Chapter 6

Physician and Professional Services

The following sections are included in this chapter:

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Definitions

Advanced Practice Registered Nurse (APRN): An individual licensed as an APRN 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 (CNS), Certified Nurse Practitioner (CNP), Certified Nurse Midwife (CNM), or Certified Registered Nurse Anesthetist (CRNA).

Allergenic Extract: The refined injectable form of antigen either commercially prepared or refined in the physician's office under his/her supervision.

Antigen: The raw form of pollen (e.g., venom, stinging insect, etc.) prior to refinement for administration to humans.

Certified Nurse Midwife (CNM) 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 non-pharmacologic treatment within a system that

provides for consultation, collaborative management, and referral as indicated by the health status of patients.

Certified Nurse Practitioner (CNP) Practice: Diagnosing, directly managing, and preventing acute and chronic illness and disease. A certified nurse practitioner (CNP) is an advanced registered nurse practitioner (ARNP) who is certified in a specific field of CNP practice.

Certified Registered Nurse Anesthetist (CRNA) Practice: The provision of anesthesia care and related services, 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 (CNS) Practice: The provision of patient care in a particular specialty or subspecialty of advanced practice registered nursing which includes: (1) diagnosing illness and disease; (2) providing non-pharmacologic treatment, including psychotherapy; (3) promoting wellness; and (4) preventing illness and disease. The certified CNS is certified for advanced practice registered nursing in a specific field of CNS practice.

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.

Consultation: When the treating physician or other qualified health care professional asks the advice or opinion of another physician or qualified health care professional.

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. Cosmetic surgery is excluded from coverage.

Developmental Disability (DD) Screening Document: Assessment tool required for any person being admitted to an institution. This process is to be used to provide people with community service options in order to prevent admissions or to provide transition assistance in the event an admission cannot be avoided. If a person is admitted and requests RSC-TCM services, this process includes a means for assessing the enrollee's health, psychosocial, and functional strengths and needs, in addition to assisting the enrollee to identify needed and available services.

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.

Genetic Counselor or Geneticist: An individual who is board-certified by the American Board of Genetic Counseling (ABGC).

Hub Site: A medical facility telemedicine site where the medical specialist is located.

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.

Institutions: Includes hospitals and nursing facilities (NFs), including certified boarding care facilities (BCFs), Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs), and Regional Treatment Centers (RTCs) providing inpatient services to enrollees currently receiving Medical Assistance (Medicaid).

Investigative: A health service or procedure with limited human application and trial, which lacks wide

recognition as proven and effective in clinical medicine (as determined by the National Blue Cross and Blue Shield Association Medical Advisory Committee, InterQual™ or other nationally-recognized medical or health organizations).

Long-Term Care Consultation (LTCC) Screening Document: An assessment tool required for any enrollee admitted to an institution. The screening is to provide community service options in order to prevent admissions or to provide transition assistance in the event an admission cannot be avoided. If an enrollee is admitted and requests transition services, the screening includes a means for assessing an enrollee's health, psychosocial, and functional strengths and needs, in addition to assisting the enrollee to identify needed and available services.

Physician: A person who is licensed to provide health services within the scope of his/her profession under MN Statutes 2019, ch. 147. For purposes of this chapter, a physician means a licensed doctor of medicine or osteopathy.

Physician Assistant (PA): A person licensed pursuant to MN Statutes 2019, ch. 147A who meets the qualifications in MN Statutes 2019, sec. 147A.02.

Physician Extender: PA or APRN who chooses not to enroll with MHCP, genetic counselor, registered nurse, or licensed acupuncturist who is:
1. Employed by the physician;
2. Employed by the same provider organization that employs the physician; or
3. Supervised by a physician.

Plastic Surgery: The alteration, replacement, or restoration of visible parts of the body performed to correct a structural defect or for cosmetic effect.

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.

Professional Services: Physician-ordered allergen immunotherapy and services either performed by the physician or qualified personnel under the physician.

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.

Registered Nurse (RN): A nurse licensed under and within the scope of Minnesota Statutes.

Relocation Service Coordination - Targeted Case Management (RSC-TCM): A type of targeted case management for enrollees residing in eligible institutions who want to move into the community. RSC-TCM helps an enrollee who resides in an eligible institution to plan, arrange, and gain access to needed medical, social, educational, financial, housing, and other services and supports that are necessary to move from an eligible institution to the community.

Spoke Site: A remote site where the referring health professional and patient are located.

"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, magnetic resonance imaging (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.

Targeted Case Management (TCM): Services that assist an enrollee in gaining access to needed medical, social, educational, and other services.

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.

Physician Services

Enrollment Requirements

Physicians must enroll with the Minnesota Department of Human Services (DHS) to receive payment. If you are not eligible for participation with DHS, please contact IMCare. Physicians must receive an individual National Provider Identifier (NPI), even if they are a member of a group or clinic, or are employed by an outpatient hospital or other organized health care delivery system that employs physicians. (Refer to the *Locum Tenens Physicians* section of this chapter.)

Covered Services

Services provided by a physician are not restricted to a specific place of service (POS), unless specified by Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code description. Physicians may provide services in an enrollee'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 Minnesota Statutes.

Outpatient Physician-Administered Drugs

Drugs that are administered to a patient as part of a clinic or other outpatient visit should be billed to IMCare using the appropriate HCPCS code(s). Do not bill drugs administered during an outpatient visit through the pharmacy point-of-sale system. IMCare does not allow "brown-bagging" or "white-bagging" of prescription drugs administered in an office setting.

Pharmacies (including mail order pharmacies) that provide drug(s) for a clinic visit should bill the clinic, and not IMCare, for the drug(s) dispensed. IMCare will make an exception only if an enrollee has third-party liability and the third-party payer requires that the drugs be billed through the pharmacy benefit. Pharmacies should not dispense drugs directly to a patient if the drugs are intended for use during a clinic or other outpatient visit.

For injections that involve multiple national drug codes (NDCs), bill the initial line with the HCPCS code, units and NDC with modifier KP (first drug of a multiple drug unit dose formulation). Bill the second, and any subsequent line items of the same HCPCS code with modifier KQ (second or subsequent drug of a multiple drug unit dose formulation). If billing the same HCPCS code on more than two lines, the KQ modifier and an additional modifier are needed on each subsequent line.

Outpatient Physician-Administered Drugs National Drug Code (NDC) Reporting

The Federal Deficit Reduction Act of 2005 (DRA) requires states to collect rebates for covered outpatient drugs administered by physicians. In order to comply, states must gather utilization data including the NDC, quantity, and unit of measure from claims submitted for physician-administered drugs.

Include the correct NDC information on all claims, including Medicare and other third-party claims, when billing non-vaccine drugs using HCPCS codes. Participants in the 340B Drug Pricing Program are included in the NDC reporting requirements; however, drugs purchased through 340B are exempt from NDC reporting. Add the UD modifier to drugs purchased through the 340B Program. Refer to the HCPCS Codes Requiring NDC list when submitting claims for reimbursement.

NDC Reporting of Outpatient Physician-Administered Compound Drug

Enter one compound drug (HCPCS code) per claim transaction with up to 25 individual NDCs in the Drug Identification loop. The NDC quantity and dose form are reported in the Quantity and Unit or Basis for Measurement Code areas.

Multiple service lines are necessary to report a compound drug. One NDC is allowed per line. Report the HCPCS code as a separate line for each associated NDC.

Reporting the Discarded Portion of Administered Drugs

When a provider must discard the remainder of a single use vial or other single use package after administering a dose or quantity of the drug or biological, report the amount of the unused and discarded drug on a separate claim line using the JW modifier. Providers are expected to use the package size that minimizes the amount of waste billed to MHCP. For example, if a patient needs 50 mg of drug and the product comes in 50 mg and 100 mg vials, use the 50 mg vial.

The JW modifier is not permitted when the actual dose of the drug or biological administered is less than the billing unit. The JW modifier is not appropriate for drugs that are from multiple dose vials or packages.

Evaluation and Management (E/M) Services

IMCare follows CPT guidelines for billing E/M services.

Concurrent Care

IMCare pays concurrent care when the medical condition of an enrollee requires the services of more than one physician. In general, an enrollee condition that requires physician input in more than one specialty area establishes medical necessity for concurrent care.

Non-Covered Concurrent Care Services

IMCare will not pay for concurrent care when either of the following occurs:

1. A physician makes a routine call at the request of the enrollee or family, or as a matter of personal interest.
2. Available information does not support the medical necessity of concurrent care.

Billing Concurrent Care

If an enrollee's condition requires concurrent care, bill the appropriate E/M code and modifier.

Consultations

IMCare follows CPT guidelines for office, outpatient and inpatient consultations.

Critical Care

Follow CPT guidelines for reporting critical care. Services not included in critical care may be reported separately.

Observation Services
Follow CPT guidelines for reporting E/M observation codes. Up to 48 hours of observation services are allowed, and in some circumstances, up to 72 hours.

Physician Services For Enrollees In Inpatient Status
For services or procedures done while an enrollee is considered in an inpatient status, use POS code 21 (inpatient hospital).

Physician Services in Long-Term Care Facilities (LTCFs)
Payment for physician and professional services in an LTCF must be medically necessary. Refer to the *Physician Extenders* section of this chapter for use of physician extender services provided in LTCFs. Refer to Chapter 27, Long-Term Care, for additional information on covered services in LTCFs.

Prolonged Physician Services
Prolonged services involving direct (face-to-face) patient contact are covered. Use CPT guidelines to report prolonged services.

Physician Standby Services
Physician standby services are only covered when they are requested by another physician, involve prolonged attendance without direct (face-to-face) patient contact, and are due to documented distress or an existing risk.

Physician Case Management (Team Conferences)
A medical team conference conducted for the purpose of coordinating an enrollee's care with an interdisciplinary team of health professionals and/or representatives of community agencies is a covered service. The medical record must document the content 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 at least 50% of the encounter is spent counseling and/or coordinating care, 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 IMCare. Refer to Chapter 32, COVID-19 Response, for exceptions that apply during peacetime emergency.

Care Plan Oversight
Care plan oversight services are not covered by IMCare.

Preventive Medicine Services
Follow CPT guidelines for billing preventive health services. IMCare covers United States Preventive Services Task Force (USPSTF) Grade A and B recommendations.

Non-Covered Preventive Services
The following are not covered as preventive services:
1. Services that are only for vocational or educational purposes that are not health-related.
2. Services that deal with external, social, or environmental factors that do not directly address the enrollee'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/or group counseling.

Education and Counseling

Eligible Providers

Eligible providers include enrolled physicians, physician clinics, community clinics, outpatient hospitals, public health clinics, family planning agencies, CNPs, PAs, CNSs, CNMs, Community Mental Health Centers (CMHCs), and physician extenders.

Covered Education or Counseling Services			
Reason for Education or Counseling	**CPT/HCPCS Code(s)**	**Eligible Providers**	**Billing Directions**
Education/counseling is the primary reason for the visit. Services to healthy individuals for the purpose of promoting health and anticipatory guidance (e.g., family planning, smoking cessation, infant safety, etc.).	99401-99409 (individual) 99411-99412 (group)	• Physicians • Enrolled PAs and APRNs • Physician extenders	Use modifier U7 when a physician extender provides the service.
Education/counseling is the primary reason for the visit for services to people with symptoms, a diagnosis, or established illness (e.g., prenatal, joint care, pain, HIV, asthma). Refer also to nutritional, diabetic, and weight reduction guidelines.	98960 (individual) 98961-98962 (group)	• Enrolled PAs and APRNs • Physician extenders	Use modifier U7 when a physician extender provides the service.
Education/counseling is an add-on to the office visit (e.g., provided as part of the regular office visit and dominating more than 50% of the visit, then time may be considered the key or controlling factor to qualify for a particular level of E/M service).	99201-99205 (new patient) 99211-99215 (established patient)	• Physicians • Enrolled PAs and APRNs	
Asthma education, per session. Asthma education may be reported outside of the office visit when an asthma action plan (AAP) has been written by the clinician and discussed with patient/family, documented in the medical record, and a copy provided to the asthma educator.	S9441	Report asthma education with S9441 by using the supervising clinician's NPI for one of the following: • Non-enrolled APRNs • RNs • Pharmacists • Certified Asthma Educators (CAE)	Bill 1 unit for each class.

Covered Education or Counseling Services			
Reason for Education or Counseling	**CPT/HCPCS Code(s)**	**Eligible Providers**	**Billing Directions**
Birthing classes per session.	S9442	Clinics and outpatient hospitals whose prenatal education program is directed by an MHCP enrolled provider may report S9442, S9443 and H1003 with one of the following: • Non-enrolled APRNs • RNs • Health educators with at least a baccalaureate level degree in health education or national certification with the International Childbirth Education Association (ICEA), Lamaze or the National Commission for Health Education Credentialing (NCHEC) for prenatal certification or International Board of Certified Lactation Consultants (IBCLC) for lactation certification.	Bill 1 unit for each time the class meets.
Lactation classes per session.	S9443		Bill 1 unit for each time the class meets.
Enhanced prenatal services provided to "at-risk" pregnant women only. An at-risk determination is based on the results of a prenatal risk assessment (e.g., American College of Obstetricians and Gynecologists (ACOG) Obstetric Medical History)).	H1003		Bill one unit for the entire class (e.g., three weeks of nutrition education = 1 unit).
Counseling to assess and minimize problems hindering normal nutrition, and to improve the patient's nutritional status.	97802 (initial individual) 97803 (reassess individual) 97804 (group)	• Physicians • Licensed dieticians • Licensed nutritionists	Bill 15-minute unit. Medical Nutrition Therapy (MNT) is reimbursed when a licensed dietician or nutritionist is under the supervision of a physician.
Reassessment due to change in diagnosis, medical condition or treatment regimen requiring a second referral in the same year.	G0270 (individual) G0271 (group)	• Physicians • RNs • Licensed dieticians • Licensed nutritionists	Bill 15-minute unit. MNT is reimbursed when a licensed dietician/nutritionist is under the supervision of a physician.

Covered Education or Counseling Services			
Reason for Education or Counseling	**CPT/HCPCS Code(s)**	**Eligible Providers**	**Billing Directions**
Diabetic Outpatient Self-Management Training (DSMT) services including education about self-monitoring blood glucose, diet, exercise and sliding scale insulin treatment for the patient who is insulin dependent.	G0108 (individual) G0109 (group)	• Physicians • RNs • Licensed dieticians • Licensed nutritionist • A provider of dually eligible Medicare and Minnesota Health Care Program (MHCP) enrollees must be a certified provider according to the National Diabetes Advisory Board Standards.	Bill 30-minute unit. Initial training 10-hour limit per 12 months. Additional training limited to 1 hour per year.

Refer to the *Community Health Worker (CHW) Patient Education* section of Chapter 8, Clinic Services, for IMCare covered education services provided by a CHW.

Non-Covered Services
Services provided as part of a day treatment program, partial hospitalization, or other similar health care program may not be billed as physician services provided in an educational or counseling setting.

Documentation
A physician order for educational or counseling services is required. Documentation of the enrollee's participation, number of participants in the educational or counseling group, name and credentials of the person who provided the service and topic content must be in the medical record or class record.

Billing
Refer to the following billing guidelines:
1. The cost of educational materials is included in the payment. No additional payment will be made for handouts, textbooks, or other materials.
2. Physician extenders must modify their services using the appropriate modifier. (Refer to the *Physician Extenders* section in this chapter.)

Smoking Cessation Services
IMCare covers smoking cessation education, counseling and products. Smoking cessation products must be approved by the Food and Drug Administration (FDA) and covered under the Medicaid Drug Rebate Agreement.

Medical Supplies Provided by a Physician's Office
Eligible Providers
For the purposes of this section, eligible providers include 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 from durable medical equipment (DME) providers. Refer to Chapter 23, Equipment and Supplies. Routine supplies are not paid separately. Supplies applied or used in a 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 IMCare.

Non-Covered Services
Supplies sent home with enrollees are not covered by IMCare.

List of Routine Office Supplies
The following list of routine physician office supplies cannot be billed separately (list is not all-inclusive):

Adhesive tape, all sizes	Intravenous pyelogram (IVP) dyes
Alcohol or peroxide, per pint	Kerlix, Kling bandages
Alcohol wipes	Masks
Autolet	Micropourous tape
Band-Aids	Needles, sterile
Betadine, Iodine, Providine swabs/wipes	Opsite
Betadine, Phisohex, per pint	Patient electrode pads
Chux pads	Razor
Cold packs	Sanitary belt, napkins, tampons
Cotton balls	Silver nitrate stick
Cotton tip application (sterile/non-sterile)	Specimen collection
Culturette	Steri-strips
Emesis basins	Sterile saline, 30cc
Enema kits	Sterile water, 30cc
Gauze pads, sterile or non-sterile	Suction tubing
Gelfoam	Surgical drapes
Gloves (latex, plastic, rubber, sterile, etc.)	Suture removal tray
Gowns	Syringe (with/without needles)
Hemostatic cellulose (e.g., surgical, any size)	Thermometer (any size)

Casting Provided in a Physician's Office
Please follow applicable coding guidelines for casting and recasting.
1. If no surgery or manipulation is done, bill the appropriate E/M code and HCPCS casting supply code.
2. If surgery or manipulation is done, bill the appropriate CPT surgery code and HCPCS casting supply code.
3. If recasting is done, bill the appropriate CPT casting code and HCPCS casting supply code.

Immunizations and Vaccinations
IMCare covers vaccines, toxoids and an administration fee.

IMCare covers only the administration fee for vaccines and toxoids provided free by the Minnesota Vaccines for Children (MnVFC) program, 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 Chapter 9, Children's Services, and Chapter 9A, Immunizations and Vaccinations.

Please follow current DHS billing policies when using your private stock of vaccines as replacement for MnVFC vaccines. DHS policies may change from year to year.

Electrocardiogram (EKG) Interpretations
EKG interpretation services may be billed in addition to the E/M service. IMCare covers one physician interpretation for each EKG.

Acupuncture

Eligible Providers

Acupuncture is covered only when provided by a licensed acupuncturist, a chiropractor who has met Minnesota Board of Chiropractic Examiners acupuncture registration requirements, or a physician who has specific acupuncture training/credentialing.

Covered Services

Acupuncture is covered for the following conditions:

- Acute pain
- Chronic pain
- Depression
- Anxiety
- Schizophrenia
- Post-traumatic stress disorder
- Insomnia
- Smoking cessation
- Restless legs syndrome
- Menstrual disorders
- Xerostomia (dry mouth) associated with:
  - Sjogren's syndrome
  - Radiation therapy
- Nausea and vomiting associated with:
  - Post-operative procedures
  - Pregnancy
  - Cancer care

Non-Covered Services

Acupuncture is not covered for the following conditions (list is not all-inclusive):

- Weight loss
- Drug or alcohol dependence
- Infertility
- Fatigue
- Allergies or asthma
- Acne
- Nausea due to conditions other than surgery, pregnancy or cancer care
- High blood pressure
- Cold or influenza
- Sexual dysfunction

In addition, IMCare does not cover:

- Acupressure
- Massage
- Herbal supplements

Services that fall within an acupuncturist's scope of practice, such as breathing techniques, dietary guidelines, etc., are considered part of the visit and are not reimbursed separately. IMCare does not cover maintenance treatment, where symptoms are not improving/regressing. Acupuncture treatment is not considered medically-necessary if the recipient does not demonstrate improvement in symptoms.

Please refer to Chapter 5, Service Authorization, for IMCare acupuncture limits and prior authorization requirements. Documentation must include:

- The diagnosis for the cause or origin of the symptom being treated.
- Evidence that the patient is responding favorably to the acupuncture treatment and that further improvement is expected with additional treatment.
- The acupuncture technique being requested.
- A comprehensive history and physical evaluation of the patient.
- Plan of care for the acupuncture treatment.
- Other treatments the patient is receiving for the diagnosis, regardless of where or by whom they are being treated. Examples of other treatment may include opioids, physical therapy and medical cannabis.
- When applicable, provide documentation that favorable outcomes from acupuncture treatments have reduced the patient's need for opioids or led to improved utilization of other treatment modalities.

Allergy Immunotherapy - Allergy Testing

Covered Services

IMCare covers the following allergy immunotherapy or testing services.

1. Professional services to prepare raw antigen to a refined state that will become an allergenic extract.
2. Professional services to administer the allergenic extract.
3. Providing the injectable allergenic extract.
4. Physician-ordered allergen immunotherapy and services performed by the physician or qualified personnel under the direction of a physician.
5. Professional services to monitor the enrollee's injection site and observe for anaphylactic reaction.
6. Allergy testing when clinically significant symptoms exist and conservative therapy has failed.
7. Provision of inhalants (a pharmaceutical). Refer to Chapter 22, Pharmacy Services.

E/M services are eligible for separate payment on the same day as allergen immunotherapy only when a significant, separately identifiable service is performed.

Non-Covered Services

Testing

Allergy testing includes the performance, evaluation and reading of cutaneous and mucous membrane testing. The physician work of taking a history, performing the physical examination, deciding on the antigens to be used, interpretation of results, counseling and prescribing treatment should be reported using an E/M code.

The following allergy testing procedures are considered investigative, and therefore, are not covered:

- Cytotoxic leukocyte testing (Brian's test)
- Leukocyte histamine release testing
- Provocation-neutralization testing (sublingual, subcutaneous, intradermal, or intracutaneous)
- Rebuck skin window test
- Passive transfer or Prausnitz-Kustner (P-K) Test
- Candidiasis hypersensitivity syndrome testing
- IgG level testing general volatile organic screening test (volatile aliphatic panel)
- ELISA/ACT immunotherapy (Serammune Physician Lab, Reston, VA)
- Antigen Leukocyte Cellular Antibody Test (ALCAT)

Treatment

The following allergy treatments are considered investigative, and therefore, are not covered:

- Provocation-neutralization treatment (sublingual, subcutaneous, intradermal, or intracutaneous)
- Oral and sublingual immunotherapy (includes oral drops, solutions, oral capsules, and tablets)
- Rinkel immunotherapy

- Autologous urine immunizations
- Clinical ecology urine immunizations
- Candidiasis hypersensitivity syndrome treatment and related services
- Intravenous (IV) Vitamin C therapy
- Enzyme potentiated desensitization
- Rhinophototherapy
- Poison Ivy/Poison Oak extracts for immunotherapy
- Trichophyton, Oidiomycetes, and Epidermophyton (T.O.E.) immunotherapy for chronic otitis media

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, which involves the following:
1. Sterile preparation of an allergenic extract by titration, filters, etc.
2. Checking the integrity of the extract by cultures or other qualitative methods.

Purchasing refined antigens, measuring dosages, and adding diluent are not considered refining raw antigens.

Adding Diluent
As with any other medication administration, adding diluent is not a separately covered service. This service is an integral part of the professional services for providing an allergenic extract.

Identifiable services not included in an office visit may be billed separately.

Surgical Services

Global Surgery Package

IMCare follows coding guidelines regarding the global surgical package. The global surgical package period starts on the day of surgery and includes 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.

IMCare covers medically necessary surgical services. Reimbursement for all surgeries is based on a global surgery package, following Medicare global surgery guidelines and including pre, post, and intraoperative work related to the surgical procedure. IMCare follows Medicare guidelines for the number of days in the global package. Preoperative physicals by a primary care provider are not included in the global package.

Evaluation of the need for surgery by the surgeon is also covered outside of the global surgical 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. 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.

Postoperative care includes:
- E/M services
- Pain management
- Treatment of complications (e.g., infection related to the surgery)

- Miscellaneous services (e.g., dressing changes and other 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 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. If further specifics are required, refer to the Medicare global surgery guidelines.

Assistant-at-Surgery
IMCare follows Medicare assistant-at-surgery guidelines. IMCare does not cover assistant-at-surgery services provided by surgical technicians, surgical assistants or Registered Nurse First Assistants (RNFAs). Physician assistant surgeons must bill using modifier 80 or 82. PAs and APRNs must use modifier AS.

Billing
Refer to the following billing guidelines for physician services:

- Submit claims for physician services at surgery electronically in the 837P format.
- Refer to Chapter 31, Tribal and Federal Indian Health Services, for physician services provided in an Indian Health Service (IHS), tribal or 638 facility.

Bilateral Procedures
Please refer to coding guidelines regarding the appropriate use of modifiers. Use modifier 50 only when the exact same service/code is reported for each bilateral anatomical site.

1. Report bilateral surgical procedure codes on one line, appended with modifier 50.
2. Enter 1 unit on a line reported with modifier 50 (e.g., 49500 - 50 - 1 unit).
3. Do not use modifier 50 with procedure codes that are identified as bilateral or for codes that use the words one or both within the code description.

Locum Tenens Physicians

IMCare 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, military service, pregnancy, etc. IMCare acknowledges locum tenens arrangements and pays the regular physician for the services provided by the substitute physician if all of the following are met:

1. The regular physician is unavailable to provide services.
2. The enrollee has arranged or seeks to receive the services from the regular physician.
3. The regular physician pays the locum tenens physician on a per diem or a fee-for-service basis.
4. The locum tenens physician does not provide services over a continuous period of longer than 60 days.

Covered Services
IMCare covers locum tenens physician services using Medicare guidelines. Locum tenens services provided by an APRN are also covered. Current licensure is required.

Documentation
The regular physician must keep a record of each service provided by the locum tenens physician along with the substitute physician's NPI.

Billing
Refer to the following billing guidelines for locum tenens physicians:

- The enrollee'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.
- Postoperative services performed by a 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

An enrollee's regular physician may submit a claim for a covered service that the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if all of the following are met:
1. The regular physician is unavailable to provide the services.
2. The enrollee has arranged or seeks to receive services from the regular physician.
3. 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.

Covered Services

IMCare covers substitute physician services following 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

Refer to the following billing guidelines for reciprocal 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, nor enrolled with DHS.
- Bill with modifier Q5.
- 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

Telemedicine is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. To be eligible for reimbursement, providers must self-attest that they meet all of the conditions of the MHCP telemedicine policy by completing and submitting the Provider Assurance Statement for Telemedicine (DHS-6806) (PDF). Refer to Chapter 32, COVID-19 Response, for telemedicine guidelines that apply during peacetime emergency.

IMCare allows payment for the following services:
- Interactive audio and video telecommunications that permit real-time communication between the distant site provider and the enrollee. The services must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face encounter.
- "Store and Forward": The asynchronous transmission of medical information to be reviewed at a later time by a provider 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 provider at the distant site reviews the case without the patient being present. "Store and Forward" is a substitute for an interactive encounter with the patient present. The patient is not present in real-time.

In addition to other requirements, refer to the following general telemedicine information:

- Out-of-state coverage policy applies to services provided via telemedicine.
- Payment will be made for only one reading or interpretation of diagnostic tests such as x-rays, lab tests and diagnostic assessments.
- Payment is not available to providers for sending materials to enrollees, other providers or facilities.

Originating Site

The originating site is the location of an eligible IMCare enrollee at the time the service is being furnished via a telecommunication system. Authorized originating sites include:

- Provider office
- Hospital (inpatient or outpatient)
- Critical access hospital (CAH)
- Rural health clinic (RHC) and Federally Qualified Health Center (FQHC)
- Hospital-based or CAH-based renal dialysis center (including satellites)
- Skilled nursing facility (SNF)
- End-stage renal disease (ESRD) facilities
- Community mental health center
- Dental clinic
- Residential settings (e.g., group home, assisted living, shelter or temporary lodging)
- Home (a licensed or certified health care provider may need to be present to facilitate the delivery of telemedicine services provided in a private home)
- School
- Correctional facility based office
- Mobile Stroke Unit

Eligible Providers

The following provider types are eligible to provide telemedicine services:

- Physician
- CNP
- PA
- CNM
- CNS
- Registered dietitian or nutrition professional
- Dentist, dental hygienist, dental therapist, advanced dental therapist
- Mental health professional, when following DHS Telemedicine Delivery of Mental Health Services requirements
- Pharmacist
- Certified genetic counselor
- Podiatrist
- Speech therapist
- Physical therapist
- Occupational therapist
- Audiologist
- Public health nursing organization

Eligible Recipients

All IMCare enrollees.

Telemedicine Services

The CPT and HCPCS codes that describe a telemedicine service are generally the same codes that describe an

encounter when the health care provider and patient are at the same site. Examples of telemedicine services include, but are not limited to, the following:

- Consultations
- Telehealth consults (e.g., Emergency Department or initial inpatient care)
- Subsequent hospital care services (limit of one telemedicine visit every 30 days per eligible provider)
- Subsequent nursing facility care services (limit of one telemedicine visit every 30 days)
- End-stage renal disease services
- Individual and group medical nutrition therapy
- Individual and group diabetes self-management training (requires a minimum of one hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training)
- Smoking cessation
- Alcohol and substance abuse (other than tobacco) structured assessment and intervention services

Billing

Submit claims for telemedicine services using the CPT or HCPCS code that describes the services rendered. Beginning November 1, 2017, all claims for telemedicine services require a POS of 02, which attests that the service meets all telemedicine requirements, including the rendering of services to a patient located in an eligible originating site via an interactive audio and visual telecommunications system.

Include the GQ modifier when billing for services provided via asynchronous telecommunication. IMCare does not pay an originating site facility fee. Services billed on an outpatient claim with the GQ modifier will zero pay. Beginning April 1, 2018, MHCP no longer requires use of the GT modifier on claims for telemedicine services.

Two-Way Interactive Video Consultation in an Emergency Department (ED)

Two-way interactive video consultation may be billed when nursing staff is caring for a patient at an originating site, without a physician present. The ED physician at the distant site bills the appropriate ED CPT codes, with a POS of 02. The nursing services at the originating site would be included in the ED facility code. If the ED physician requests the opinion or advice of a specialty physician at a "hub" site, the ED physician bills the appropriate ED CPT codes, and the consulting physician bills the consultation E/M code with a POS of 02.

Coverage Limitations

The following limitations apply:

- Payment for telemedicine services is limited to three per week for each enrollee.
- Payment is not available for sending materials to a enrollee, other provider or facility.

The following are not covered under telemedicine:

- Electronic connections that are not conducted over a secure encrypted website, as specified by the Health Insurance Portability & Accountability Act of 1996 Privacy & Security rules (e.g., Skype)
- Prescription renewals
- Scheduling a test or appointment
- Clarification of issues from a previous visit
- Reporting test results
- Non-clinical communication
- Communication via telephone, email or fax
- Day treatment
- Partial hospitalization programs
- Residential treatment services
- Case management face-to-face contact

Advanced Practice Registered Nurse (APRN) Services

Eligible Providers

APRNs are licensed 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 (CNS), Certified Nurse Practitioner (CNP), Certified Nurse Midwife (CNM), or Certified Registered Nurse Anesthetist (CRNA). An enrolled CRNA, CNS, or CNP receives 90% of the physician rate. An enrolled CNM receives 100% of the physician rate. Refer to the *Physician Extender* section of this chapter for information regarding APRNs who choose not to enroll.

Covered Services

Services performed by APRNs are covered, if the services are a covered benefit through IMCare and within the scope of practice for an APRN.

Non-Covered Services

Clinical Nurse Specialists (CNSs) are not covered for assisting at surgery.

Billing

Bill for APRN services using appropriate HCPCS and CPT codes, and follow IMCare requirements for covered physician and professional services. For independently practicing enrolled APRNs, enter the APRN NPI as the billing provider. For organizations employing enrolled APRNs, enter the APRN NPI as the rendering provider.

Physician Assistants (PAs)

Eligible Providers

Enrolled PAs receive 90% of the physician rate and should not use the physician extender modifier when billing IMCare. The services of those who choose not to enroll will be paid as physician extender services through the supervising physician at 65% of the physician rate, and require modifier U7 when billing IMCare.

Covered Services

Services performed by a PA are covered if the services are within the scope of practice for a PA as described in MN Statutes 2019, ch. 147A and meet all required criteria by the appropriate certifying, regulatory and/or licensing entities. IMCare enrolls PAs as treating providers, not pay-to providers.

Supervision of PAs

IMCare allows off-site or remote supervision of PAs, provided the terms of the collaborative agreement are being met and the physician and PA are, or can be, easily in contact with one another by radio, telephone, or other communication device. Off-site or remote supervision does not apply to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), for which 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 clinic records) to provide the following:

- Medical direction
- Medical services
- Consultation
- Supervision

The physician must be available through direct telecommunication for consultation, assistance with medical emergencies, and patient referral.

Billing

Bill PA services using the appropriate CPT/HCPCS codes. IMCare requirements for covered physician services include:

- Enter the NPI as the rendering provider.
- Use the clinic/group name and address and NPI as the billing provider.
- Non-enrolled PAs must use modifier U7 when billing.
- PAs should continue to use modifier AS when assisting-at-surgery.

Physician Extenders

IMCare covers health services provided by a physician extender under the supervision of a physician. Physician extender services are not covered, unless they replace or substitute for the physician service.

Supervision of Physician Extenders (Except PAs)

The process of control and direction by which the physician accepts full professional responsibility for the supervisee, instructs the supervisee in his/her work, and oversees or directs the work of the supervisee. The process must meet the following conditions:

1. The physician must be present, available, and on the premises more than 50% of the time when the supervisee is providing health services.
2. The diagnosis must be made by or reviewed, approved, and signed by the physician.
3. The plan of care for a condition other than an emergency may be developed by the supervisee, but it must be reviewed, approved, and signed by the physician before care begins.
4. 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.

Role of Physician Extenders in Long-Term Care Facilities (LTCFs)

Physician services provided by a physician extender in an LTCF must be provided under the direction of a physician who is an enrolled IMCare provider. 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, APRNs or PAs who are not enrolled with MHCP and are not employees of the facility (but are working in collaboration with a physician) may provide the following physician services in an LTCF:

1. Develop a written plan of care as required by federal regulation.
2. Conduct a periodic visit as required by federal regulations. At the discretion of the physician, and in accordance with facility policy, required visits (after the initial visit) may alternate between visits by the physician and visits by a PA or APRN.

Genetic Counselor or Geneticist

A genetic counselor or geneticist may conduct a consultation and render an opinion. The following conditions apply:

1. The genetic counselor or geneticist may only initiate diagnostic or therapeutic services at the request of the attending physician.
2. Follow-up consultations may be performed, if medically necessary to re-evaluate an enrollee regarding a previously rendered opinion.
3. Consultations provided by a genetic counselor may be billed using 96040 or S0265.

Use of Modifiers

Do not use modifier U7 for a minimal service E/M code, as it represents a level of service supervised by a physician, but does not necessarily require his/her immediate ongoing presence. Use modifier U7 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. Do not use modifier U7 for physician extender services associated with enhanced prenatal care services for "at risk" pregnancies. Refer to the *Family Planning* and

Obstetrics and Gynecology (OB/GYN) Services sections of Chapter 10, Reproductive Health – Obstetrics and Gynecology (OB/GYN).

Billing Physician Extender Services
Include the following when billing for these services:
1. Enter the NPI of the physician who supervised the service as the rendering provider.
2. Enter the appropriate procedure code for the level of care provided.
3. Enter the appropriate modifier.

Non-Covered Services
Services provided by personnel such as office/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.

Outpatient Hospital Services

Billing Requirements
For clinic services provided in an outpatient hospital setting, including provider-based clinics, physicians must bill the appropriate CPT/HCPCS code and use POS 22. Failure to identify the POS as outpatient hospital services may be considered fraudulent or abusive billing, subject to monetary recovery or program sanctions.

MHCP has designated specific HCPCS codes that may be separated into professional and facility components. Providers billing and delivering professional services in outpatient hospitals will be paid for the professional component. The outpatient hospital will receive the facility component.

Provider-Based Status for Clinics
Clinics owned by hospitals authorized with provider-based status according to federal regulations must comply with 42 CFR 413.65.

Off-Campus Provider-Based Hospital Department Services
Bill for outpatient services furnished at an off-campus provider-based hospital department using:
- 837P professional claim must include POS 19
- 837I facility claim must include modifier PO

Beginning January 1, 2017, off-campus provider-based hospital department services must identify non-excepted service lines on claims using modifier PN (non-excepted off-campus service). See *January 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)*.

Billing
Professional Component
For the professional component of outpatient clinic services provided in a hospital-owned clinic, bill professional services in the 837P claim format using the appropriate HCPCS or CPT code(s) and POS 22. Failure to identify the POS as outpatient hospital may be considered fraudulent or abusive billing, and may be subject to monetary recovery or program sanctions.

Facility Fee
For the facility component of outpatient clinic services provided in a hospital-owned clinic, bill facility fees in the 837I claim format using the appropriate revenue and CPT/HCPCS codes.

Non-emergency care provided in an emergency department is considered urgent care and must be billed as urgent care services. Emergent care provided in an emergency department is considered emergency care and must be billed as emergency services. If, in a physician's professional opinion, emergency treatment for the

patient's condition cannot be provided in the emergency department, the physician may seek inpatient admission certification for the patient and bill inpatient admission services. Refer to Chapter 13, Inpatient Hospital Notification and Authorization.

Hospital Physician Services

Eligible Providers

Physicians, APRNs and PAs, in accordance with hospital bylaws, may provide inpatient hospital services.

Billing

Bill physician services provided in an inpatient hospital setting using the 837P format. Enter the dates of hospital admission and discharge in the appropriate date fields. If the enrollee has not been discharged, do not enter a discharge date.

Urgent Care Clinic Services

The following apply for urgent care clinic services:

1. Urgent care clinic services provided in an outpatient hospital setting are covered.
2. Urgent care services provided in a freestanding facility (including physician clinics) must be billed as an office visit.
3. No facility fee is paid in a physician's clinic for after-hours care.

Authorization Policy

Authorization is required for some IMCare-covered services, including procedures/surgeries that may be considered cosmetic and all investigative services/procedures. Refer to Chapter 5, Service Authorization, for current IMCare authorization requirements and information regarding the processes for authorization request and review.

Authorizations are reviewed on a case-by-case basis. IMCare uses regulatory and/or evidence-based criteria to determine medical necessity. Certain situations may require a unique piece of information that will aid the medical review agent in the decision-making process. A request will be made for additional information as the situation requires. It is the responsibility of the provider requesting authorization to submit sufficient documentation to establish that coverage standards have been met.

Transplant Services

Covered Services

IMCare coverage of organ and tissue transplant procedures is limited to those procedures covered by Medicare or approved by IMCare. Transplant coverage includes preoperative evaluation; retrieval of organs or tissues; enrollee and donor surgery; and follow-up care for the enrollee and live donor. All transplant-related services are billed under the enrollee's IMCare identification (ID) number.

Eligible Providers

All organ/tissue transplants provided to IMCare enrollees must be performed in a Medicare-certified transplant facility and comply with all applicable laws, rules and regulations governing all of the following:

1. Coverage by Medicare
2. Federal financial participation by Medicaid
3. Coverage by the Medical Assistance (Medicaid) program. (All transplants performed out-of-state must be prior authorized.)

It is the responsibility of the transplant center to submit their certification documentation to MHCP Provider Enrollment.

Eligible Enrollees
Transplant coverage applies to Medical Assistance (MA) and MinnesotaCare enrollees. MinnesotaCare enrollees should be referred to their county human services agency for application to MA. If an enrollee is not eligible for MA, any maximum benefit limits applicable to the MinnesotaCare enrollee will apply. Refer to the *MinnesotaCare* section of Chapter 2, Health Care Programs and Services, for further information.

Authorization
All out-of-network transplants require prior authorization for IMCare MA and MinnesotaCare enrollees. Refer to Chapter 5, Service Authorization, for information regarding IMCare authorization request and review processes.

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 Chapter 5, Service Authorization, for out-of-state services. Out-of-state hospitals must include evidence of meeting the requirements of Medicare, the United Network for Organ Sharing (UNOS) and the Foundation for the Accreditation of Cellular Therapy (FACT).

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 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
- 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;
- The facility must include documentation that shows how the patient meets that criteria; and
- The facility must include documentation showing evidence of social support to assure assistance in alcohol rehabilitation and immunosuppressive therapy following the transplant.

Intestine transplants are covered for patients with short bowel syndrome who are parenterally-dependent and experiencing life-threatening or potentially life-threatening complications due to the original disease or to complications of total parenteral nutrition (TPN). Intestine-liver transplants are covered for people who develop liver disease secondary to TPN treatment.

Allogenic 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. Stem cell or bone marrow transplant centers must meet the standards established by the FACT. Transplant centers must be participating providers of the Medicare program, meet FACT criteria for stem cell transplants, and be located in Minnesota or contiguous counties to receive payment for stem cell transplants.

Autologous pancreatic islet cell transplant (after pancreatectomy) is covered when performed in a Minnesota facility that meets UNOS criteria. Pancreatic islet cell allograft transplant for enrollees with type 1 diabetes

mellitus is non-covered.

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 Diagnosis Related Group (DRG) payment for the recipient (IMCare enrollee). All charges for the donor should be billed using the recipient's IMCare ID number.

Other Payers
Liable third-party coverage must be used to the fullest extent before IMCare 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, IMCare will ask the enrollee to pursue these appeals.

Sleep Testing

Sleep studies include selected diagnostic and therapeutic services provided for sleep-related disorders. In-lab sleep studies or polysomnograms are covered by IMCare. Medical necessity for the study must be documented in the enrollee's medical record.

Eligible Providers
A sleep specialist must administer an in-lab sleep study or polysomnogram.

Eligible Recipients
IMCare covers sleep studies for:

- The diagnosis of obstructive sleep apnea and other sleep-related breathing disorders
- Neuromuscular disorders with sleep-related symptoms that are not adequately diagnosed through:
  - Sleep history
  - Assessment of sleep hygiene
  - Review of sleep diaries
- Suspected narcolepsy
- Parasomnias (e.g., cases of dangerous, violent or injurious behavior; seizure cases with inconclusive EEG; or atypical parasomnias)
- Periodic limb movement disorder (PLMD)

Covered Services
Sleep testing must be:

- Conducted in a sleep laboratory.
- Attended by a trained sleep specialist.
- Conducted following a careful exam and history that includes a standardized questionnaire.

Attended in-home (portable) studies will be covered only in cases where the patient is unable to undergo an in-lab study due to circumstances such as:

- Non-ambulation
- Severe and persistent mental illness

Non-Covered Services
IMCare will not cover unattended home sleep studies**,** because they are considered investigative and not medically necessary.

Billing
Bill sleep testing services in the 837P claim format using the appropriate HCPCS and CPT code(s).

Medical Nutrition Therapy (MNT)

Medical Nutrition Therapy (MNT) is a preventive health service designed to assess and minimize problems hindering normal nutrition, in order to improve a patient's nutritional status. MNT services may be provided in a physician's office, clinic, or outpatient hospital setting. Medical necessity for MNT must be documented in the enrollee's medical record.

Eligible Providers

Licensed dieticians and nutritionists may provide MNT services for IMCare enrollees, when prescribed or referred by a physician, CNP, CNM, CNS or PA.

Eligible Recipients

MA and MinnesotaCare enrollees are eligible for MNT. MNT is a preventive health service and is not a covered service under the following programs:

- Emergency Medical Assistance (EMA)
- MinnesotaCare Limited Benefit (MLB)

Covered Services

MNT covered services include evaluation, follow-up, and group counseling prescribed by an eligible provider.

Weight Loss Services

IMCare covers physician visits, MNT, mental health services and laboratory work provided for weight management. Services must be billed by enrolled providers on a component basis using current CPT codes. If an IMCare enrollee elects to participate in a weight loss program, the enrollee may be billed for components of the program that are not covered, as long as the enrollee is informed of the charges in advance.

Non-Covered Weight Loss Services

1. Weight loss services on a program basis.
2. Nutritional supplements or foods for the purpose of weight reduction.
3. Exercise classes.
4. Health club memberships.
5. Instructional materials and books.
6. Motivational classes.
7. Counseling or weight loss services provided by people who are not enrolled providers.
8. Counseling that is part of the provider's covered services for which payment has already been made.
9. Nutritional counseling for diabetic education, when it is part of a diabetic education program (See the *Diabetic Self-Management Training (DSMT) Services* section of this chapter).

Billing

IMCare reimburses the following dietician or nutritionist services, only when prescribed by an eligible provider and provided in an office or outpatient setting. MNT and DSMT are separate benefits and may not be billed for the same date of service. Payment for MNT 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 (two or more), each 30 minutes.

For MNT assessment or intervention performed by a physician, use E/M or preventive medicine service codes:

- 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 (two or more), each 15 minutes.

Enrolled Provider	Billing
Licensed dieticians or nutritionists in private practice	Use your NPI as the billing provider and the rendering provider.
Licensed dieticians or nutritionists who contract with a private agency to provide services	To directly receive payment: Use your NPI as the billing provider and the rendering provider. If the private agency receives payment: It must be an enrolled IMCare provider. Use the private agency's NPI as the billing provider, and the dietician's or nutritionist's NPI as the rendering provider.
Licensed dieticians or nutritionists employed by a hospital, public health or community health clinic, clinic, or an individual physician	Use the hospital, public or community health clinic, clinic, or individual physician's NPI as the billing provider, and the dietician's or nutritionist's NPI as the rendering provider.

If services are rendered somewhere other than the listed billing provider address or in the enrollee's home, include the service facility location's name, address, and NPI/Unique Minnesota Provider Identifier (UMPI).

National Diabetes Prevention Program (DPP)

The National Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program designed by the Centers for Disease Control and Prevention (CDC). The National DPP is a year-long program intended for adults at high risk for developing type 2 diabetes. The program includes lifestyle health coaching through weekly classes that teach skills needed to lose weight, become more physically active and manage stress.

The program includes an initial six-month phase, during which a minimum of 16 one-hour sessions are offered over a period lasting 16-26 weeks. The second six-month phase consists of at least one one-hour session each month. Additional sessions may be delivered if participants require additional support.

The National DPP may be provided in a clinic, outpatient hospital or community setting. The covered code was effective January 1, 2016. Organizations can use the curriculum available on the CDC website. If your organization chooses to use a different curriculum, it must be evaluated by the Diabetes Prevention Recognition Program (DPRP) to ensure that it is consistent with the current evidence base.

Eligible Providers

An organization must have full or pending CDC recognition as a DPRP to provide the National DPP to IMCare enrollees. The CDC determines provider eligibility. CDC-recognized organizations are responsible for training coaches to the 2012 National DPP curriculum or the Prevent T2 curriculum. DPP coaches may have credentials (e.g., RD or RN), but credentials are not required. Coaches do not need to enroll with MHCP.

Eligible Recipients

Enrollees must meet all of the following requirements:

- 18 years of age or older
- Body mass index (BMI) $\geq$ 24 ($\geq$ 22 if Asian)
- No previous diagnosis of type 1 or type 2 diabetes

- At least one of the following test results within the past year:
  - Hemoglobin A1C = 5.7% - 6.4%
  - Fasting plasma glucose = 100 - 125
  - Two-hour plasma glucose (after 75g glucose load) = 140 - 199 mg/dl
  - History of gestational diabetes

Billing
Use CPT code 0403T for DPP (Preventive behavior change, intensive program of prevention of diabetes using a standardized prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day). Do not bill nutritional counseling, E/M codes or other procedure codes when billing for DPP.

Diabetic Self-Management Training (DSMT) Services

DSMT is a preventive outpatient health service for people diagnosed with diabetes. The program includes education about self-monitoring of blood glucose, diet and exercise. In addition, an insulin treatment plan is developed specifically for patients who are insulin-dependent. The program motivates patients to use learned skills for successful self-management of diabetes. DSMT services minimize the occurrence of disease and disability through instructions on maintaining health and well-being of the patient.

Eligible Providers
The following are eligible to provide DSMT services:

- Diabetic care instructions may be provided by a physician or RN.
- Nutritional counseling may be provided by a physician, licensed dietician or licensed nutritionist. Referrals should be made to licensed dieticians or licensed nutritionists for in-depth nutritional counseling.
- Licensed RNs may only provide nutritional counseling to the extent that their scope of practice and education experience allow.

A provider of services for dually-eligible IMCare enrollees must be a "certified provider" according to the Medicare definition and meet National Diabetes Advisory Board standards.

Eligible Recipients
IMCare enrollees are eligible for DSMT services. DSMT is a preventive health service and is not a covered service under the following programs:

- Emergency Medical Assistance (EMA)
- MinnesotaCare limited benefit (MLB)

Covered Services
A physician, CNP, CNS, CNM or PA must order all DSMT services, which include:

- Diabetes overview
  - Type of diabetes
  - Blood glucose testing
  - Blood glucose self-monitoring education
  - Insulin treatment plan for patients who are insulin dependent
  - Foot, skin, and dental care
- Diabetes management
  - Stress and psychosocial adjustment
  - Family involvement and social support
  - Medications (monitoring and use of results)
  - Prevention, detection and treatment of chronic complications
  - Prevention and treatment of low/high blood sugar

  - Benefits, risks and management options for improving glucose control
- Nutritional counseling
  - Meal planning, carbohydrate counting and label reading
  - Dietary fat and cholesterol modification
  - Role of fiber on blood sugar and cholesterol control
- Exercise and activity
  - Relationships between nutrition, exercise, medication and blood glucose levels
  - Behavior change strategies, goal setting, risk factor reduction and problem solving
- Other
  - Preconception care, pregnancy and gestational diabetes
  - Use of health care systems and community resources

Billing

Use one of the following DSMT HCPCS codes when billing (as appropriate):

- G0108 - Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109 - Diabetes outpatient self-management training services, group session (two or more), per 30 minutes

Bill one unit per 30 minutes of DSMT services, with a maximum of 10 hours within a continuous 12-month period for each enrollee. After the initial training, additional DSMT services are limited to one session (group or individual), no longer than two hours in length per year. Do not bill nutritional counseling, office visit E/M codes, facility codes or other procedure codes with DSMT codes.

Nutritional Products

A nutritional product is a commercially formulated substance that provides nourishment and affects the nutritive and metabolic processes of the body. Nutritional products are covered by IMCare.

Eligible Providers

A parenteral nutritional product must be dispensed as a pharmacy service, as prescribed by an appropriate provider type. Refer to Chapter 22, Pharmacy Services. An enteral nutritional product may be supplied by a pharmacy, home health agency, or medical supply provider, with a written prescriber's order.

Covered Nutritional Services

IMCare covers enteral nutritional products, when the enrollee's diagnosis can be linked to the need for a nutritional product. Refer to Chapter 23, Equipment and Supplies, for additional information.

Podiatry Services

Eligible Providers

Podiatrists who practice as defined in MN Statutes 2019, ch. 153 and physicians are eligible for payment for podiatry services.

Covered Services

The following are covered podiatry services:

- Debridement or reduction of pathological toenails, and infected or eczematized corns/calluses
- Avulsion of nail plate
- Evacuation of subungual hematoma
- Excision of nail and nail bed
- Reconstruction of nail bed
- 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 to the services defined in MN Rules, part 9505.0350, subp. 3. These services are considered routine foot care, unless the patient has a systemic condition which may require the expertise of a professional. The following diseases most commonly represent the underlying conditions that may justify coverage for routine foot care (list is not all-inclusive):

- Diabetes mellitus
- Arteriosclerosis obliterans
- Buerger's Disease (thromboangiitis obliterans)
- Chronic thrombophlebitis
- Peripheral neuropathies
- Ulcerations or abscesses complicated by diabetes or vascular insufficiency
- Medical conditions that prevent self-care of these services

Non-Covered Services

Podiatry services that are not covered by IMCare include, but are not limited to:

- 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
  - Any other service performed in the absence of localized illness, injury, or symptoms involving the foot
- Services not covered by Medicare
  - Subluxation of the foot
  - Treatment of flat feet
  - Routine foot care
- Stock orthopedic shoes (except when attached to a leg brace)
- Routine supplies provided in the office (Refer to the *Medical Supplies Provided by a Physician's Office* section of this chapter.)

Coverage Limitations

The following coverage limitations apply to podiatry services:

1. LTCFs are responsible for routine foot care. When a physician or podiatrist provides services to LTCF residents, the following are required:
   - The referral must be from the resident, the resident's family/guardian, an RN or licensed practical nurse (LPN) employed by the facility, or an attending physician.
   - The LTCF must document the referral in the medical record.
2. Coverage for the debridement and reduction of nails, corns and calluses is limited to once every 60 days.
3. 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.
4. Providers may bill the avulsion and excision codes only once per nail.

Billing

Podiatry services are billed in the 837P format. Refer to Chapter 4, Billing Policy. National foot care modifiers are required on all routine foot care services, regardless of specialty. Refer to Chapter 11, Laboratory/Pathology, Radiology, and Diagnostic Services, for billing guidelines.

Relocation Service Coordination - Targeted Case Management (RSC-TCM)

RSC-TCM is a Medical Assistance (MA) reimbursed case management service, which includes the provision of both county case management (counties and tribes) and relocation service coordination, for people residing in eligible institutions who choose to move from the institution to a community-based setting.

Eligible Providers

MHCP enrolled private agencies and independent providers without a county contract to offer RSC-TCM services must be certified by the Department of Human Services (DHS) Disabilities Services Division (DSD) to provide and directly bill for services. County and tribal providers include:

- American Indian tribes
- Federally-recognized American Indian tribes
- An Indian Health Service facility provider
- County case management
- County human services agency
- Local social services

Free Choice of Case Management Provider

Enrollees using RSC-TCM may choose any eligible county, tribe, private agency (vendor), or independent practitioner as their RSC-TCM provider. RSC-TCM eligible institutions include:

- Hospitals
- Intermediate care facilities for persons with developmental disabilities or related conditions (ICF/DDs)
- Institutions for Mental Disease (IMDs) (includes Regional Treatment Centers (RTCs) licensed as hospitals or nursing facilities)
- Nursing facilities (NFs) (includes skilled nursing and certified boarding care facilities)

Intensive Residential Treatment Services (IRTS) facilities licensed as either board and lodging or supervised living facilities are not eligible RSC-TCM facilities. Facilities that have an additional federal designation such as an IMD or an RTC are eligible if they have a license as a hospital, nursing facility, or ICF/DD.

Private Agencies and Independent Providers

Private agencies and independent providers can apply for certification by DHS, not the individual service coordinators employed by the agency. DHS-certified private agencies and independent providers guarantee their employees' qualifications and compliance with RSC-TCM education and experience requirements. A DHS-certified private agency or independent provider must:

1. Have or employ case managers who have a minimum of a bachelor's degree or a license in a health or human services field (or comparable training and two years of experience in human services) and meet all state requirements, or who have been credentialed by an American Indian tribe.
2. Demonstrate the administrative capacity and case management experience to serve, coordinate and link community resources needed by the eligible MHCP population for whom services will be provided.
3. Have the administrative capacity to coordinate with county administrative functions, ensure the quality of services, and to document and maintain individual case records under both state and federal requirements.
4. Have a financial management system that provides accurate documentation of services and costs.
5. Have no financial interest in the provision of out-of-home residential services (such as foster care and boarding care services) in the county where the recipient requesting services is seeking to relocate.

County or Tribe and Contracted Providers

County or tribal case managers must meet the employment requirements of their employer. County case managers' employment qualifications are determined by the county or tribe, but cannot be lower than the educational and experience requirements for service coordinators employed by certified agencies.

A county case management provider or tribe must:
1. Enroll with MHCP and have the legal authority to provide RSC-TCM services.
2. Demonstrate the ability to provide the services and activities outlined in Minnesota statutes.

A contracted provider with a county or tribe must:
1. Demonstrate the ability to provide the services and activities that are defined in their contract. Contracted providers are monitored for quality assurance and compliance by the county or tribe.
2. Employ case managers who meet minimum educational standards outlined in the county or tribal contract and any additional county requirements to provide RSC-TCM services.
3. Receive referrals as stipulated in their contract.
4. Comply with all conflict of interest regulations, and have a procedure that notifies enrollees or their legal representative of any conflict of interest if the contracted provider also provides, or will provide, the person's services and supports. Contracted providers may provide RSC-TCM case management, out of home residential and direct services to the same person as allowed in their contract and under the supervision of the county or tribe.
5. Negotiates their payment rate with the county or tribe, and relies on the county or tribe for resolution of claim denials and disallowances.

Required Certification and Enrollment
Providers must follow all DHS requirements for certification and enrollment.

Monitoring and Recertification
The DHS DSD monitors and reviews compliance with RSC-TCM policy and procedures for DHS-certified RSC-TCM private agencies and independent providers every two years and recommends decertification or corrective action if problems are identified. Counties and tribes also provide oversight for contracted RSC-TCM providers and recommend corrective action if problems are identified. DHS certified private agencies or independent providers and contracted providers must submit the following information to the county or tribal contact person identified in their contract at the specific times identified in their contract.
1. Number of enrollees who:
   a. Received RSC-TCM services
   b. Relocated from institutions in 180 days or less
   c. Relocated from institutions in one year
   d. Did not relocate after receiving RSC-TCM services
2. Narrative summary and total hours of trainings attended, including:
   a. Conferences
   b. Lecture
   c. Online
3. Summary of complaints (all sources) and steps taken to remedy concerns.
4. Summary of customer satisfaction results or outcomes.

DHS certified RSC-TCM private agencies or independent providers must be recertified by DHS every two years. Decertified private agencies or independent providers and terminated contractors may reapply for certification or county or tribal contracts after complying with all conditions listed in their written corrective action plan notice.

Eligible Enrollees
IMCare enrollees are eligible for RSC-TCM services when all of the following are met:
- The enrollee resides in an institution that qualifies for services at the time of service delivery.
- The enrollee chooses to move into the community.
- The enrollee chooses to receive services.
- The enrollee's TCM benefit is not exhausted.

- Eligible for MA.

IMCare eligibility should be verified prior to providing services, online through the IMCare HealthX provider web portal or Minnesota Information Transfer System (MN-ITS), or by calling Enrollee Services at 1-800-843-9536 (toll free). IMCare Classic enrollees should contact IMCare at 1-800-843-9536 (toll free) to request relocation assistance. The RSC-TCM provider must coordinate with IMCare to ensure continuity of care and non-duplication of effort.

Covered Services

Enrollees in an institution may receive certain services during the last 180 days of placement, for the purposes of helping the enrollee relocate to the community. The service must not duplicate the services of the institution's discharge planner. This federal law applies to:

- RSC-TCM
- Mental Health-Targeted Case Management (MH-TCM)

The use of any one of these case management types will begin the 180-day time span, and the benefit will be exhausted after 180 days.

Enrollees must have a service plan. A county case manager develops, monitors and reviews the plan using a person-centered process. At a minimum, the service plan must identify:

1. The enrollee and his or her legal representative
2. All case manager(s) responsible for coordinating and planning services
3. Enrollee goals
4. Needed services
5. Amount, duration and frequency of services
6. Anticipated service outcomes
7. Method and frequency of monitoring the plan of care

If there are multiple case managers, the service plan must identify and attribute specific case management activities to each case manager to demonstrate their differing roles and responsibilities. Counties and tribes may use the community support plan or the developmental disability individual service plan to record services. The case manager must document the following information in the enrollee's case record following delivery of service:

1. Date of service
2. Name of the provider agency and person providing the service
3. Narrative statement describing the nature of the service provided
4. Place of service
5. Enrollee name
6. Units of service

The narrative statement must be detailed to identify the activity as an approved case management service. Undocumented claims result in a claim's disallowance and claims adjustment.

RSC-TCM services provided by a county, certified private agency, independent agency, or county or tribe contracted providers include:

- Assistance to access needed services, including travel to visit a enrollee to develop or implement the goals of the written plan.
- Coordination, monitoring and support of overall service delivery and advocacy, as needed to ensure quality of services, appropriateness and continued need.
- Coordination with the facility discharge planner during the 180-day period prior to the enrollee's discharge.
- Documentation that supports and verifies the activities.
- Routine contact or communication with:

- Legal representative
- Primary caregiver
- Enrollee
- Enrollee's family members
- Service provider(s) or other persons identified as necessary to the development or implementation of the goals of the written plan
- Substitute care provider

County or tribe required services also include:

- Assessment of the enrollee's need for RSC-TCM and service coordination options.
- Coordination of referrals for and the provision of appropriate service providers.
- Development, completion, monitoring and planned review of a written individual service plan, designed to help a person access needed services and supports.

Enrollees have the right to appeal an action that denies, delays, suspends, reduces or terminates their services. County case managers are responsible for informing enrollees of their appeal rights under the law.

Non-Covered Services

Non-covered services include (list is not all-inclusive):

- Transition assistance when an enrollee moves from one institution to another. (For example, if a NF closes, a provider cannot bill for activities related to finding another NF for the enrollee, unless the enrollee's relocation plan indicates that a move to another institution is a necessary step toward the eventual community integration of that enrollee.)
- Administrative functions:
  - Intake for MA and other MHCP programs
  - Eligibility determinations and redeterminations for MA or a Medicaid-funded benefit (e.g., Adult Rehabilitative Mental Health Services (ARHMS), waivered services and VADD-TCM)
  - Prior authorization of services
  - LTCC or DD screening
  - Appeals or conciliation activities
  - Direct services such as treatment, therapy, and other habilitative or rehabilitative services provided to the enrollee
- Other non-billable activities:
  - Outreach services and marketing activities
  - Information and referral activities prior to eligibility determinations
  - Services without proper documentation in the enrollee's service plan
  - Services to enrollees ineligible for MA
  - Services covered by another billing source such as private insurance or other third-party payers
  - The time and services of the institution's discharge planner
  - Case management activities covered as a part of another covered service such as development of a treatment plan for home care or physical therapy services
  - Services prior to the county of financial responsibility (CFR) authorization

Authorization Requirements

Services are available to eligible enrollees at any time upon request during an institutional placement. After establishing an enrollee is eligible for services, determine the date of the last long-term care consultation (LTCC), MNChoices Assessment or developmental disability (DD) face-to-face screening. If a new screening is necessary, complete the screening using the appropriate DHS LTCC, MNChoices Assessment or DD screening form.

Limitations

- Enrollees living in the community or an ineligible institution, such as an Intensive Residential Treatment Services (IRTS), that is not licensed as a hospital or NF, cannot receive RSC-TCM.
- The RSC-TCM benefit is available during the last 180 consecutive days of a continuous institutional placement, following the date on the first paid claim for RSC-TCM, or MH-TCM, regardless of the length of that placement.
- RSC-TCM benefits end once an enrollee is discharged from an eligible institution.
- RSC-TCM is available for each and every institutional placement episode. If a person is discharged from an institution with or without RSC-TCM services, remains in a community living arrangement for a full day, and then returns to an institution, he/she may receive RSC-TCM services to assist with relocation. There must be documentation of community placement that lasted for at least one day.
- Enrollees cannot receive RSC-TCM and another type of TCM (e.g., MH, VADD or Child Welfare) during the same month that they reside in an institution. Do not bill for another type of TCM during the month(s) RSC-TCM is provided.

Billing

A contracted county or tribe, certified private agency or independent provider may receive direct referrals for RSC-TCM from an enrollee. If these provider types receive a request for service, they must direct enrollees to contact their CFR or tribe. Before any RSC-TCM service can be provided and billed, the CFR must determine enrollee eligibility and develop a service plan signed by all parties. Notifying the CFR of a request for service is not billable; this is considered informational (referral prior to eligibility determination or an outreach or marketing activity).

Providers are not required to wait for discharge to occur before billing for RSC-TCM services. Providers may submit a claim regardless of whether the community reintegration takes place through a home and community-based waiver, by other means, or not at all.

Bill using HCPCS code T1017. Services are limited to 32 units/day (8 hours maximum) and 5 days/week. Bill each date of service separately (date spans will deny), using your NPI or UMPI number.

While MH-TCM and RSC-TCM can be used alternately (e.g., RSC-TCM one month, MH-TCM the following month, and RSC-TCM the following month), IMCare does not recommend this practice. Use one of these TCMs for the duration of the relocation effort. The 180-day limit starts with the service date of the first paid, MH-TCM, or RSC-TCM claim. RSC-TCM services provided after the 180-day limit will deny.

Certified private agencies, independent providers and county or tribe contracted providers must work closely with county case managers to avoid claim denials due to ended eligibility or exceeded service limits.

Legal References

Minnesota Rules, part 9505.0325 - Nutritional Products
Minnesota Rules, part 9505.0330 - Outpatient Hospital Services
Minnesota Rules, part 9505.0345 - Physician Services
Minnesota Rules, part 9505.0355 - Preventive Health Services
Minnesota Rules, part 9505.0350 - Podiatry Services
Minnesota Rules, part 9505.5010 - Prior Authorization Requirement
Minnesota Rules, part 9505.5035 - Surgical Procedures Requiring Second Medical Opinion
Minnesota Statutes 2019, sec. 147A.01 - Definitions
Minnesota Statutes 2019, sec. 148.624, subd. 1 - Dietetics
Minnesota Statutes 2019, sec. 148.624, subd. 2 - Nutrition
Minnesota Statutes 2019, ch. 153 - Podiatry
Minnesota Statutes 2019, sec. 256B.0625, subd. 3 & 4 - Physicians' services & Outpatient and physician-

directed clinic services
Minnesota Statutes 2019, sec. 256B.0625, subd. 4a - Second medical opinion for surgery
Minnesota Statutes 2019, sec. 256B.0625, subd. 25 - Prior authorization required
Minnesota Statutes 2019, sec. 256B.0625, subd. 27 - Organ and tissue transplants
Minnesota Statutes 2019, sec. 256B.0625, subd. 28 - Certified nurse practitioner services
Minnesota Statutes 2019, sec. 256B.0625, subd. 28a - Licensed physician assistant services
Minnesota Statutes 2019, sec. 256B.0625, subd. 32 - Nutritional products
Code of Federal Regulations, title 42, sec. 413.65 - Public Health: provider-based status
Code of Federal Regulations, title 42, sec. 440.130 (c) - Public Health: preventive services definition
Code of Federal Regulations, title 42, sec. 440.166 - Public Health: nurse practitioner services
Code of Federal Regulations, title 42, sec. 440.20 - Public Health: outpatient hospital and rural health clinic services
Code of Federal Regulations, title 42, sec. 440.50 - Public Health: physicians' services and medical and surgical services of a dentist