STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates (Other than Inpatient Hospital and Long Term Care Facilities)

- the provider's usual and customary charge minus any third party payments, contractual adjustments, and any applicable Medicaid co-payment, patient pay, or spend-down amounts.

A provider's customary charge refers to the amount which the individual practitioner charges in the majority of cases for a specific medical procedure exclusive of token charges for charity patients and substandard charges for welfare and other low income patients.

Payment adjustments will be made for practitioner services provided through the following public entities:

- University of Michigan Health System
- Wayne State University
- Hurley Hospital
- Michigan State University
- Oakland University
- Western Michigan University
- CENTRAL MICHIGAN UNIVERSITY

Adjustments apply to dates of service on or after April 1, 2006. Beginning January 1, 2011, Oakland University will be eligible for pricing adjustments under this program. Beginning July 1, 2012, Western Michigan University will be eligible for pricing adjustments under this program. Beginning January 1, 2013, Central Michigan University will be eligible for pricing adjustments under this program. Eligibility for these adjustments is limited to individual practitioners or practitioner groups designated by the public entities. Service provided by the following practitioners, when not included in facility payments to the public entity, are included:

- Physicians (MD and DO)
- Ophthalmologists
- Oral Surgeons
- Dentists
- Podiatrists
- Physician's Assistants
- Nurse Practitioners
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Certified Anesthesiologist Assistants
- Optometrists

Adjustments apply to both public and private practitioners and practitioner groups. Practitioners and practitioner groups are either employees of the public entity or are under a contract with the public entity. All services eligible for the payment adjustment are billed under the federal employer number of the public entity or under the employer identification number of the practitioner/practitioner group. Billings are submitted by the public entity or by the practitioners/ practitioner groups. The Medical Services Administration must concur with the public entity's designations in order for the payment adjustment to be applied.

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Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically and Medically Needy

d) Inpatient services related to a diagnosed mental health condition are covered only when rendered by a psychiatrist or physician (M.D. or D.O.), or psychological testing by a licensed psychologist under the direction of psychiatrist or physician (M.D. or D.O.); and

e) The following specific items are excluded:

1) routine physician examinations not medically necessary for diagnosis or treatment of an illness, injury, or for the prevention of disability with the following exceptions:

a. screening and preventive services are covered under the EPSDT program for children under the age of 21. See item 4B under this attachment;

f) Certain selected surgeries, as specified by the MA program, that may be performed on an outpatient basis are not covered when performed on an inpatient hospital basis unless there are medical factors that contraindicate the performance of the procedures on an outpatient basis.

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13. **OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES**

a. **Diagnostic - PAP Smears** (Same for categorically needy and medically needy clients) Routine annual PAP smears are covered for eligible females when performed by a licensed physician, whether furnished in the physician's office. an inpatient or outpatient setting, or elsewhere. Additional PAP smears may be covered if a physician determines that the patient's medical history or condition warrants a PAP smear before the required 12-month period has elapsed.

NOTE: Payment to a physician for the administration of a PAP smear must not duplicate payment to an inpatient or outpatient facility.

b. **Screening services** - Provided With limitations

Screening mammography is covered according to the American Cancer Society guidelines.

c. **Preventive Services** – Provided With limitations

One preventive medicine visit per year may be covered for any recipient.

Recommended preventive immunizations are covered

d. **Rehabilitative Services**

1) **Substance abuse rehabilitation services**

The program covers medically necessary rehabilitation services for persons with a chemical dependency diagnosis. Medical necessity is documented by physician referral or approval of the treatment plan.

Services may be provided in residential settings or on an outpatient basis. Reimbursement will be excluded for rehabilitation services provided to any individual who is a patient in an IMD.

Substance Abuse Treatment Programs have been defined as those meeting the following criteria which assure that providers have the capacity to provide services but do not restrict client freedom of choice: