503 is required, the utilization review process must be re-established.

**Nursing Assistant (NA) Registry**

**Nursing Assistant Training and Competency Evaluation**

A LTC facility may employ an individual working in the facility as a nursing assistant for more than four months, if the individual:

- Is a permanent employee, competent to provide nursing and nursing related services; and
- Has successfully completed an approved training and competency evaluation program or a competency evaluation program approved by the state; or
• Has been deemed or determined competent as provided by the MDH.

A LTC facility may employ an individual working in the facility as a nursing assistant for less than four months, if the individual:

• Is a permanent employee enrolled in an approved training and competency evaluation program; or
• Has demonstrated competence through satisfactory participation in a state approved training and competency evaluation program or competency evaluation; or
• Has been deemed or determined competent as provided by the MDH.

A LTC facility may employ a non-permanent (temporary or contract) employee working in the facility as a nursing assistant, if the individual:

• Is competent to provide nursing and nursing-related services; and
• Has successfully completed a training and competency evaluation program or a competency evaluation program approved by the state.

Nursing facilities may employ an individual to work as a nursing assistant if the individual meets any of the requirements outlined above, but the facility must also seek and obtain a copy of the Nursing Assistant Registry verification for the permanent employment file. In the case of non-permanent (temporary or contract) staff, the nursing facility remains the responsible party to ensure that staff employed in their facility meet all requirements.

Information in Registry

The Nursing Assistant Registry includes substantiated findings of resident abuse, neglect, or misappropriation of resident property involving an individual listed in the Registry. It may also include a brief statement by the individual disputing the findings.

Contacting the Registry

When the Nursing Assistant Registry is contacted by telephone, the LTC facility will receive immediate verbal verification of the individual’s status on the Registry. If the NA is active on the registry, the facility can request an inquiry letter be mailed or faxed verifying the Nursing Assistant’s status. The facility will be instructed to speak to a registry representative if the NA is inactive, not on the registry, or has abuse allegations or findings on record.

Contact the Registry at:

Minnesota Department of Health
Division of Facility and Provider Compliance
85 East 7th Place, Suite 300
P.O. Box 64501
St. Paul, MN 55164-0501
(651) 215-8705 or 1-800-397-6124
Information on Nurse Aide Reimbursement

For questions related to nurse aide reimbursement policies, contact: Long Term Care Policy Center (651) 297-3583 or DHS.LTCPolicycenter@state.mn.us

Preadmission Screening (PAS) Under State and Federal Statutes

Minnesota statutes and federal law require that all applicants to certified nursing facilities, hospital “swing” beds, and certified boarding care facilities be screened by the county prior to admission.

The purpose of the preadmission screening program is to prevent or delay certified nursing facility placements by assessing applicants and residents and offering cost-effective alternatives appropriate for the person’s needs. Another goal of the program is to contain costs associated with unnecessary certified nursing facility admissions. The purpose of the screening activity is to determine the need for nursing facility level of care, and to complete activities required under federal law related to mental illness and mental retardation.

Preadmission Screening for Mental Illness or Mental Retardation

All applicants to certified nursing and boarding care facilities, as well as hospital “swing” beds must be screened prior to admission, regardless of income, assets, or funding sources, and except as outlined below. A person who has a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must receive a preadmission screening before admission, regardless of the exemptions related to level of care determinations outlined below, to identify the need for further evaluation and/or specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law Number 100-508.

The local agency will use qualified professionals, and forms and criteria developed by the commissioner to identify people who require referral for further evaluation and determination of the need for specialized services.

The local county mental health authority or the state mental retardation authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508.

Exemptions: Exemptions from the federal requirements for screening people for mental illness or mental retardation (and subsequent referrals for more completed evaluation as needed) are limited to:

- A person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility;
• A person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

• Certain hospital discharges when:
  ▪ The person is entering a certified nursing facility directly from an acute care hospital after receiving acute inpatient care at the hospital; and
  ▪ The person requires NF services for the same condition for which he or she received care in the hospital; and
  ▪ The attending physician has certified before admission that the individual is likely to receive less than 30 days of NF services. ALL of these conditions must be met in order for an admission to be considered exempt from preadmission screening.

Preadmission Screening for NF Level of Care Determination

The determination of the need for nursing facility level of care shall be made according to criteria developed by the commissioner. In assessing a person’s needs, screeners shall have a physician available for consultation and shall consider the assessment of the individual’s attending physician, if any. The individual’s physician shall be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies.

Exemptions: Persons who are exempt from preadmission screening for purposes of level of care determination include:

• Persons exempt under the federal requirements related to screening for mental illness or mental retardation as outlined above;

• An individual who has a contractual right to have nursing facility care paid for indefinitely by the veteran’s administration;

• An individual who is enrolled in the Ebenezer/Group Health social health maintenance organization project, or enrolled in a demonstration project under MS 256B.69, subdivision 8, at the time of application to a nursing facility;

• An individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the Social Security Act; or

• An individual admitted to a certified nursing facility for a short-term stay, which, based upon a physician’s certification, is expected to be 14 days or less in duration, and who have been screened and approved for nursing facility admission within the previous six months. This exemption applies only if the screener determines at the time of the initial screening of the six-month period that it is appropriate to use the nursing facility for short-term stays and that there is an adequate plan of care for return to the home or community-based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days.
days of the referral. Payment limitations listed below will apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.

**Individuals Under 21 Years of Age**

Exemptions outlined above DO NOT apply to people under age 21. Face-to-face assessment must occur before admission to an NF for all individuals under age 21, regardless of projected length of stay or admission source. At the face-to-face assessment, all community alternatives must be explored and presented to the person, his/her family, and/or the person’s representative. If an NF admission cannot be prevented, the admission must be approved by the Department of Human Services (DHS) by calling (651) 582-1921.

**Preadmission Screening and Medical Assistance Reimbursement**

Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the local county agency has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement or, if indicated, has not had an evaluation completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with mental retardation or related condition is approved by the state mental retardation authority.

The nursing facility shall not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under state and federal law. The nursing facility must include an unreimbursed resident day in the nursing facility resident day totals reported to DHS.

See MS 256B.0911 and Minnesota Rules 9505.2450 for authority for these payment limitations.

**Emergency Admissions**

Persons admitted to the Medicaid certified nursing facility from the community on an emergency basis as described in (1), or from an acute care facility on a nonworking day must be screened the first working day after admission.

Emergency admission to a nursing facility prior to screening is permitted when a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours and:

- The physician has determined that delaying admission until preadmission screening is completed would adversely affect the person’s health and safety.

- There is a recent precipitating event that no longer enables the client to live safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver is unable to continue to provide care.
The attending physician must authorize the emergency placement and document the reason that emergency placement is recommended.

The county screener must be contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation (i.e., stabilization of medications), or care in an emergency room without hospital admission, or following hospital 24-hour bed care.

**PAS Summary**

The table below summarized timelines and other requirements for preadmission screening as well as some follow-up activity performed by county Long Term Care Consultation staff.

<table>
<thead>
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<th>TIMELINES FOR PAS &amp; ASSESSMENTS FOR NURSING FACILITY ADMISSIONS</th>
<th>Preadmission Screening</th>
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<td>Under 65</td>
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<tr>
<td>Hospital Discharge: NF Admission Meets Criteria for a 30-Day Exemption</td>
<td>No PAS Required</td>
</tr>
<tr>
<td>Inter-facility Transfer (NF-NF or NF-Hosp-NF)</td>
<td>No PAS Required</td>
</tr>
<tr>
<td>Initial Admission Under a Qualifying 30-Day Exemption But Stay Exceeds 30 Days</td>
<td>By 40th Day of Admission: Face-to-face LTCC visit, OBRA Level 1, any needed OBRA Level 2</td>
</tr>
<tr>
<td>Hospital Discharge to NF: Stay Projected to be 30 Days or Longer, or Admission Doesn’t Meet Other 30-Day Delay Criteria</td>
<td>Before Admission. May be telephone or face-to-face. If telephone: LTCC visit must occur within 20 working days of admission.</td>
</tr>
<tr>
<td>Admission from a hospital to NF on non-working county day</td>
<td>Next work day after admission LTCC visit within 20 working days of admission if telephone screen</td>
</tr>
<tr>
<td>Initial screening after emergency NF admission</td>
<td>Next work day after admission LTCC visit within 20 working days of admission if telephone screen</td>
</tr>
<tr>
<td>Age 20 and under</td>
<td>Face-to-face LTCC &amp; DHS approval required for any admission to NF</td>
</tr>
<tr>
<td>Required face-to-face assessment for persons age 21 to 64 admitted to NF if admitted by telephone screening</td>
<td>Within 20 work days of admission</td>
</tr>
</tbody>
</table>

**County Responsibility**

- Under certain circumstances, counties have the option to complete a PAS face-to-face or by telephone. PAS must be completed by a public health nurse and/or social worker.
- The LTC facility must notify all applicants who request admission, and their families, that a PAS is required before admission. The LTC facility must also notify the county PAS screener of all new applicants.
• Under most circumstances, the “county of location” is responsible for PAS for recipients requesting admission to a certified nursing facility or certified boarding care facility.

• If the person leaves a correctional facility (on medical release) to enter a NF, the person must be screened by the county in which the prison is located.

• If the person is being discharged from the hospital to the nursing facility, contact the county in which the hospital is located.

**Nursing Facility and Boarding Care Home Responsibility**

NFs' and certified boarding care facilities' responsibilities under the PAS program include the following:

• Determining if applicant has been screened;
• Informing applicants of PAS program requirements and background;
• Obtaining consent for PAS and notifying the county; and
• Providing the screener with pertinent information obtained from the applicant or family.

For further details on PAS, contact the PAS screener in your county or PAS coordinator at DHS at (651) 297-3805.

The LTC facility should retain the following documents:

• PAS notice to resident that he/she has been screened;
• Statement of applicant’s choice for placement; and
• A copy of the Level I form signed by the screener.

**Medicare Revenue Enhancement Program (MREP)**

The Medicare Revenue Enhancement Program (MREP) recovers MA funds and identifies other areas of savings to the MA program. MREP also appeals denied Medicare benefits in cases where Medicare should cover the services.

**MREP Process**

• LTC staff initially determines Medicare coverage.
• A resident that has been denied Medicare coverage upon admission to the LTC facility, or is no longer coverable under Medicare, must be given written notice by the LTC facility.
• LTC facilities may be required to refer cases to MREP when:
  ▪ The resident is an MA recipient;
  ▪ MA eligibility is pending; and
The resident is MA eligible and has Medicare through fee-for-service Medicare, an HMO, MSHO or MnDHO.

To request information or obtain instructions for the referral process, contact:

Medicare Revenue Enhancement Program
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3863
Phone numbers: (651) 297-7797 or (651) 297-1098

Referral and Screening Process

The LTC facility must complete the steps listed below for referral and screening Medicare/MA eligible recipients:

- The LTC facility determines Medicare coverage on admission and/or continued stay.
- The LTC facility must submit the above information to DHS within four weeks of denial.
- DHS screens the case for Medicare/MA eligibility and Medicare skilled level of care/skilled services.
- DHS requests a specific demand bill from the LTC facility, if applicable.
- The NF completes Medicare demand bill and submits to Medicare with paperwork required by the fiscal intermediary in the next billing cycle. The LTC facility may reverse the original decision and submit a covered claim in place of a demand bill.
- DHS receives the resolution of demand bills, reviews cases for further appeal, and will recover funds from LTC facility. If Medicare did not cover the entire month, the SNF must submit a claim to DHS for the non-covered days.
- DHS screens appealable cases for cost effectiveness. If cost effective, cases are referred for reconsideration and an administrative law judge (ALJ) hearing.
- DHS receives results of the reconsideration, including justification for denial. If the decision is reversed, the LTC facility must submit a claim to Medicare with the proper documentation.
- DHS pursues ALJ hearings. If the decision is reversed, the LTC facility will be paid by completing a payment adjustment.

The HMO appeals process does not require a demand bill be sent. Once services are denied by the HMO, a request for a review of the denied services goes directly to the reconsideration level of appeal. The request for reconsideration must be made within 60 days from the date the HMO made its determination not to cover the stay. It is very important to send the MREP denial referral as soon as the provider knows the HMO has denied the stay, or part of the stay.
Covered Services

MHCP covers room and board care for an MA recipient in a certified NF, certified boarding care facility or ICF/MR. The care and monthly room and board services (per diem) cannot be billed until the beginning of the following month (e.g., January services cannot be billed until February 1).

**Items/services usually included in the per diem (not an all-inclusive list):**

- Nursing services;
- Laundry and linen services;
- Dietary services;
- Personal hygiene items necessary for daily personal care (e.g. soap, shampoo, toothpaste, toothbrush, shaving cream, etc.); and
- Over-the-counter drugs or supplies used on an occasional, as needed basis (e.g. aspirin, acetaminophen, antacids, cough syrups, etc.)

**Items/services not included in the per diem (not an all-inclusive list):**

MA covers the majority of costs incurred while in a nursing facility. However, a resident may be responsible for some non-covered MA services, such as:

- Special Services;
- Other services not covered by MA; and
- Spenddown amounts

**Additional Charges for Special Services**

State law allows a facility to charge residents for special services that are not included in the per diem. Special services must be available to all residents in all areas of the facility and charged separately at the same rate for the same services. In order to qualify as a special service, the following conditions must be satisfied for MA and private-pay residents:

- The facility must provide a detailed explanation of what is included in the case-mix rate;
- The facility must provide a detailed explanation of the special service and the additional charge;
- The cost of the special service must not have been included in the facility’s historical cost in the cost report for the prior reporting year;
- The service cannot be a licensure or certification requirement;
- Each resident or potential admission must be free to choose whether or not he/she desires to purchase the special service from the facility; and
- The facility must allocate and report the cost and charges associated with the provision of special services under unallowable costs in the facility’s annual cost report (for those required to file).
Questions regarding nursing facility services may be directed to:

Long Term Care Policy Center  
(651) 297-3583  
or  
DHS.LTCpolicycenter@state.mn.us

Rehabilitative Services

Long-term care facilities may provide rehabilitative services to their residents and members of the community, utilizing either their own staff or by contracting with an outside service vendor (rehab agency). Services must be provided on the premises.

The billing party may only bill physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP), if it is not a part of the facility’s per diem. MHCP will not make separate reimbursement for therapy services for residents of an LTC facility that includes therapy as part of the per diem rate. The party designated to do the billing shall bill for all rehabilitative services. Refer to the Rehabilitative Services chapter (Ch. 17) for covered services.

**Note:** The provider that bills for and receives payment for services is responsible for the accuracy of the claims and for maintaining patient records that fully disclose the extent of the benefits provided. Also, if Medicare requires the LTC facility to do the billing for Medicare covered rehabilitative services for dually eligible recipients, you must follow Medicare’s requirements until Medicare benefits are exhausted.

Leaves Days (SNF/NF/BCH)

Leave days are eligible for MA payment. A leave day must be for hospital leave or therapeutic leave of a recipient who has not been discharged from an LTC facility. A reserved bed must be held for a recipient on hospital leave or therapeutic leave. Payment for leave days in an SNF or NF is limited to 79% of the applicable payment rate.

To be eligible for MA payment, the following criteria must apply:

**Hospital leaves:**

- The recipient must have been transferred from an LTC facility to the hospital;
- The recipient’s record must document the date the recipient was transferred to the hospital and the date the recipient returned to the LTC facility; and
- The hospital leave days must be reported on the claim submitted by the LTC facility with the appropriate hospital leave revenue code.

**Therapeutic leaves:**

- The recipient’s record must document the date and time the recipient leaves the LTC facility and the date and time of return;
• The recipient may go on a home visit or vacation, to a camp that meets MDH licensure requirements, or to another residential setting except another LTC facility, hospital or other entity eligible to receive federal, state or county funds for his/her maintenance; and
• The therapeutic leave days must be reported on the claim submitted by the LTC facility with the appropriate therapeutic leave revenue code.

Leave day limitations:

Payment for hospital leave days is limited to 18 consecutive days for each separate and distinct episode of medically necessary hospitalization. Separate and distinct episode means:

• The occurrence of a health condition that is an emergency;
• The occurrence of a health condition that requires inpatient hospital services, but is not related to a condition which required previous hospitalization and was not evident at the time of discharge; or
• The repeat occurrence of a health condition that is not an emergency, but requires inpatient hospitalization at least two calendar days after the recipient’s most recent discharge from the hospital.

MA payment for therapeutic leave days is limited to the number of days listed below:

• Recipients in an SNF or NF or certified boarding care facility are entitled to 36 leave days per calendar year.

MA payment for leave days beyond the 18 or 36-day limit is prohibited, regardless of the occupancy rate. However, the resident or family may opt to pay the LTC facility to hold the bed beyond the MA benefit period, if the facility offers this special service. If a resident is on leave day status, under most circumstances the facility may not discharge the resident or fill the bed with another resident until after the 18 or 36-day leave period has elapsed, and not at all if the resident has elected to self-pay for days beyond the 18 or 36-day leave period. This policy applies regardless of the facility’s occupancy rate. MA residents that exhaust their hospital leave days and are subsequently discharged from the facility, are entitled to be readmitted to the facility to the next available bed.

Note: A 30-day notice may be required before a resident can be discharged due to leave days being exhausted, as provided in MS 144.652, subd.29.

Intermediate Care Facilities for Mental Retardation (ICF/MR)

For information on ICF/MR therapeutic leave day policy and payment, go to http://www.dhs.state.mn.us, select “reports & manuals” and scroll down to ICF/MR.

Determining the Number of Leave Days

According to the definition of “leave day,” an overnight absence of more than 23 hours is considered a leave day that must be reported. An absence of less than 23 hours on the first day is not a leave day. After the first 23 hours, each time the clock passes midnight counts as an additional leave day.
Examples:

<table>
<thead>
<tr>
<th>LEAVE</th>
<th>RETURN</th>
<th>NUMBER OF LEAVE DAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:30 p.m. Friday</td>
<td>11:30 a.m. Saturday</td>
<td>0 (Less than 23 hours)</td>
</tr>
<tr>
<td>4:30 p.m. Friday</td>
<td>5:00 p.m. Saturday</td>
<td>1 (More than 23 hours)</td>
</tr>
<tr>
<td>4:30 p.m. Friday</td>
<td>8:00 p.m. Sunday</td>
<td>2 (More than 23 hours; past midnight once)</td>
</tr>
<tr>
<td>4:30 p.m. Friday</td>
<td>7:30 a.m. Monday</td>
<td>3 (More than 23 hours; past midnight twice)</td>
</tr>
</tbody>
</table>

**Occupancy Rate**

Payment for hospital leave and therapeutic leave days are subject to the following occupancy rates:

- LTC facilities with 25 or more licensed beds will not receive payment if the average occupancy rate was less than 93% during the month of leave;
- LTC facilities with 24 or fewer licensed beds will not receive payment if a licensed bed has been vacant for 60 consecutive days prior to the first leave day. (Date of death or discharge will be considered day one when counting consecutive days.); and
- The LTC facility charge for a leave day must not exceed the charge for a leave day for a private paying resident in the same type of bed.

The occupancy rate may be calculated separately for each level of care in the facility as follows:

- Determine the number of days each licensed bed was occupied during the month. (Note: A reserved bed is to be considered an occupied bed for this purpose.)
- Total to determine the number of occupied bed days for the month;
- Divide by the number of days in the current month; and
- Divide by the number of licensed beds to determine the occupancy rate for the month.

For questions on SNF/NF/BCH bed hold and leave day policy, contact:

Department of Human Services  
Long Term Care (LTC) Policy Center  
444 Lafayette Road  
St. Paul, MN 55155-3836  
(651) 297-3583  
DHS.LTCpolicycenter@state.mn.us

**Private (Single Bed) Rooms in NFs**

To receive MA payment for a single bedroom for an MA recipient, the following requirements must be met:
• The recipient’s attending physician must determine and certify that a single bed room is necessary because of a medical or behavioral condition that affects the health of the recipient or other residents (the estimated length of time the private room is needed must also be indicated);
• The single bed room must be located in an NF which has chosen to assign a greater proportion of their costs to single bed rooms;
• The bed in the single bed room must be certified for MA by the MDH;
• The Quality Assessment and Assurance Committee (QAAC) must review the attending physician’s recommendation for the single bed room, and sign a statement that a single bed room is required; and
• The attending physician’s statement, the QAAC’s statement and any additional relevant documentation from the recipient’s medical record, must be submitted to DHS for review.

Mail the above information to:

Department of Human Services
Continuing Care for Elderly – Attn: Kent DuFresne
444 Lafayette Road
St. Paul, MN 55155-3836

Swing Bed Hospital Services (NF/Swing Beds)

State law allows MA payments for swing bed services provided by a designated licensed hospital, if the following criteria are met:

• The hospital is the sole community provider, or is a public hospital owned by a government entity with 15 or fewer acute care beds;
• The MA patient requires skilled nursing care per Medicaid guidelines;
• A nursing home bed is not available within 25 miles of the facility;
• The patient is transferred from an acute care hospital bed and acute care is no longer needed;
• The person must receive a preadmission screening prior to placement as specified in the Preadmission Screening section of this chapter; and
• The hospital enrollment criteria, specified in the Requirements for Providers chapter (Ch. 1) are met.

Eligible Provider

To be eligible as a swing bed provider in the MA program, a provider must accomplish the following:
• Receive Medicare certification as a Medicare swing bed provider. Medicare certification requires a survey by the MDH. Certification information may be obtained from:

  Minnesota Department of Health (MDH)
  Facility and Providers Compliance Division
  85 East 7th Place
  P.O. Box 64900
  St. Paul, MN 55164
  (651) 215-8701

• Sign a Swing Bed Provider Agreement with DHS. Provider agreement information may be obtained from:

  Minnesota Department of Human Services
  Continuing Care for Elderly – Attn: Kent DuFresne
  444 Lafayette Road
  St. Paul, MN 55155-3836

Exceptions: Swing bed services may be billed by a hospital not enrolled in the MA program only in the case of a Qualified Medicare Beneficiary (QMB) receiving Medicare swing bed services. Coinsurance and deductible on QMB claims will be paid for the length of the Medicare approved stay. MA also covers up to 10 days of nursing care provided to a patient in a swing bed if:

• 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 moving the recipient would not be in the best interests of the recipient and the recipient’s family;
• A nursing home bed is not available within 25 miles of the facility; and
• An open bed is not available in any Medicare hospice program within 50 miles of the facility.

Eligible Recipients

To be eligible for swing bed payment, there must be documentation that the recipient requires a level of skilled nursing care consistent with admission to an LTC facility and no longer requires acute care hospital services. If the need for skilled nursing care cannot be documented, the services are not eligible for MA payment. A copy of the preadmission screening document must be attached to the claim.

Preadmission Screening

All persons seeking placement in a swing bed must be screened either through a community screening or through a telephone screening prior to admittance to a swing bed in accordance with the policy described in the Preadmission Screening (PAS) section of this chapter. Exceptions to PAS in swing bed placement are:
• Persons admitted from the community on a physician certified emergency basis or persons admitted on a county non-working day must be screened on the first county working day after admission;
• Persons returning to a swing bed who entered an acute care facility from a swing bed;
• Persons in a swing bed who are transferring to another swing bed in another facility;
• Persons who have a contractual right to have their swing bed services paid for by the Veterans Administration; and
• Persons who are enrolled in the Ebenezer/Group Health Social HMO Project at the time of application to the swing bed.

Limitations

In accordance with state law, payment for swing bed services for an MA recipient is limited to 40 days, unless the Commissioner of MDH grants an extension. Approval for services in excess of 40 days must be requested in writing from MDH at least ten days before the end of the maximum 40-day stay. The extension approval must be attached to claims, which include service dates beyond the initial 40-day period. Eligible hospitals are allowed a total of 1,460 days of swing bed use per the state's fiscal year, (July 1 to June 30) provided that no more than 10 hospital beds are used as swing beds at any one time.

Ancillary Services

Routine care and services, similar to those provided in an NF, are included in the daily swing bed payment rate. All other covered services may be billed to the MA program. All ancillary services must be billed in accordance with the respective guidelines for the service, as outlined in the appropriate chapters of this manual.

Billing Guidelines

• Room and board services must be billed in the UB-92 format using the hospital’s provider number. The type of bill must be 281.
• The daily room and board payment rate for swing bed services is set by law as the statewide average payment rate of all MA nursing facilities’ per diem. This rate is computed annually, effective each July 1.
• Only non-over-the-counter (OTC) DHS formulary pharmacy services can be billed outside the room and board per diem. Stock medications and OTC products are not separately reimbursable.
• Ancillary services for Medicare eligible people must be billed to Medicare. If the services are not covered by Medicare, MHCP may be billed (fee-for-service recipients only).

ICF/MR Rate Adjustment Options (as of 7/1/02)

The ICF/MR system manual has been compiled as the training and information tool for ICF/MR providers and counties. To access this manual go to www.dhs.state.mn.us/infocenter/docs.htm. Scroll down to ICF/MR systems manual and double-click to open. The thumbprints on the left side
of the manual identify the page numbers so that a single page can be printed. All information is current as of 7/1/02.

**Variable Rate Process**

An ICF/MR provider may request a variable rate increase if there were a significant client change of condition. Completion of a full team screening or an updated ISP is required at the time the significant change is identified.

- A variable rate request form is completed and submitted to the county for review, and if the county agrees, their signature. The form is then forwarded to the Disability Services Division (DSD) for review.
- If approved, DSD initiates a service agreement. The ICF/MR provider will receive a copy of the service agreement so that approved services can be billed.

Use the information on the service agreement to complete the HCFA-1500 form. The following DHS codes must be used to bill for services supported by a variable rate request:

- X5635 - medical, behavioral, retirement, partial retirement
- X5638 - professional consultant

**Note:** the variable rates have a limit of 12 months per individual recipient. Only retirement variable rate requests can be re-applied for. Approved variable rates are recipient and provider specific.

**ICF/MR 75-Day Occupancy Facility Rate Adjustment**

A rate adjustment is available for an ICF/MR facility when a vacancy to a licensed bed occurs due to discharge or death when the necessary criteria is met. Refer to the specific information in the ICF/MR provider manual referenced in the section “Rate adjustment options for ICF/MRs as of 7-1-02”.

**ICF/MR Statewide Advisory Committee**

The Statewide Advisory Committee (SAC) is composed of five-members. They include:

- One county representative;
- One advocate;
- Two provider representatives (plus one alternate); and
- One DHS representative.

Membership on the SAC rotates membership with two-year terms in rotation so that three of the members may rotate off every two years. The role of the SAC is to consider proposals from providers for rate increases in the following categories:

- Rate increases;
- Closures;
• Downsizing; and

Once the proposals are considered at a SAC meeting, a recommendation is made to the commissioner for approval, denial, or table of the proposal for further information. The SAC committee will use ranking criteria for ranking like proposals. The amount available for the committee decisions will be set aside by legislative action.

Once every two years Disability Service Division will publish a notice in the *State Register*, which will include information about guidelines for submitting proposals and the level of funding available.

• Proposals will be reviewed at the meetings identified in the *State Register*. Once proposals are requested, submit proposals to:

  ICF/MR Coordinator - DSD  
  444 Lafayette Road North  
  St. Paul, MN 55155-3857

A copy of the SAC meeting minutes, including decisions made, is sent to Care Providers, ARRM, Advocacy, committee members and the providers whose proposals were discussed. Meeting minutes will be made available to others upon request.

**Equalization**

State law prohibits LTC facilities from charging private-pay residents higher rates than those approved by DHS for MA recipients. The law also allows residents to be awarded three times the payments that result from a violation. For more information on Equalization and Special Services, refer to the section in this Chapter on “Special Services.”

**Exceptions**

• The Equalization Law does not apply to third party payers; and
• The Equalization Law may or may not apply to private paying residents in single bed rooms, depending on the cost allocation method for single bed rooms chosen by the facility on their annual cost report;

**Conditions of Participation**

**Termination of Provider Agreement**

A LTC facility that chooses not to comply with the Equalization Law may voluntarily withdraw or involuntarily be withdrawn from the MA program. Under most of these circumstances, the provider becomes ineligible to receive payment under other state and county programs. Special laws apply to Nursing Facility providers that withdraw from the Medicaid program (contact the LTC Policy Center at (651) 297-2383 for more information). If discharge of residents is
necessary, discharge planning and relocation must be done in accordance with all provisions of
state and federal Resident Rights and the state Resident Relocation Law.

Segregation of MA Residents

Partial certification or de-certification of a distinct part of an NF may result in the segregation of
MA residents. These practices discriminate against residents based on their source of funding
and may violate both the Equalization Law and anti-discrimination laws. DHS will not enroll
facilities that stigmatize residents receiving public assistance or practice other forms of resident
discrimination. LTC facilities that intend to or have segregated MA residents will be investigated
by DHS.

Solicitation of Contributions

Federal law prohibits soliciting contributions, donations, or gifts directly from MA residents or
family members. General public appeals for contributions are not considered direct solicitation of
MA residents or families. If an MA resident or family member makes a free-will contribution, the
LTC provider is required to execute a statement for signature by the contributor and the LTC
administrator, stating services provided in the LTC facility are not predicated upon contributions or
donations and the gifts are free-will contributions.

Change of Ownership

The Social Security Act requires a LTC facility to promptly report any organizational or ownership
changes to the Minnesota Department of Health (MDH) to maintain enrollment with MHCP.

MDH will determine if the LTC facility continues to meet minimal state and federal standards under
new ownership. MDH will submit copies of the certification to the LTC facility, DHS, and the
county.

When DHS receives notification of change of ownership, the Provider Enrollment Unit will
terminate the MHCP provider number assigned to the previous owner. The new owner must submit a
new application and agreement to the Provider Enrollment Unit for a new MHCP provider number.

DHS will forward the new MHCP provider number to the county. The county will update its records
and reassign MA recipients with the new provider number.

According to state law, the owner of the LTC facility is liable for any overpayment amount owed by
a former owner for any facility sold, transferred, or reorganized.
Resident Trust Account

Administration of Resident Fund Accounts

A LTC facility resident may deposit his/her funds, including the personal needs allowance established under Minnesota statutes, in a resident fund account administered by the facility. An LTC facility must comply with MDH regulations concerning resident funds in addition to the following provisions:

- Credit to the account all funds attributable to the account including interest and other forms of income;
- Not co-mingle resident funds with the funds of the facility;
- Keep a written record of the recipient’s resident fund account, including the date, amount, and source of deposit or withdrawal recorded within five working days of the account activity;
- Require a recipient who withdraws $10.00 or more at one time to sign a receipt for the withdrawal. A withdrawal of $10.00 or more that is not documented by a receipt must be credited to the recipient’s account. Receipts for the actual item purchased for the recipient’s use may substitute for a receipt signed by the recipient;
- Not charge the recipient a fee for administering the recipient’s account;
- Not solicit donations or borrow from a resident fund account;
- Report and document to the county a recipient’s donation of money to the facility when the donation equals or exceeds the statewide average MA payment for SNF care;
- Not use resident funds as collateral for or payment of any obligations of the facility; and
- Treat funds remaining in a recipient’s account upon death or discharge as required by MDH regulations.

Limitations on Use of Trust Funds

Funds in the recipient’s resident fund account must not be used to purchase the following items or services generally reported in the facility’s cost report:

- Medical transportation;
- Initial purchase or replacement purchase of furnishings or equipment required as a condition of certification as an LTC facility;
- Laundering the recipient’s clothing;
- Furnishings or equipment not requested by the recipient for personal convenience;
- Personal hygiene items necessary for daily personal care (e.g., bath soap, shampoo, toothpaste, toothbrushes, dental floss, shaving cream, razor, facial tissues); and
- Over the counter drugs or supplies used by the recipient on an occasional, as needed basis, not prescribed for long-term therapy of a medical condition (e.g., aspirin, acetaminophen, antacids, antidiarrheals, cough syrups, rubbing alcohol, talcum powder, body lotion, petroleum jelly, mild antiseptic solutions, etc.).
These limitations do not prohibit the recipient from using his/her funds to purchase a brand name supply or other furnishings not routinely supplied by the LTC facility.

Questions on LTC policy and services may be directed to:

Long Term Care Policy Center  
Department of Human Services  
444 Lafayette Road  
St. Paul, MN 55155-3836  
(651) 297-3583

Legal References

MS 144.562, subd. 2 & 3  
MS 256B.27, subd. 1  
MS 256B.0625, subd. 2  
MS 256B.0911 (section 5-PAS)  
Minnesota Rules 9505.2390 to 9505.2500 (Rule 65)  
MS 256B.48 (Section 8: 186)  
MS 256B.501, subd. 8; 8a  
Minnesota Rules 9510.1020 to 9510.1140 (Rule 186)  
Minnesota Rules 9549.0060, subp. 11  
Minnesota Rules 9549.0070 subp. 3.
Chapter 28
Hospice Services

The hospice benefit is a comprehensive package of services offering palliative care support to terminally ill recipients and their family. Hospice care is palliative, with a focus on holistic support and relieving pain and other symptoms of the terminal illness. Recipients electing the hospice benefit agree to receive only palliative care for their terminal illness or condition. When a recipient voluntarily elects the hospice benefit, they agree to forego curative care for their terminal diagnosis. In exchange, the recipient receives the hospice package of services.

The hospice benefit is available to recipients who have been certified by a physician as terminally ill. A recipient is considered to be terminally ill if he or she has a medical prognosis with life expectancy of six months or less when the disease runs its normal course. Hospice may be in effect greater than 6 months. Recipients who meet these requirements may elect the hospice benefit. Dually eligible recipients who elect the Medicare hospice benefit must also elect the MA hospice benefit. Recipients with a terminal illness must be informed of all MA services and support options including the hospice benefit. Hospice care is entirely optional and the recipient may revoke their election at any time.

The MA hospice benefit follows the same rules and regulations as the Medicare hospice benefit, which was designed to supplement the care provided by primary care givers such as family (as the recipient defines family), friends and neighbors. The hospice benefit is not intended to replace the supportive role of the recipient’s informal support network of primary care givers. As such MA-covered services that replace the duties of primary care givers do not duplicate the hospice team’s services. Examples of supportive functions that are provided by primary care givers include:

- Coordinating the recipient’s care;
- Performing personal care;
- Assisting with activities of daily living, assisting with incidental activities of daily living;
- Providing nutrition; and
- Assisting with medications.

Examples of services that may resemble the supportive role provided by primary care givers include:

- Adult foster care services;
- Personal care assistant services;
- Home delivered meals;
- Lifeline; and
- CAC, CADI, TBI, EW, and MR/RC waiver services, and the Alternative Care program.
Definitions

**Cap Amount**: The limit on overall hospice payment.

**Crisis**: A period during which the recipient requires continuous care for palliation or management of acute medical symptoms.

**Continuous Home Care Day**: A day in which the recipient receives nursing services including home health or homemaker services, on a continuous basis during a period of crisis, for at least eight hours and as many as 24 hours per day, as necessary to maintain the recipient at home. More than half the care during the crisis must be nursing care provided by a registered nurse or licensed practical nurse. The hospice uses the hourly rate for the actual hours of services provided, up to 24 hours.

**Employee**: An employee of the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization assigned to the hospice unit, including a volunteer under the supervision of the hospice.

**General Inpatient Day**: A day in which the recipient receives general inpatient care in a hospital, skilled nursing facility, or inpatient hospice unit for control of pain or management of acute or chronic symptoms that cannot be managed in the home.

**Home**: The recipient's place of residence.

**Hospice Care**: The services provided by a hospice to a terminally ill recipient.

**Inpatient Care**: The hospice services provided by an inpatient facility to a recipient who has been admitted to a hospital, long term care facility, or facility of a hospice that provides care 24 hours per day.

**Inpatient Facility**: A hospital, long term care facility, or facility of a hospice that provides care 24 hours per day.

**Interdisciplinary Group**: A group of qualified individuals with expertise in meeting the special needs of hospice recipients and their families, including, at a minimum, providers of core services. An interdisciplinary group must have at least one physician, one registered professional nurse, one social worker, and one pastoral or other counselor.

**Legal Representative**: A person who, under Minnesota law, may execute or revoke an election of hospice care on behalf of the recipient because the terminally ill recipient is mentally or physically incapacitated.

**Palliative Care**: Care affording relief, but not cure. Providing an alleviating medicine. Managing the symptoms experienced by the hospice recipient with the intent to enhance the quality of life for the hospice recipient and his/her family, but not directed at curing the disease.
Respite Care: Short-term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient.

Social Worker: A person who has at least a bachelor’s degree in social work from a program accredited or approved by the Council on Social Work Education and who complies with the Minnesota statues related to social work licensure.

Terminally Ill: A medical prognosis with a life expectancy of six months or less, given that the terminal illness runs its normal course.

Eligible Providers

A hospice organization may enroll as an MHCP hospice provider if it is licensed and certified for Medicare as a hospice by the Minnesota Department of Health. In order for hospice services to be covered, a plan of care must be established.

A hospice may use contracted staff to supplement hospice employees during periods of peak recipient loads or other extraordinary circumstances. The hospice remains responsible for the quality of services provided by contracted staff.

Eligible Recipient

To be eligible for hospice services, a recipient must be:

- MA (Medicaid) or MinnesotaCare eligible; and
- Certified as terminally ill by the medical director of the hospice, or a physician member of the interdisciplinary group, and the recipient’s attending physician, if he/she has one.

MA recipients who may be eligible for Medicare must be directed to the Social Security Administration for Medicare application. MinnesotaCare recipients must be directed to their local county human services agency for MA eligibility determination.

Dually eligible recipients who elect Medicare hospice must also elect MA hospice. The Medicare hospice election form must be sent to DHS on the day of election.

GAMC recipients who are terminally ill are not eligible for hospice care and should be referred to their county human services agency for MA eligibility determination.

A recipient may receive hospice care until:

- They are no longer certified as terminally ill; or
- The recipient or their representative revokes the election of hospice care.
Covered Services

The hospice benefit includes coverage for the following services, when provided directly in response to the terminal illness:

- Physician services
- Nursing services
- Medical social services
- Counseling
- Medical supplies and equipment
- Outpatient drugs for symptom and pain control
- Dietary and other counseling
- Short-term inpatient care
- Respite care
- Home health aide and homemaker services
- Physical, occupational, and speech therapy
- Volunteers
- Other items and services included in the plan of care that are otherwise covered medical services

Hospice Care Provided In Conjunction with Other MA-Covered Services

DHS understands that recipients facing death may have a complex set of health care needs. These needs often stem from their terminal condition. These needs may also stem from other medical conditions that either (a) pre-existed their terminal condition, or (b) arise during the course of their terminal condition but are unrelated to their terminal condition. A recipient should never be asked to make an “either/or” choice between an otherwise MA-covered, medically necessary service which is not related to the terminal condition, and covered, medically necessary hospice benefit service that is related to the terminal condition.

Pre-existing health care needs

Some MA-covered services may already be needed and/or in place before the recipient seeks hospice, due to the recipient’s pre-existing medical conditions or disability. The hospice benefit is not intended to duplicate health services or supports that relate to a pre-existing condition. Examples include continuing care services such as home care related to a previous stroke, waiver services related to a disability, or adult foster care related to a disability such as elderly dementia. Examples of pre-existing medical care include services for conditions such as diabetes, ALS, arthritis, cardiac conditions, AIDS, or high blood pressure.

Pre-existing continuing care services may need to be adjusted during the period that the recipient is receiving the hospice benefit. Recipients with pre-existing needs, such as quadriplegia or stroke, may have more intensive physical needs due to the terminal illness compared to persons without such pre-existing conditions. The resulting higher needs are an interaction of the two conditions together; some of which may need to be addressed through increased continuing care services.
Medical needs that arise during the period of the hospice benefit but which are unrelated to the terminal illness

Sometimes recipients need new health care services in addition to the services that are offered as part of the hospice benefit. MA-covered services may be provided in response to conditions not related to the terminal condition. Examples of this include treatment for a hip fracture unrelated to the terminal diagnosis, or the development of a new condition or symptom unrelated to the terminal diagnosis.

How to Determine When a MA-Covered Service Duplicates of a Hospice Benefit Service

Generally, the determination about whether a service duplicates a hospice benefit service will be made as part of the hospice provider’s general responsibility to provide care coordination. The hospice care coordinator must assume the lead responsibility for collaborating with the county case manager, home care agency, physician, or other provider providing the services, which are outside of the hospice benefit.

Because some hospice benefit services and MA-covered services may be similar, this determination process should focus on the purpose, rather than the type of service -- that is, what recipient need is the service addressing?

The following considerations may be helpful in approaching the determination:

- Is the purpose of a service to address a pre-existing condition or a pre-existing need?
- Is the purpose of a service to address a health care problem that would have existed even without the terminal illness?
- Is the purpose of a service to facilitate the recipient’s ability to live in the community setting rather than an institution, and would that need have been present with or without the terminal illness?

Documentation Requirements When A Case Manager is Involved

When the MA-covered service is the type that includes county-based home and community based services (HCBS) case management, the hospice must notify the case manager in writing of the recipient’s election of hospice and the anticipated start date. Written notification via fax, mail, or hand delivery must be given to the case manager within two business days using the AHCA Form 5000-25, Notice of Hospice Election.

The hospice agency staff must assume lead responsibility for collaboration and documentation of that collaboration with the case manager. The hospice staff must forward the documentation within eight calendar days of the effective date of hospice services. Collaboration may be completed via telephone, fax, e-mail, or a face-to-face visit. Documentation such as this should be included in the recipient’s hospice record.

The case manager will be invited to participate in the hospice interdisciplinary care team meetings for a recipient receiving home and community-based services.
The case manager will keep a copy of the cooperative agreement in the recipient’s record. (This is not a mandated form but to be used as a tool for preventing duplication of services.)

When the recipient is receiving “traditional MA” home care and no case manager is involved, the hospice must coordinate care and communicate with the home care agency involved with the recipient, rather than through a county case manager.

**Seeking HCBS After Hospice Election**

When a recipient is receiving concurrent HCBS and hospice services, the HCBS are usually in place before the hospice services began.

There may be situations where a recipient seeks case-managed HCBS or an increase in HCBS, after electing the hospice benefit. Example: An adult with a disability is living with an aging mother, who is the primary care giver. The aging mother experiences a decline in health status, and has to cut back on the amount of primary care she is able to provide the recipient. The recipient therefore applies for HCBS to access available services and supports that the primary caregiver can no longer provide. In situations where the initial HCBS is added or increased after the hospice benefit is elected, county case management documentation must justify the addition/increase of the HCBS services.

**County Case Manager Approval of Services that are Concurrent with the Hospice Benefit**

An MMIS informational edit will appear on the HCBS service agreement to alert counties that the recipient has elected the hospice benefit. Following coordination with the hospice provider agency, county case managers must add comments on the county DHS Comment Screen of the MMIS service agreement, documenting the coordination of services. The notes must indicate why continuing care services are necessary. (Either they are pre-existing, or they are new but treated as a condition not related to the terminal condition.) The MMIS service agreement line items must be adjusted as needed to reflect the type and amount of services required. Changes to services continue to require a ten-day notice to recipients to allow for continuity of care, recipient rights, and transitional needs.

When continuing care waiver or Alternative Care provider claims are received by DHS, a claim edit suspends the claim when the date of service overlaps with the hospice benefit period. Because the hospice provider becomes the primary payer of services, DHS will manually review HCBS provider claims to determine if payment is appropriate. Case management notes in MMIS will be reviewed at that time to ensure hospice provider coordination with the county case manager has occurred. If it appears that the coordination by the hospice provider has not occurred, the claim will remain in suspense until the coordination process is completed. If it appears that the coordination process has occurred, then the claim will be paid. When payment appears appropriate, the claim will be paid as requested. The informational edit and manual review of claims will remain in place temporarily to encourage consistent coordination between the provider areas.
Physician Services

An attending physician’s services are separately billable as long as the attending physician is not an employee of or under contract with the hospice. Bill Medicare Part B for dual eligibles and MA if the person has MA only.

Billing for Consulting Physician Services

When billing for the services of a consulting physician for an MA-only recipient (no Medicare or other third party payer involved), break out the technical portion and bill MHCP for the physician portion only. Services provided to dual eligibles are first billed to Part B Medicare and cross-over for MA payment of co-pays and deductibles.

Establishing the Plan of Care

The attending physician, the hospice medical director or physician designee, and the interdisciplinary group must establish a written plan of care for providing hospice services. The care provided by the hospice must follow the established plan of care.

Content of Plan of Care

The written plan of care must:

- Include an assessment of the recipient's needs;
- Identify services, including the management of discomfort and symptom relief; and
- Detail the scope and frequency of services needed to meet the recipient's and family's needs.

The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each recipient.

Review of Plan of Care

The plan of care must be reviewed and updated at intervals specified in the plan by the attending physician, the hospice medical director or physician designee, and the interdisciplinary group. The reviews must be documented.

Hospice Services for Residents of Long Term Care Facilities

MA eligible residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) and Nursing Facilities (NFs) who also meet hospice service eligibility may elect to receive hospice services where they live. The hospice provider becomes the primary provider of the service, and authorizes and funds the hospice benefits. Medicare and MA payments are made to the hospice provider for both the hospice services it provides, and for the residential services provided by the hospice.
facility. Current law requires a payment, to the hospice provider, of at least 95% of the rate that would have been paid for facility services for the individual. **Effective July 1, 2001**, payments to be made by DHS are indicated in column (E):

<table>
<thead>
<tr>
<th>Facility Type Type</th>
<th>DHS Payment Rate (A)</th>
<th>Percentage of Rate (B)</th>
<th>Private Room Rate (C)</th>
<th>Hospice Payment For Room &amp; Board (D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICF/MR</td>
<td>ICF/MR</td>
<td>100%</td>
<td>100%</td>
<td>95% * {(B)*(C)}</td>
</tr>
<tr>
<td>NF</td>
<td>NF Case Mix</td>
<td>100%</td>
<td>115%</td>
<td>95% * {(B)*(C)}</td>
</tr>
<tr>
<td>NF First 30 Days</td>
<td>NF Case Mix</td>
<td>120%</td>
<td>115%</td>
<td>95% * {(B)*(D)}*(C)}</td>
</tr>
<tr>
<td>out-of-state NF</td>
<td>NF Rate</td>
<td>100%</td>
<td>100%</td>
<td>95% * {(B)*(C)}</td>
</tr>
</tbody>
</table>

enuous with date of NF admission on or after July 1, 2003 (not MA eligibility date).

The hospice must contract with and negotiate a rate with the long-term care facility for the recipients who reside in the facility and elect hospice care. The long-term care facility must coordinate with the hospice all of the recipient's services and care. The hospice may negotiate with the long-term care facility for the long-term care facility to continue to collect the recipient's spenddown.

The hospice must notify the local county human services agency of the recipient's hospice election by sending (or faxing) a copy of the front page of the [MHCP Hospice Transaction Form](#) to the county. The hospice will become the designated provider for the medical spenddown, and the payment to the hospice for the room and board will exclude the amount of the recipient's medical spenddown.

Residents of ICF/MRs and NFs may receive end-of-life care from their residential provider without making the hospice election. Facilities may be able to arrange for the specific care needs of persons with terminal illness by making internal staffing adjustments, or by also purchasing the specialized services, or making staff additions. ICF/MR facilities may apply through their host counties for a variable rate adjustment in order to accommodate the increased needs of a person with terminal illness. **Bulletin #00-56-23** describes the variable rate process.

**Bed-hold Billing**

When a hospice patient resides in a nursing home and is absent from the nursing home for hospitalization, home visits, etc., the hospice agency must verify that the nursing facility is eligible for bed-hold days. Bed-hold days are available up to 18 days per occurrence when the facility occupancy rate is 93% or greater. Bed-hold rates are 60% of the case-mix rate (as of July 1, 2003), of which the agency is entitled to 95% of the adjusted case-mix rate for that LTC facility. Example: If stay is May 1-10 with May 107 in NH, submit 659 revenue code with the case-mix; and May 8-10 hospital, submit 659 revenue code separate for bed-hold with just the rate of charges billed.
Hospice Transaction Form

The MHCP Hospice Transaction Form (HTF) (DHS-2868, 8/02) is a multipurpose form which is a tool for hospice providers to report hospice election, certification, revocation of hospice services, change of hospice provider, and recipient death.

Submitting the Hospice Transaction Form

DHS must be notified of recipients who are enrolled in hospice (regardless of whether MA is the primary payer).

The Medicare and Medicaid (MA) approved criteria on hospice agency’s election form is to be submitted to DHS immediately upon enrolling with Medicare hospice. This election form must be completed with all the required/appropriate information (e.g., PMI, DOB, MHCP provider number, ICD-9, and patient’s signature). DHS must receive the information within two days of election.

Dual eligible Medicare and MA recipients may submit the Medicare approved hospice election criteria plus the DHS required elements to DHS in place of the DHS hospice transaction form.

Page one of the election form must also be sent to the county financial worker when a spenddown is involved. State staff will make the institutional to medical change in the system if the change has not been made by the county.

For recipients enrolled in a prepaid health plan, only submit their hospice election forms to DHS if they are residing in a long-term care facility.

DHS must also be notified when the recipient is no longer receiving hospice care. Fax or mail the HTF to:

Minnesota Department of Human Services
Attention: Hospice Notification
444 Lafayette Road North
St. Paul, MN 55155-3849
Fax (651) 282-6744

Hospice overpayments for spenddowns may be sent back to the following address. A copy of the original RA must be included for correct claim credit.

Minnesota Department of Human Services
Attention: Benefit Recovery/Hospice
444 Lafayette Road North
St. Paul, MN 55155-3850
Recipient Information

Enter the recipient's name, address, MHCP ID number, and date of birth. If the recipient is Medicare/Medicaid eligible, he or she must elect Medicare hospice care in addition to Medicaid hospice care. Federal guidelines prohibit recipients from choosing hospice care through one program and not the other when they are Medicare/Medicaid eligible.

Election of Hospice Services

The recipient or a legal representative (if the recipient is physically or mentally unable) must sign and date the HTF to elect hospice care and waive rights to any other medical services related to the treatment of the terminal condition. A witness signature and date are required only if the recipient is unable to sign. The hospice must:

- Explain the benefits the recipient will receive;
- Explain the benefits the recipient is waiving;
- Give the recipient or legal representative a copy of the signed HTF; and
- Retain the signed HTF in its files.

The election statement must include the date hospice services are to begin, and the name and MHCP provider ID number of the hospice that will provide the care. DHS will not use the physician certification dates unless the HTF was not signed in accordance with the guidelines stated in the Certification of Terminal Illness section below. **DHS must receive the form within two days of the recipient's signature.** Diagnoses such as “failure to thrive” or “weakness” are invalid hospice election diagnoses.

Discharge Statement

Complete the discharge statement if a recipient is no longer considered to have a life expectancy of six months or less or the recipient is no longer eligible to receive hospice services and is discharged from the hospice program. The hospice medical director or designee and attending physician must sign and date the statement.

Revocation of Hospice Services

A hospice recipient may elect, at any time, to receive curative care and terminate hospice services. The recipient or a legal representative must sign and date revocation of hospice services. The effective date of the revocation must be on or after the date the form is signed.

Change of Designated Hospice Provider

A recipient may change hospice providers while receiving hospice services. Enter the names and MHCP ID numbers of both the new and replaced hospice providers. Both hospice providers must retain copies of the HTF. DHS and county if applicable must be notified of the change.
Recipient Date of Death

The hospice must enter the recipient's date of death. DHS must receive a copy of the HTF within two days of the recipient's date of death.

Non-covered Services

The following services are not covered and must be waived while the recipient is in hospice care:

- Other forms of health care for treatment of:
  - The terminal illness for which hospice care was elected; or
  - A condition related to the terminal illness;

- Other hospice services or hospice services equivalent to hospice care, except those provided by the designated hospice or its contractors; and

- Services provided under home and community based waivers that are related to the terminal illness.

Hospice Payments/Limits

Hospice providers are paid at one of the four fixed daily rates that apply to all services except certain physician services, and room and board in a long-term care facility.

MHCP will pay a hospice for each day a recipient is under the hospice's care. The payment methodology and amounts are the same as used by the Medicare program.

The limits and cap amounts are the same as used in the Medicare program except that the inpatient day limit on both inpatient respite days and general inpatient days do not apply to recipients afflicted with AIDS.

Additional payment is not made for bereavement counseling.

The hospice may be paid for an amount that does not exceed the hospice cap payment. Room and board payments for a long term care facility and certain payments to the recipient's attending physician are not considered when the cap amount is calculated.

Billing Hospice Services

- Use the UB-92
• Type of bill:
  - 811 Non-hospital based hospice (817 for non-hospital based hospice replacement claims)
  - 821 Hospital based hospice (827 for hospital based hospice replacement claims)

• Use one of the following revenue codes:
  - 651 Routine home care day, bill number of days
  - 652 Continuous home care day, 8 or more hours of nursing care each day up to 24 hours per day, bill hourly rate for each date of service

When billing routine home care or continuous home care (revenue codes 651 and 652, respectively), enter value code 61 and the appropriate MSA code in form locator (FL) 39-41, right justified. MSA codes are the same for Medicare and MA. **If the value code or MSA code is not entered, DHS will deny the claim.**

  - 655 Inpatient respite day, billing may include date of admission but not date of discharge, unless discharged deceased
  - 656 General inpatient day, billing may include date of admission but not date of discharge, unless discharged deceased

  The total number of general inpatient care days and inpatient respite care days may not exceed 20% of the total days provided to a hospice recipient.

  - 659 Long term care facility room and board, the recipients must:
    - Reside in a long-term care facility; or
    - ICF/MR; and
    - Billed fee-for-service.

  (DHS does not pay for discharge day, even upon death, while residing in a LTC facility.)

**Billing Hospice Physician Services**

• Use the HCFA-1500.
• Use appropriate CPT/HCPCS codes and any applicable modifiers.
• Enter the physician's MHCP provider ID number in box 24K or the Treating Provider Number field on ITS.
• Enter the hospice MHCP provider ID number in box 33, GRP#, or the Physician GRP# field on ITS.
• The hospice payment for physician services is the MHCP physician payment rate, and is included in the hospice cap amount.

• Patient care services not related to the terminal illness rendered by an independent attending physician (a physician who is not considered employed or under contract with the hospice) must be billed using physician billing guidelines (refer to the Physician chapter [Ch. 6] of this manual), and are not part of the hospice cap amount.

• Do not submit denied Medicare physician payments that are related to the terminal illness.

• Denied Medicare payments for physician services must have an attachment stating the reason(s) Medicare denied the services. (Services must not be related to the terminal illness).

Hospice Transaction Form

PDF document

Legal References

Minnesota Rules 9505.0297; 9505.0446
Balanced Budget Act of 1997
42 CFR 418
42 CFR 1396a
Chapter 29
Renal Dialysis

This chapter includes information on coverage policy and billing for MHCP fee-for-service recipients receiving renal dialysis and related services for End-Stage Renal Disease (ESRD). DHS follows Medicare guidelines for coverage. For dually eligible Medicare patients, refer to the coverage policy and billing requirements from Medicare.

Refer to the Physician Services chapter (Ch. 6) for coverage and billing requirements for kidney transplant services.

Definitions

**Acute Dialysis:** Dialysis given to patients who are not ESRD patients, but who require dialysis because of temporary kidney failure due to a sudden trauma; or ingestion of certain drugs or back-up dialysis under special circumstances.

**Apheresis:** Autologous procedure when performed as plasma exchange in the treatment of glomerulonephritis.

**Biological:** A medicinal preparation made from the living organisms and their products. These include serum, vaccines, and antitoxins.

**Continuous Ambulatory Peritoneal Dialysis (CAPD):** A variation of peritoneal dialysis, which is a continuous dialysis process using the patient's peritoneal membrane as a dialyze. The solution exchange is performed manually by the patient. The exchange is performed three to five times per day.

**Continuous Cycling Peritoneal Dialysis (CCPD):** A treatment modality which combines the advantages of long dwell, continuous steady state dialysis of CAPD and the advantages of automation inherent in intermittent peritoneal dialysis (IPD).

**Continuous Renal Replacement Therapy (CRRT):** A short-term treatment in critically ill patients with acute or chronic renal failure. It is an alternative treatment to the standard intermittent hemodialysis treatment. CRRT is covered only as an inpatient in the critically ill setting using FDA approved procedures and machines.

**Dialysis:** A process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. There are two types of renal dialysis:

- **Hemodialysis:** A process by which blood passes through an artificial kidney machine and the waste products diffuse across a man-made membrane into a bath solution, known as dialysate, after which the cleansed blood is returned to the patient's body.
• **Peritoneal Dialysis:** A process by which fluid (dialysate) waste products pass from the patient's body through peritoneal membrane into the peritoneal abdominal cavity where the bath solution is introduced and removed periodically.

**Drugs:** A substance recognized in an official pharmacopeia or formulary which is used in the diagnosis, cure, mitigation, treatment or prevention of disease.

**End-Stage Renal Disease (ESRD):** Or "chronic kidney failure" is a stage of renal impairment requiring either a regular course of dialysis or kidney transplantation to maintain life.

**Epoetin (EPO):** A biologically engineered protein which stimulates the bone marrow to make new red blood cells. Chronic renal failure patients with symptomatic anemia considered for EPO therapy should have a hematocrit less or equal to 36% or hemoglobin less than 10 grams when therapy is initiated.

**Hemofiltration (diafiltration):** A process that removes fluid, electrolytes, and other toxic substances from the blood by filtration through hollow artificial membranes. The process requires an arteriovenous access.

**Hemoperfusion:** A process which removes substances from the blood through the dialysis membrane by using a charcoal or resin artificial kidney.

**Home Dialysis Equipment:** Home dialysis equipment includes all the medically necessary home dialysis equipment prescribed by the physician including, but not limited to artificial kidney and automated peritoneal dialysis machines, and support equipment.

**Inpatient Dialysis:** Dialysis furnished to ESRD patients on a temporary inpatient hospital basis.

**Intermittent Peritoneal Dialysis (IPD):** A process where waste products pass from the body through the peritoneal membrane into the peritoneal cavity where the dialysate is introduced and removed periodically by a machine.

**Maintenance Dialysis:** Dialysis treatments given to patients with ESRD in order to sustain life. Maintenance dialysis is generally required two to three times per week.

**Method I - Composite Rate:** A payment option for dialysis services to patients who receive staff-assisted dialysis or home dialysis treatment from a renal dialysis facility.

**Outpatient Dialysis:** Dialysis provided on an outpatient basis at a renal dialysis center or facility. Includes:

- Staff-assisted dialysis
- Self dialysis
- Home dialysis
- Self-dialysis and home dialysis training
Renal Dialysis Facility: A Medicare certified facility where maintenance dialysis is furnished to outpatients.

Self-dialysis: Performed with little or no professional assistance by the ESRD patient including a helper, where applicable, who has completed an appropriate course.

Staff-assisted Dialysis: Dialysis performed by the staff of the center or facility.

Ultrafiltration: Process where excess fluid is removed through the dialysis membrane by means of pressure. Not a substitute for dialysis.

Eligible Providers

Medicare approved ESRD facilities in hospitals, renal transplant centers, renal dialysis facilities and centers, outpatient hospitals, self-dialysis units, and special purpose renal dialysis facilities may enroll as ESRD providers with MHCP.

Eligible Recipients

- All MHCP recipients are eligible for acute (emergency) dialysis.
- Only MA and GAMC recipients are eligible for maintenance dialysis.
- Medicare covered patients who have not reached age 65, who suffer from "end-stage renal disease." ESRD benefits include all Part A and B items and services covered under the Medicare program. For dually eligible Medicare/Medicaid recipients, MA pays the coinsurance and deductibles amounts.
- MA and GAMC recipients under age 65 who do not meet the two year disability requirements, but need dialysis or renal transplantation for treatment of end-stage renal disease, may be eligible for Medicare when the following conditions are met:
  - Entitlement begins after a three-month waiting period if a transplant or dialysis is not needed before the three-month period ends; or
  - Entitlement begins before the three-month waiting period if the patient needs a transplant, receives self-dialysis training, and begins the first course of self-dialysis after.

All renal dialysis recipients must apply for Medicare benefits as soon as dialysis begins. Providers should refer recipients as soon as possible to the Social Security Administration (SSA) to apply for Medicare.
ESRD Covered Services

DHS only covers dialysis services with a composite rate. Composite rates are only billable by Medicare approved ESRD facilities. Recipient may choose to receive their dialysis at a facility or perform their own home dialysis after receiving self-dialysis training certification.

Services provided in a Renal Dialysis Facility (same as Medicare guidelines):

- Personnel (physician, licensed registered nurse, licensed practical nurse, technician, social worker, dietician);
- Equipment and supplies (dialysis machine and maintenance, disposable supplies);
- Some laboratory services (refer to the laboratory services section in this chapter);
- Certain injectible drugs (such as heparin and its antidote) and biologicals; and
- Overhead and general administrative services.

Method I: Composite Rate

All items and services included under the composite rate must be furnished, either directly or under arrangements, to all dialysis patients. The ESRD facility must furnish all of the necessary dialysis services, equipment and supplies. The following items and services are included in the Method I Composite Rate and may not be billed separately:

- HCPCS codes E1510 - E1699;
- HCPCS codes A4650 - A4927;
- All dialysis services furnished by the facility's staff and the staff time used to:
  - Administer blood
  - Administer separately billable drugs and vaccines
  - Non-routine parenteral care
  - Treatment of medical complications
  - Declot shunts and any supplies used to declot shunts
  - Oxygen and the administration of oxygen

- Medically necessary dialysis equipment and dialysis support equipment for hemodialysis and peritoneal dialysis.
- Use of IV pumps for convenience.
- Medically necessary dialysis supplies.
- Home dialysis support services including the delivery, installation, maintenance, repair and testing of home dialysis equipment and home support equipment.
- Purchase and delivery of all medically necessary dialysis supplies and equipment.
- Home health services provided in the home are included as support services.
- Drugs used in the dialysis procedure and staff time to administer those drugs, (drugs that are used to accomplish the same effect are also covered under the composite rate).
Antibiotics are covered under the composite rate when used at home to treat an infection of the catheter site or peritonitis.

Oral medications are included in the composite rate since the form of the drug is usually self-administered. If a physician gives a patient an injection which usually is self-administered, for example insulin, the drug is administered in an emergency situation.

**Note:** Albumin used as a substitute for drugs covered under the composite rate or used to accomplish the same effect (e.g., as a volume expander) are included in the composite rate payment for maintenance dialysis.

The following laboratory services are included in the composite rate:

- **Laboratory tests for patients receiving:** hemodialysis, intermittent peritoneal dialysis (IPD), and continuous cycling peritoneal dialysis (CCPD).
- **Routine ERSD laboratory services** performed by either the facility staff or an independent laboratory are included in the composite rate at the following frequency:
  - Per treatment: all hematocrit, hemoglobin, and clotting time tests
  - Weekly: prothrombin time for patients on anticoagulant therapy
  - Weekly or thirteen per quarter: BUN
  - Monthly: serum calcium, serum potassium, serum chloride, CBC, serum bicarbonate, serum phosphorous, total protein, serum albumin, alkaline phosphatase, AST, SGOT, LDH. (Refer to the Laboratory chapter (Ch. 11) for billing instructions on organ and disease panels).

- Medically necessary laboratory tests outside of the routine levels for renal dialysis may be billed separately from the composite rate when adequate documentation is sent with the claim.

**Note:** Laboratory tests performed to monitor the efficiency of a facility's dialysis treatment system, e.g. "extra dialysis screening" and "kinetic modeling studies," are not separately billable.

**Excluded Drugs and Biologicals (Billed Separately)**

Drugs and biologicals are generally covered outside the composite rate only if they meet the following requirements:

- They cannot be self-administered.
- They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice.
- They meet all the general requirements for coverage of items as "incident to" a physician's services.
- The following immunizations are covered outside the composite rate: pneumovax (pneumococcal vaccine), influenza vaccine and hepatitis B vaccine.
- Analgesics
• Tranquilizers
• Hematinic
• Sedatives
• Muscle relaxants
• Anabolics
• Thrombolytic/thrombolysis (used to declot central venous catheters)
• Supplies used to administer separately billable drugs and blood
• Non-routine parenteral care supplies
• Tests to diagnose hepatitis B
• The following antibiotics are covered outside the composite rate:

- Ampicillin sodium
- Ampicillin sodium/sulbactam
- Azithromycin dihydrate, oral
- Cefazolin sodium
- Cefonicid sodium
- Cefotaxime sodium
- Cefoxitin sodium
- Ceftriaxone sodium
- Cephalothin sodium
- Cephapirin sodium
- Chloramphenicol sodium suc
- Colistimethate sodium
- Erythromycin gluceptate
- Erythromycin lactobionate
- Flagyl
- Garamycin, gentamicin
- Kanamycin sulfate
- Levofoxacin
- Lincomycin HCL
- Methicillin sodium
- Oxacillin sodium
- Oxytetracycline
- Penicillin G benzathine
- Penicillin G benzathine and
- Penicillin G procaine
- Penicillin G potassium

**Services Outside the Composite Rate**

Separately billable ESRD laboratory services include all ESRD-related laboratory tests that are not covered under the composite rate. The billing of these tests must include medical documentation including the ICD-9 CM codes.

- For hemodialysis, IPD and CCPD:
  - Serum Aluminum - limit of one every 3 months
  - Serum Ferritin - limit of one every 3 months

- For CAPD:
  - WBC, RBC, and platelet count limited to every 3 months
  - Residual renal function, 24 hour urine volume limited to every 6 months

- Physician services (refer to the Physician Services for ESRD section of this chapter.)
Note: Non-renal related services are not separately billable when provided in an independent dialysis facility.

Payment Limitations

- MHCP covers dialysis and related services for the first three months of therapy under fee-for-service. Recipients must submit a formal application to the Social Security Administration to apply for Medicare coverage for dialysis services. If Medicare coverage is denied, attach a copy of the denial to the ESRD claim.
- When used in the treatment of life threatening drug overdose, hemoperfusion is a covered service for patients with or without renal dialysis. Hemoperfusion is also covered when used in conjunction with deferoxamine (DFO) to treat aluminum toxicity.
- Apheresis is covered in renal patients only when performed as plasma exchange in the treatment of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage.
- All E/M services related to the patient's end-stage renal disease, rendered on a day when dialysis is performed and all other patient care services rendered during the dialysis procedure are included in the dialysis procedure.
- If the facility fails to furnish any part of the items and services covered under the composite rate, either directly or under arrangements, payment cannot be made for any part of the services provided.
- Separately billable drugs must be approved for coverage by Medicare and may be billed by an ESRD facility only if they are actually administered in the facility by the facility staff.
- Payment may not be made directly to home health agencies for dialysis-related services provided in the home or a facility.
- EPO is not covered separately when administered in a renal dialysis facility under the "incident to" provision.
- Artificial kidney machines and accessories and dialysis supplies can only be used for dialysis patients. DHS pays for rental only, no purchase of equipment unless the recipient is denied Medicare coverage from SSA.

Non-covered Services

The following are not covered when provided by a dialysis facility:

- Items or services which are not medically necessary for the diagnosis or treatment of ESRD or do not improve the patient's condition.
- Hemoprofusion when used to improve the results of hemodialysis or when used in conjunction with DFO to remove iron overload.
- Apheresis when used before or after kidney transplant services.
- Missed appointments. If the facility prepares for a dialysis treatment, but the treatment is never provided, no payment is made.
Documentation

- Documentation must be attached to the claim to establish medical necessity for maintenance dialysis when the frequency is more than three times per week.
- DHS must receive documentation of Medicare coverage for ESRD recipients for drugs billable outside the composite rate.
- When billing for an unclassified drug, enter a description of the drug in the Remarks box on the UB-92 or box 19 on the CMS-1500, or submit an attachment to the claim including the:
  - Date administered
  - Name of drug or biological
  - ICD-9-CM diagnosis code
  - Route of administration
  - Charge per dose (unit price)
  - Statement of medical necessity
  - Documentation of coverage for Medicare dialysis use

- Home dialysis patients who use EPO must have a current care plan (a copy of the plan must be maintained by the designated facility).
- Laboratory tests for patients receiving hemodialysis, intermittent peritoneal dialysis (IPD), and continuous cycling peritoneal dialysis (CCPD), as covered by Medicare and performed for dialysis patients at a frequency greater than specified, are covered only if medically justified by accompanying documentation.

Billing Renal Dialysis and Dialysis Related Services

The following billing instructions are for MHCP fee-for-service claims and Medicare crossover claims:

- To bill for unclassified injectible drugs, use HCPC J3490 (Unclassified Drugs). If billing on the UB-92, attach documentation (refer to the documentation section of this chapter for required documentation).
- Renal dialysis outpatient maintenance and home dialysis composite rate (Method I) services must be billed on UB-92. Use one of the appropriate revenue codes:
  - 821: Hemodialysis
  - 831: Peritoneal
  - 841: CAPD
  - 851: CCPD

- Hemodialysis fee-for-service recipients: bill the composite rate with revenue code 821 on the first line item and the laboratory services, drugs, and blood products on subsequent line items with the date of service, the appropriate HCPCS code and number of units provided.
• Hemodialysis Medicare/Medicaid claims that do not cross over: bill the composite rate with revenue code 821, with the total amount indicated on the Medicare EOMB on one line.
• DHS will deny services denied by Medicare on crossover claims.
• Continuous cycling peritoneal dialysis (CCPD): bill revenue code 851.
• EPO administered in dialysis facility or at home:
  - Identify EPO and the number of injections with;
    - Revenue code 634 for EPO administration under 10,000 units
    - Revenue code 635 for EPO administration of 10,000 units or more, and;
  - Use value code:
    - 48 for reporting the hemoglobin reading
    - 49 for reporting the hematocrit reading
    - 68 for reporting the EPO units administered during the billing period.

Note: Round the number of units to the nearest 100 units of EPO furnished. One unit equals 1000 units of EPO. (Follow Medicare guidelines for coverage, administration and billing of EPO.)

When billing both supplies and administrations, total the units supplied and the units administered and show this amount for Value Code 68. Complete FL 46 for administrations only.

Billing Drugs Outside the Composite Rate

Bill for allowable drugs outside the composite rate using the appropriate HCPCS code, along with revenue code 636, "Drugs Requiring Specific Information." Use the units field as a multiplier to arrive at the dosage amount.

Note: When the dosage amount of the drug is greater than the amount indicated for the HCPCS code, round up to determine units.

• To bill for supplies used to administer the drug, use revenue code 270 and Medical/Surgical Supplies HCPCS codes. The number of administrations must be entered in the units field. This covers the cost of any size syringe, swabs, needles and gloves.
  - The HCPCS code is used to identify a drug, and is entered in FL 44. For drugs requiring specific identification on the UB-92, attach documentation with the claim to explain why this is billed separately from the composite rate.
Physician Services for ESRD Monthly Capitation Payment (MCP)

The monthly capitation payment (MCP) is a comprehensive monthly payment that covers all physician services provided in connection with uncomplicated and complicated renal dialysis sessions in outpatient maintenance facilities and at home.

- MCP is a global physician service payment for outpatient dialysis and ongoing evaluation and management services related to outpatient dialysis.
- Payment for physician services furnished to patients on continuous ambulatory peritoneal dialysis (CAPD), and continuous cycle peritoneal dialysis (CCPD) are covered under the MCP capitation rate. The monthly payment for CAPD and CCPD include:
  - Payment for both supervisory and direct care services routinely provided in connection with an ordinary course of maintenance dialysis;
  - For services related to the renal care of the patient; and
  - Interpretation of the following tests:
    - Bone mineral density studies, non-invasive vascular diagnostic studies of hemodialysis access, nerve conduction studies, and electromyography studies.

- All non-dialysis procedures are excluded from the MCP.

Billing for Outpatient ESRD-Related Services

The following billing instructions apply to ESRD-related services:

- Use ESRD CPT codes to bill for kidney disease related physician services.
- Physicians must bill the full month or daily codes as appropriate.
- A combination of the full month and daily MCP codes cannot be billed for ESRD related services provided to a patient in the same calendar month.
- All care provided to an ESRD patient in a single calendar month should be billed on the same claim submission.
- Subsequent claims received for care provided during the same calendar month will be denied.
- The appropriate full month CPT code (90918 - 90921) on the CMS-1500 should be billed with one unit.
- When billing a partial month use CPT codes 90922-90925 on the CMS-1500, bill the actual date of service.
- The number of days of ESRD related care must be entered in the days/units field of the claim submission.
- Claims for ESRD related care cannot be submitted until all care for the month has been completed. The patient's age at the end of the month must be used to determine the correct full month code to report.
• Groups or associations billing for ESRD related services under the monthly capitation option, must report the MHCP provider identification number of the physician who rendered or supervised the services.

• If more than one physician in the group rendered or supervised the services throughout the month, it is not necessary to identify each providing physician for services included in the monthly charge. The identity of the patient's attending physician within the group should be reported as the rendering physician for the MCP charge.

**Inpatient Billing/Non-CAP Payment**

There are circumstances where inpatient dialysis is medically appropriate, and more intensive action/physician involvement is required.

• Use CPT codes 90935 - 90947 on the CMS-1500 for dialysis sessions.
• For inpatient dialysis, the physician must be physically present with the patient at some time during the course of the dialysis procedure.

**Separately Billable Physician Services**

The following services are not included in the MCP and may be billed separately on a fee-for-service basis:

• Physician services which are of a non-supervisory nature (non-routine) that represent treatment beyond those provided in connection with the ordinary course of renal dialysis treatments.
• Specific surgical services.
• Interpretation of tests (other than those included in the MCP) that have a professional component (e.g., electrocardiograms, echocardiograms, biopsies, 24 hour blood pressure monitoring, spirometry, and complete pulmonary function test).
• Complete evaluation for renal transplantation. While the physician assessment of whether the patient meets preliminary criteria as a renal transplant candidate is included under the MCP, the complete evaluation for renal transplantation is excluded from the MCP.
• Evaluation of potential living transplant donors.
• Non-renal related physician's services. These services may be furnished by the physician providing renal care or by another physician.
• Training of patients to perform home or self-dialysis.
• Covered physician services furnished to hospital inpatients, including services related to inpatient dialysis, by a physician who elects not to continue to receive MCP during the period of inpatient stay. In these cases, the physician receives a prorated portion of the MCP for that month.
• All physician services before the initiation of outpatient dialysis.
• When inpatient dialysis is necessary, the physician can be paid on a fee-for-service basis if the condition for which the patient was hospitalized was other than chronic renal disease. If the patient was hospitalized for no reason other than to receive maintenance dialysis (e.g., the only diagnosis on the claim is end-stage renal disease), then the dialysis will be considered an outpatient service and reimbursed under the MCP.
Transportation To and From Renal Dialysis Facilities

For Medicare recipients follow transportation coverage guidelines as determined by Medicare. MHCP covers the least costly mode of transportation that is medically necessary for the recipient. Coverage policy and billing instructions can be found in the Medical Transportation chapter (Ch. 21).

- Patients receiving maintenance dialysis on an outpatient basis do not generally require ambulance transportation.
- Ambulance transportation must meet the criteria outlined in the Medical Transportation chapter (Ch. 21).
- Ambulance transportation of ESRD patients to and from Medicare approved renal dialysis facilities may be covered when certain medical necessity conditions are met. Examples of such conditions include, but are not limited to, the patient being bed confined before and after the ambulance trip.
- Physicians must determine the medical necessity for ambulance, and special transportation for dialysis treatment.
- Patients may receive special transportation with a completed and approved Physician Certification of Need for Special Transportation” form (refer to Ch. 21).
- Common carrier transportation may be utilized for recipients not eligible for special transportation, by contacting their local county agency for policies regarding common carrier transportation. Refer to the Provider Requirements chapter (Ch. 1).

Legal References

Minnesota Rules 9505.0170
Minnesota Rules 9505.0210
Minnesota Rules9505.0392
42 CFR 413 subp. A-I
42 CFR 414.300-414.335
42 CFR 405 subp. U, 405-2100-405.2184
Medicare Renal Dialysis Facility Manual
Chapter 30

Child Welfare Targeted Case Management (CW-TCM)

Case management activities coordinate social and other services designed to help the child under 21 and the child’s family gain access to needed social services, mental health services, habilitative services, educational services, health services, vocational services, recreational services, and related services including, but not limited to, volunteer services, advocacy, transportation, and legal services.

Case management services include developing an individual service plan, assisting the child and child’s family in obtaining needed services through coordination with other agencies and assuring continuity of care. Case managers must assess the delivery, appropriateness, and effectiveness of services on a regular basis. (Minnesota Statutes § 256B.094, subd. 1)

Eligible Recipients

Children under the age of 21 on MA or MinnesotaCare who meet one of the following criteria:

- At risk of out-of-home placement or in placement as defined in Minnesota Statutes § 260C.212, subd. 1; or
- At risk of maltreatment or experiencing maltreatment as defined in Minnesota Statutes § 626.556, subd. 10e; or
- In need of protection or services as defined in Minnesota Statutes § 260C.007, subd. 6.

This determination must be made by the county agency responsible for child welfare services. The activities involved in the determination of eligibility are not claimable as CW-TCM. A CW-TCM claim may be submitted only after the determination of eligibility for CW-TCM services, and the case finding and case plan are recorded in the case file.

A child who meets the eligibility criteria for both CW-TCM and MH-TCM may receive both services from the same agency and both services may be claimed in the same month as appropriate.

Certified Providers of CW-TCM

County and tribal social service agencies must be certified to receive MA reimbursement for CW-TCM. To become certified, these agencies must apply to the Department of Human Services. A certified provider may contract with a qualified vendor to provide the case management services. Qualified vendors must enroll as MHCP providers and negotiate a contract with the certified provider. The contract must contain the negotiated monthly rate for case management services. A copy of the contract must be submitted to DHS for approval.
Case Manager Qualifications

Case managers must be employed by a certified CW-TCM provider or a qualified vendor contracting with a certified CW-TCM provider to provide CW-TCM services and:

- Must be skilled in the process of identifying and assessing a wide range of children’s needs; and
- Must be knowledgeable about local community resources and how to use these resources for the benefits of the child; and
- Must hold either:
  - a bachelor’s degree in social work, psychology, sociology, or a closely related field from an accredited four year college or university; or
  - a bachelor’s degree in a field other than social work, psychology, sociology or closely related field, plus one year of supervised experience in the delivery of social services to children as a social worker in a public or private social services agency.

CW-TCM Activities

Case management activities are those which assist the eligible recipient to gain access to needed medical, social, educational, and other services as identified in an individual service plan. Only services delivered on a face-to-face basis are claimable as CW-TCM unless the client is in placement more than 60 miles beyond county or reservation boundaries. In such a case, a telephone contact may be claimed in two consecutive months. There must be a face-to-face contact in a month preceding or succeeding the telephone contacts.

Examples of CW-TCM activities include, but are not limited to the following:

- Assessment of the recipient’s need for case management services to gain access to medical, social, educational, and other related services;
- The development, completion, and regular review of a written individual case plan based on the assessment of need for case management services;
- Routine contact or other communication with the recipient, the recipient’s family, primary caregiver, legal representative, substitute care provider, service providers or other relevant persons identified as necessary to the development or implementation of the goals of the individual case plan;
- Coordinating referrals for, and the provision of, services for the recipient with appropriate service providers, consistent with section 1902(a)(23) of the Social Security Act (free choice of provider);
- Coordinating with the MA facility discharge planner in the 30 day period prior to the recipient’s discharge into the community (this is the only claimable CW-TCM service provided to patients or residents in a MA funded facility and is limited to a maximum of two 30 day periods per calendar year);
- Coordinating and monitoring the overall service delivery to ensure quality of services;
• Monitoring and evaluating services on a regular basis to ensure appropriateness and continued need;
• Completing and maintaining necessary documentation which supports and verifies the above activities;

Activities Outside the Scope of CW-TCM

• Assessments prior to opening of case;
• Therapy and treatment services;
• Legal services, including legal advocacy, for the recipient;
• Information and referral services provided to clients who are not part of the target group or eligible for MA/MinnesotaCare;
• Outreach services including those provided through the community support services program;
• Services that are not documented as required under Minnesota Rules, parts 9505.2165 and 9505.2175;
• Services that are otherwise eligible for payment on a separate schedule under rules of the Department;
• Case management services that duplicate the same services from another case manager for the same recipient;
• Case management services provided to patients or residents in a MA reimbursed facility (except as defined in CW-TCM activities); and
• CW-TCM services for children in non-MA reimbursable foster care, group homes or residential care that do not focus on permanency planning or return to the family home and/or duplicate a facility’s discharge planning. 256B.094, subd.8 (10);
• Transportation of a client

Non-Duplication of Child Welfare Targeted Case Management Services when the Client is a Tribal Member

Most children who receive Child Welfare Targeted Case Management (CW-TCM) services need only one case manager. However, there are situations in which a child who is a tribal member will require services from both the county social services agency and the tribal social services agency. When this happens, there must be no duplication of services, since federal regulations prohibit Medicaid from paying for duplicate services. In these situations there should be notification between the agencies, coordination of services delivered by the two agencies and written documentation of the services each agency will provide in enough detail that there can be no question about the need for services from each agency.

Here are some examples of considerations to make to determine when dual case management is necessary and appropriate for a client who is a tribal member:
• Does state or federal law require involvement of both the tribe and the county to provide child welfare/child protection services to the client?
  or
• What are the needs of the client and his/her family? Will the client/family need to be referred to the county for services such as family preservation services, CD services, etc.?
  or
• Can the client’s needs be met by a single case manager from the tribal agency, or will the services of a county case manager also be needed (not county services, but actual case management)?
  or
• Does a court order exist that requires the county to be responsible for the execution of a court ordered case plan?

The answers to these and other questions that may arise will guide the decision regarding the need for dual case management.

Notification

Once it has been determined that a client needs services from both the tribe and the county, the agencies must work closely together to assure that each is kept informed of the activities of the other. In all instances of determination of eligibility for CW-TCM services made by the county for an Indian child, the tribe must be notified of such eligibility within seven days, in accordance with the Minnesota Tribal/State Agreement on Indian Child Welfare and the Minnesota Indian Family Preservation Act (MIFPA). In these cases the tribal social services agency and the county agency should decide jointly what case management services are needed and who can best provide them. The case plan is developed based on these decisions.

Coordination of Services

The Minnesota Tribal/State Agreement states that tribes have jurisdiction over any child custody proceeding concerning an Indian child with few exceptions. Since this is the case, the burden of assuring that services being provided by the tribal social services agency are not duplicated by the county social services agency rests with the county. In the event that the tribal capacity to provide needed services is limited, or the tribe and the county agree that the county should provide certain services, it is the responsibility of the county to deliver necessary case management services. The client/family may be referred to the county by the tribal case manager for county-provided services other than CW-TCM.

When appropriate, the tribal agency is responsible for ensuring compliance with the Indian Child Welfare Act, fostering the continuation of the child’s relationship with the tribe, and assuring that culturally appropriate services are being provided. The tribal workers might also assess a need for additional services not specified by the court and available from tribal agencies, and would assist the family in accessing these services. The county would have the responsibility of enforcing the orders of the county court and facilitating access to those services available from the county. Both agencies are responsible for monitoring the effectiveness and continued need for services provided.
When it is determined that case management services are needed from both the county and the tribe, a primary case manager should be designated. If a primary case manager has been designated by mutual consent of the county, tribe and family, this individual’s role and responsibilities in this capacity should be clearly outlined in the written case plan. If an agreement regarding a primary case manager cannot be reached, the tribal agency is responsible for making this decision with the best interests of the child in mind, and this should also be recorded. The roles of each case manager must be delineated in detail. It must be clear that each case manager has a distinctive role with the family, and the written case plan must indicate how and with what frequency communication between case managers will be maintained.

In the case where a county and a tribal social services agency are unable to coordinate, but they are providing appropriate services to the same child, both agencies must document the activity accurately and completely. If duplication does occur they will be at risk in the case of a state or federal audit.

**Documentation**

There are two components of documentation – case plan and service delivery. Documentation in the case plan must be clear and detailed regarding a client’s need for more than one case manager. The jointly developed case plan must describe the circumstances that necessitate dual case management services, and the specific non-duplicative roles each case manager will fulfill in accomplishing the goal of the case plan, including who will act as the primary case manager. The case plan should contain information about who will coordinate, assure access, and monitor each type of service needed by the client. It should also state the frequency with which contact between case managers will occur for the purpose of coordinating services.

Each agency must retain a copy of the case plan in the case record.

In addition, the case record must contain a written description of each encounter of CW-TCM services provided to each individual client. This description must include: client name, case number, date of birth, date of service, name and relationship of the contacted person to the client, nature and extent of service being provided, name and professional title of the person providing the services, type of contact (face-to-face or telephone) and location of contact. The case record should contain a description of all case management activities on behalf of the client whether or not a billable contact occurs.

CW-TCM is child-specific, therefore, each child must have his/her own case file. This documentation may be part of an existing case file. The following information must be in each child’s case file:

- Case number, client identification, client name, and client date of birth;
- The assessment
  - The determination that the child is eligible to receive CW-TCM services. It must contain a written description of the child’s/family’s situation and which condition of eligibility the child meets;
• The Case Finding
  ▪ A statement that identifies that case management is necessary and will be provided. This may be one sentence combined with the assessment. (Sample assessment and case finding: “Janie is in foster care and will be provided CW-TCM”);

• The written Individual Case Plan
  ▪ Plan including the necessary services, the plan to obtain those services, and how the agency will monitor the services; and

• Details of each contact, including: identification of client, name of contact, relationship of person contacted to the client, location of contact, type of contact (face-to-face or telephone), kind of service provided, and date of contact.
  ▪ A telephone contact only applies to a child placed in an excluded time facility or through the Interstate Compact more than 60 miles beyond the county or reservation borders. There may not be more than two consecutive months without a face-to-face contact.

Billing CW-TCM

• Bill on the CMS-1500 form.
• Counties and contracted vendors may submit a claim each month that a documented, reimbursable contact occurred.
• One county and one tribal case manager and one case manager under contract with the county/tribe may each bill for a month they provided and documented services.
• DHS pays the contracted vendor the rate negotiated with the county or tribal agency. The county of financial responsibility or the tribe is then billed for the non-federal share.
• For county providers and contracted vendors, the appropriate HCPCS codes are:
  ▪ T2023 with the modifier U3 for face-to-face contact; and
  ▪ T2023 with the modifiers U3 and U4 for telephone contact. Counties bill one unit per month per recipient.
• For tribal governments, the appropriate HCPCS codes are:
  ▪ T1017 with the modifier U3 for face-to-face contact; and
  ▪ T1017 with the modifiers U3 and U4 for telephone contact. Bill only one encounter per client per 24 hour period.
• Bill DHS regardless of the recipient’s enrollment in a pre-paid health plan (PMAQ).
• Do not bill for services reimbursed under another funding source; such as the Indian Child Welfare Time Study, or Local Collaborative Time Study (LCTS).
• DHS will retain a portion of the federal share of reimbursement for administrative services.
Legal References

Minnesota Statutes, section 256B.0625, subd. 33
Minnesota Statutes, section 256B.094
Chapter 31
Federal Indian Health Services

American Indians (AI) and Alaskan Natives (AN) are Indian Health Service (IHS) eligible individuals. AIs/ANs eligible for one of the Minnesota Health Care Programs (MHCP), including Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare, are eligible for all covered services of the applicable MHCP program, not only the services provided through the Federal IHS facilities.

The purpose of this chapter is to explain the payment method for health care services provided directly by the federal government through an IHS facility or a tribally owned facility funded by Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638), as amended, hereafter referred to as "638." This chapter provides special instructions for billing MHCP covered health care services that are provided to MHCP recipients through an IHS facility or a 638 facility that has elected to be paid at the IHS reimbursement rates (638 IHS). Refer to other chapters of the MHCP Provider Manual for information about coverage and billing policy.

The Indian Health Service publishes the IHS reimbursement rates in the Federal Register, under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248(a) and 249(b) and section 601 of the Indian Health Care Improvement Act (25 U.S.C. 1601).

**Indian Health Service (IHS) Facility:** A hospital, clinic (medical or dental), or pharmacy established and operated by the Federal Indian Health Service.

**IHS Inpatient Per Diem Rate:** The IHS inpatient per diem rate is the payment amount established to cover services provided to an inpatient at a hospital that is part of the Federal Indian Health Service. See the hospital chapter of this manual.

**IHS Facility Outpatient Encounter/Visit:** An IHS facility outpatient encounter/visit means a face-to-face encounter/visit between a recipient and any health professional at an IHS outpatient facility. Encounters/visits with more than one health professional and multiple encounters/visits with the same professional, within the same service category, that take place on the same day and at a single IHS outpatient location constitute a single encounter/visit, except when the recipient, after the first visit, suffers an illness or injury requiring additional diagnosis or treatment (see instructions for billing a second medically necessary encounter).

**Tribal Facility Designated as an IHS Provider (638 IHS):** Effective July 11, 1996, the definition of a facility of the Indian Health Service was expanded to include tribally owned facilities funded by Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638). This includes all facilities that are under contract, compact, or are receiving grants from the IHS under Public Law 93-638. The 638 facility is operated by a tribal organization that is recognized by the Federal government, under a funding agreement with IHS. The 638 facilities that have elected to be paid at the IHS rates are hereafter referred to as 638 IHS facilities in this chapter.
638 IHS Facility Encounter/Visit: A 638 IHS encounter/visit means a face-to-face encounter/visit between a recipient and any health professional at the 638 IHS service locations. Encounters/visits with more than one health professional and multiple encounters/visits with the same professional, within the same service category, that take place on the same day constitute a single encounter/visit, except when the recipient after the first encounter/visit suffers an illness or injury requiring additional diagnosis or treatment (see instructions for billing a second medically necessary encounter).

Tribal Facility: A health care facility, operated by a Tribal organization that is recognized by the Federal government, which has not elected designation as a 638 IHS provider. This includes all 638 facilities that are not listed with DHS as IHS facilities.

Health Professional: A health professional is an individual who:

- Meets the training and licensure requirements for providing services under MHCP, and
- Is considered a provider who can perform billable services under MHCP.

The following list identifies occupations considered health professionals for purposes of billing IHS services (this is not an all inclusive list):

- advance practice nurse
- certified registered nurse anesthetist
- chiropractor
- clinical nurse specialist
- clinical specialist in psychiatric and mental health nursing
- counselor
- dentist
- dental hygienist
- home health aide
- licensed clinical social worker
- midwife
- nurse practitioner
- optometrist
- personal care assistant
- physical therapist
- physician
- physician assistant
- physician extender
- podiatrist
- psychologist
- registered dietician
- visiting nurse
Facility Support Staff: Individuals employed by the health care facility to support the services provided by the facility’s health professionals do not generate billable encounters. Examples of facility support staff are: clinic managers; RNs not functioning as physician extenders; RNs and LPNs not acting as visiting nurses as provided for in the Code of Federal Regulations at 42 CFR § 405.2416; lab technicians; and x-ray technicians.

Service Categories: Service categories for HIS/638 HIS facilities are:

- Ambulance
- Chemical Dependency
- Child Welfare Targeted Case Management
- Dental
- Home Health
- Medical
- Mental Health
- Pharmacy

Services

All services billed to MHCP must be:

- Provided by eligible, qualified providers performing services permitted by applicable federal and state laws and rules;
- Within program service guidelines/limitations; and
- Documented in the recipient’s medical record.

Indian Health Service Facilities: All covered MHCP services provided through IHS facilities are eligible for payment. Inpatient hospital, outpatient hospital, clinic (medical or dental), or pharmacy services provided to MA recipients are paid at the applicable IHS encounter/visit rate. Services for GAMC recipients and MinnesotaCare recipients are paid according to the payment methodology noted in the applicable individual service chapters.

638 IHS Facility: As specified in the contract, compact, or grant award, a 638 IHS provider may offer services beyond the scope of IHS facility services including home health, chemical dependency, mental health, and transportation. Tribal governments may also seek certification, from DHS, to provide Child Welfare Targeted Case Management (CW-TCM) services or Relocation Service Coordination (RSC). All covered MHCP services provided by 638 IHS facilities are eligible for payment. Services provided to MA recipients are paid at the applicable IHS encounter/visit rate, with the exception of CW-TCM and RSC. CW-TCM services are paid at the established 638 IHS CW-TCM rate. RSC is covered at the DHS established RSC rate. Services for GAMC recipients and MinnesotaCare recipients are paid according to the payment methodology noted in the applicable individual service chapters.
- **Tribal Facility**: Services provided to MHCP recipients by an enrolled Tribal Facility are covered, if the facility meets the requirements to provide services as specified in applicable chapters of this Manual. Refer to the chapter in this manual that applies to the service provided. These facilities have elected not to be paid the IHS encounter/visit rate.

### Covered Services and Payment Rates

<table>
<thead>
<tr>
<th>Services: MA and MinnesotaCare With MA Benefits</th>
<th>IHS Facility</th>
<th>638 IHS Facility</th>
<th>Tribal Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>All MA Covered Services</td>
<td>All MA Covered Services</td>
<td>All MA Covered Services</td>
<td>Rate established by DHS for the specific provider type (i.e. FQHC, Physicians Clinic, Physician, etc.). These facilities have elected not to be paid the IHS encounter/visit rate.</td>
</tr>
<tr>
<td>IHS encounter/visit rate, along with the fee-for-service rate for outpatient hospital ambulatory surgical services and inpatient physician services.</td>
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<td>Rate established by DHS for the specific provider type (i.e. FQHC, Physicians Clinic, Physician, etc.). These facilities have elected not to be paid the IHS encounter/visit rate.</td>
<td></td>
</tr>
<tr>
<td>DHS established encounter rate for 638 IHS CW-TCM services.</td>
<td>DHS established fee-for-service rate for RSC services.</td>
<td>Rate established by DHS for the specific provider type (i.e. FQHC, Physicians Clinic, Physician, etc.). These facilities have elected not to be paid the IHS encounter/visit rate.</td>
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</tr>
<tr>
<td>All GAMC or MinnesotaCare Covered Services</td>
<td>All GAMC or MinnesotaCare Covered Services</td>
<td>All GAMC or MinnesotaCare Covered Services</td>
<td>Payment methodology noted in the applicable individual service chapters.</td>
</tr>
</tbody>
</table>
Payment Requirements

MA Payment to IHS Facilities and 638 IHS Facilities

IHS and 638 IHS facilities are paid for services provided to MA recipients as follows:

- **Inpatient hospital services:** Inpatient hospital requirements such as admission certification, second medical opinion (SMO), and authorization apply. Refer to the following chapters; “Hospital Services,” “Hospital Admission Certification,” “Physician and Professional Services,” and “Authorization.” Inpatient hospital services are billed using revenue codes and charges in the UB-92 format. All inpatient hospital services are covered under the payment of the inpatient per diem rate established by the IHS.

- **Inpatient physician services:** MA pays for inpatient physician services that meet the requirements under the approved State Medicaid plan at the MA fee-for-service rates. These services are billed using the CPT guidelines. Physician charges are submitted using the appropriate CPT code, any applicable modifiers, and charges in the CMS-1500 format.

- **Outpatient services:** All covered services must be billed on the appropriate claim forms e.g. CMS-1500, ADA, Pharmacy. Only one encounter payment will occur per service category, per recipient, per service date.

All MA covered outpatient services including medical, dental, home health, mental health, chemical dependency, and pharmacy are paid at the IHS outpatient rate established by the IHS. When MA covered ambulance/special transportation services are provided under a 638 IHS provider’s contract, compact, or grant with IHS, a billable encounter may occur. See instructions, in this chapter, for billing 638 IHS ambulance/ special transportation services.

Note: Medical supplies provided, and/or diagnostic services performed on the date of service are considered to be part of the face-to-face encounter/visit with the health professional and no separate payments are made.

- **Home Health Agency/Visiting Nurse Services:** Home health agency services and visiting nurse services qualify as IHS/638 IHS encounters/visits when the services are:
  - Provided by individuals who meet training and licensure requirements,
  - Covered MHCP services meeting all standards and service limitations, and
  - Provided by an IHS/638 IHS facility that has current Medicare certification as a home health agency or has a designation as a home health agency shortage area.

- **Child & Teen Check-up (C&TC):** Child & Teen Check-up services must be billed using C&TC policy and billing instructions. Refer to the Children’s Services Chapter of this Manual.
• **Chemical Dependency Services:** Chemical dependency services are defined in the Chemical Dependency chapter of this Manual. Chemical dependency services are billed according to the instructions found in that chapter. When a face-to-face service is provided by a chemical dependency health professional at a 638 IHS chemical dependency service location an outpatient encounter occurs. Payment for chemical dependency services is limited to one payment, per recipient, per day.

• **Outpatient Hospital Ambulatory Surgical Services:** Whenever an ambulatory surgical service is provided, (the recipient does not require overnight hospital care):
  - The services provided by the outpatient hospital, (i.e., use of the facility, nursing and technical personnel, supplies, etc.) must be billed in the UB-92 format using appropriate CPT surgical procedure code(s) and modifier(s). The ambulatory surgical center facility fee is paid at the current Medicaid rate established for the technical component of the surgical procedure.
  - The professional service (component) to perform an ambulatory surgical procedure is billed using the appropriate CPT code(s), any applicable modifier(s), and charge(s) in the CMS-1500 format.

• **Transportation Services:** Ambulance and special transportation services are defined in the Transportation Services chapter (Ch. 21) of this manual.

To compensate the IHS/638 IHS provider for transportation services, payments are made independent of IHS and 638 IHS inpatient or outpatient encounter claims.

The IHS outpatient encounter/visit rate is paid, when:
  - MA covered transportation services are furnished by a 638 IHS provider by transporting the recipient to any MA enrolled provider from which the recipient is eligible to receive services; and
  - The services provided to the recipient are MA covered services; and
  - The recipient is not admitted to an inpatient hospital within 24 hours of an ambulance trip.

The IHS patient per diem rate is paid, when:
  - MA covered ambulance services are furnished by a 638 IHS provider by transporting the recipient to any MA enrolled provider from which the recipient is eligible to receive services; and
  - The services provided to the recipient are MA covered services; and
  - The recipient is admitted to an inpatient facility, either IHS or non-IHS, within 24 hours of the ambulance trip due to a medical condition related to the need for ambulance services. Box 18 on the CMS-1500 claim form must contain the inpatient admission date in order to receive the IHS inpatient rate.
  - The 638 IHS provider need not be the provider that transported the individual to the admitting facility.
When a second transportation service is medically necessary on the same service date, payment for the second trip is made when the services are provided by the 638 IHS provider as long as the destination is one that the recipient is eligible to receive services from and the service is an MA covered service. The payment for the second transportation service is at either the outpatient or inpatient rate depending on whether or not the recipient was admitted within 24 hours of an ambulance trip.

Payments for a recipient for a given service date are limited as follows:

- One outpatient rate or one inpatient rate, if a single transportation service is provided by the 638 IHS provider, or
- Two payments at the outpatient rate, if two or more transportation services are provided by the 638 IHS provider and the recipient was not admitted to an inpatient hospital facility within 24 hours, or
- One outpatient and one inpatient rate, if two or more transportation services are provided by the 638 IHS provider and the recipient was admitted to an inpatient hospital facility within 24 hours.

- All services provided to MA recipients at an IHS facility or at a 638 IHS facility, except for services provided to non-IHS eligible individuals, must be billed under the IHS facility/638 IHS facility provider number.

Services provided to non-IHS eligible individuals must be billed on the separate provider number issued to the provider. Payment for non-IHS services will be at the IHS encounter rate.

Additional provider numbers may only be granted to separate enterprises operating at separate locations.

Services billed under an individual’s provider number will not be paid at the IHS encounter/visit rate.

- With the exception of transportation services, only one encounter payment is paid within the same service category, for services that take place on the same day and at a single IHS outpatient location, except when the recipient after the first visit suffers an illness or injury requiring additional diagnosis or treatment. When such a second medically necessary encounter occurs, the second claim must include both the 22 and 76 modifiers along with an attachment explaining the circumstances which supports the request for payment of the second encounter.

- A 638 IHS organization may provide services other than traditional IHS services. Only MA covered services may be billed.

- Services provided at a tribal facility that is not a 638 IHS facility are not eligible for the IHS encounter/visit rate. These facilities must refer to the appropriate chapter that corresponds with the service provided for billing and service coverage information.
GAMC and MinnesotaCare Payment to IHS Facilities and 638 IHS Facilities

- Services provided to GAMC recipients and MinnesotaCare recipients must be billed according to the requirements designated for each service. The IHS per day and per visit rates do not apply to GAMC recipients and MinnesotaCare recipients. The IHS/638 IHS facilities, tribal facilities, and individual providers must meet the same service and licensure requirements necessary to provide services to MA patients/clients.

Legal References

MS 256B.0625, subd. 34
Appendix

County Listing

The county listing is available from DHS’ eDocs system at http://edocs.dhs.state.mn.us/lfserver/Legacy/DM-0005-ENG.