

# Covered Services

## General Coverage Principles

Montana Medicaid covers almost all services provided by physicians, mid-level practitioners, and podiatrists, including preventive care.

This chapter provides covered services information that applies specifically to services performed by physicians, mid-level practitioners, podiatrists, mid-level practitioners within public health clinics, family planning clinics, independent labs, independent imaging facilities, and independent diagnostic testing facilities. Like all healthcare services received by Medicaid members, services provided by these practitioners must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

### ***Services within Scope of Practice (ARM 37.85.401)***

Services are covered only when they are within the scope of the provider's license. As a condition of participation in the Montana Medicaid program, all providers must comply with all applicable state and federal statutes, rules, and regulations.

### ***Services Provided by Physicians (ARM 37.86.101–105)***

Physician services are those services provided by individuals licensed under the State Medical Practice Act to practice medicine or osteopathy, which as defined by state law, are within the scope of their practice.

### ***Services Provided by Mid-Level Practitioners (ARM 37.86.201–205)***

Mid-level practitioners include physician assistants licensed to practice medicine by the Montana Board of Medical Examiners and advanced practice registered nurses licensed to practice medicine by the Montana Board of Nursing. Advanced practice registered nurses include nurse anesthetists, nurse practitioners, clinical nurse specialists, and certified nurse midwives. Mid-level practitioners also include practitioners outside Montana who hold appropriate licenses in their own states. A mid-level practitioner must bill under his/her own NPI and taxonomy code, rather than under a physician's. See the Billing Procedures chapter in this manual.

### ***Services Provided by Podiatrists (ARM 37.86.501–506)***

Podiatry services are those services provided by individuals licensed under state law to practice podiatry. Refer to Routine Podiatric Care in this chapter and the podiatrist fee schedule on the Provider Information [website](#) for specific covered services.

***Services Provided by Independent Labs (ARM 37.86.3201–3205)***

Medicaid covers tests provided by independent (non-hospital) clinical laboratories when the following requirements are met:

- Services are ordered and provided by physicians, dentists, or other providers licensed within the scope of their practice as defined by law. Medicaid does not cover lab services ordered by chiropractors.
- Services are provided in an office or other similar facility, but not in a hospital outpatient department or clinic.
- Providers of lab services must be Medicare-certified.
- Providers of lab services must have a current Clinical Laboratory Improvement Amendments (CLIA) certification number. CLIA certification may be obtained in Montana through the Department. See the Contact Us link in the menu on the Provider Information [website](#).
- Medicaid does not cover reference lab services. Providers may bill Medicaid only for those lab services they have performed themselves. Modifier 90, used to indicate reference lab services, is not covered by Medicaid.

***Services Provided by Independent Imaging Facilities (ARM 37.86.3201–3205)***

Medicaid covers tests provided by independent (non-hospital) imaging facilities when the following requirements are met:

- Services are ordered and provided by physicians, dentists, or other providers licensed within the scope of their practices as defined by law.
- Services are provided in an office or similar facility, but not in a hospital outpatient department or clinic.
- Imaging providers must be supervised by a physician licensed to practice medicine within the state the services are provided.
- Imaging providers must meet state facility licensing requirements. Facilities must also meet any additional federal or state requirements that apply to specific tests (e.g., mammography). All facilities providing screening and diagnostic mammography services are required to have a certificate issued by the Federal Food and Drug Administration (FDA). For more information contact the FDA at 1-800-838-7715.
- For most imaging services and some other tests, the fee schedules show different fees depending on whether the practitioner provided only the technical component (performing the test), only the professional component (interpreting the test), or both components (also known as the global service). Practitioners must bill only for services they provided.
- Technical components of imaging services must be performed by appropriately licensed staff (e.g., x-ray technician) operating within the scope of their practice as defined by state law and under the supervision of a physician.

***Services Provided by Independent Diagnostic Testing Facilities (ARM 37.85.220)***

- Medicaid covers diagnostic testing services provided by independent diagnostic testing facilities (IDTF) under the supervision of a physician. (See the IDTF fee schedule.)
- Services may be performed in either a fixed location or mobile facility, but must be independent of a hospital.
- Before enrolling in Medicaid, IDTFs must be enrolled in Medicare.

***Services Provided by Public Health Clinics (ARM 37.86.1401–1406)***

- Public health clinic services are physician and mid-level practitioner services provided in a clinic designated by the Department as a public health clinic.
- Services must be provided directly by a physician or by a public health nurse under a physician's immediate supervision (i.e., the physician has seen the patient and ordered the service).
- Minimal services are covered when provided by a registered nurse operating under protocols. These services do not require that the physician see the patient.

***Non-Covered Services (ARM 37.85.207 and ARM 37.86.205)***

Some services not covered by Medicaid include the following:

- Acupuncture
- Naturopath services
- Surgery for weightloss (gastric bypass, banding and other bariatric surgery)
- Services provided by surgical technicians who are not physicians or mid-level practitioners
- Services considered experimental or investigational
- Services provided to Medicaid members who are absent from the state, with the following exceptions:
  - Medical emergency
  - Required medical services are not available in Montana. Prior authorization may be required. See the Prior Authorization chapter in this manual and the Prior Authorization Information page on the Provider Information [website](#).
  - The Department has determined that the general practice for members in a particular area of Montana is to use providers in another state.
  - Out-of-state medical services and all related expenses are less costly than in-state services. Check the physician's fee schedule to determine if the code is covered.
  - Montana makes adoption assistance or foster care maintenance payments for a member who is a child residing in another state.

- Medicaid does not cover services that are not direct patient care such as the following:
  - Missed or canceled appointments
  - Mileage and travel expenses for providers
  - Preparation of medical or insurance reports
  - Service charges or delinquent payment fees
  - Telephone services in home
  - Remodeling of home
  - Plumbing service
  - Car repair and/or modification of automobile

### ***Importance of Fee Schedules***

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. Fee schedules list Medicaid covered codes and provide clarification of indicators such as whether a code requires prior authorization, can be applied to a co-surgery, or can be billed bilaterally, etc. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the Provider Requirements chapter of the *General Information for Providers* manual and in this chapter. Use the fee schedule in conjunction with the more detailed coding descriptions listed in the CPT, HCPCS, and ICD coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Use the current fee schedule for your provider type to verify coverage for specific services.



Fee schedules are available on the Provider Information [website](#).

## **Coverage of Specific Services**

The following are coverage rules for specific services provided by physicians, mid-level practitioners, and podiatrists.

### ***Abortions (ARM 37.86.104)***

Abortions are covered when one of the following conditions is met:

- The member's life would be endangered if the fetus is carried to term.
- The pregnancy is the result of rape or incest.
- The abortion is determined by the attending physician to be medically necessary, even if the member's life is not endangered if the fetus is carried to term.

A completed Medicaid Healthcare Programs Physician Certification for Abortion Services (MA-37) form must be submitted with every abortion claim or payment will be denied. **This form is the only form Medicaid accepts for abortion services.** Complete only one section of this form.

When using mifepristone (Mifeprex or RU 486) to terminate a pregnancy, it must be administered within 49 days from the beginning of the last menstrual period by or under the supervision of a physician who:

- Can assess the duration of a pregnancy.
- Can diagnose ectopic pregnancies.
- Can provide surgical intervention in cases of incomplete abortion or severe bleeding, or can provide such care through other qualified physicians.
- Can assure access to medical facilities equipped to provide blood transfusion and resuscitation.
- Has read, understood, and explained to the member the prescribing information for mifepristone.



The form required for abortions can be found on the Provider Information [website](#).

### ***Cosmetic Services (ARM 37.86.104)***

Medicaid covers cosmetic services only when the condition has a severe detrimental effect on the member's physical and psychosocial well-being. Mastectomy and reduction mammoplasty services are covered only when medically necessary. Medical necessity for reduction mammoplasty is related to signs and symptoms resulting from macromastia. Medicaid covers surgical reconstruction following breast cancer treatment. Before cosmetic services are performed, they must be prior authorized. Services are authorized on a case-by-case basis. (See the Prior Authorization Information on the Contact Us link on the Provider Information [website](#).)

### ***Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (ARM 37.86.2201–2235) Program***

The EPSDT program covers all medically necessary services for children ages 20 and under. Providers are encouraged to use a series of screening and diagnostic procedures designed to detect diseases, disabilities, and abnormalities in the early stages. (See the EPSDT Well-Child chapter in the *General Information for Providers* manual.) Some services are covered for children that are not covered for adults, such as the following:

- Nutritionist services
- Private duty nursing
- Respiratory therapy
- Therapeutic family and group home care
- Substance dependency inpatient and day treatment services
- School-based services

All prior authorization and Passport approval requirements must be followed. See the Prior Authorization chapter in this manual and the *Passport to Health* manual.

***Family Planning Services (ARM 37.86.1701)***

Family planning services include the following:

- Annual visit
- Comprehensive history
- Initial physical examination
- Initial visit
- Laboratory services
- Medical counseling
- Routine visits

Medicaid covers prescription contraceptive supplies, implantation, or removal of subcutaneous contraceptives, and fitting or removal of an IUD and fitting of a diaphragm. Approval by the Passport provider is not required for family planning services. See the Submitting a Claim chapter in this manual for Passport indicators. Specific billing procedures must be followed for family planning services. (See Billing Procedures.)

***Home Obstetrics (ARM 37.85.207)***

Home deliveries are only covered on an emergency basis by a physician or licensed midwife. Home deliveries are those delivery services not provided in a licensed healthcare facility or nationally accredited birthing center and necessary to protect the health and safety of the woman and fetus from the onset of labor through delivery.

***Immunizations***

The Vaccines for Children (VFC) program makes selected vaccines available at no cost to providers for eligible children 18 years old and under. Medicaid will therefore pay only for the administration of these vaccines (oral, nasal, or injection) and only the federal mandated rate. VFC covered vaccines may change from year to year. For more information on the VFC program and current VFC covered vaccines, call the Department's Immunization program at 406-444-5580, or refer to the most recent VFC provider notice.

Medicaid does not cover pneumonia and flu vaccines for members with Medicare Part B insurance because Medicare covers these immunizations. Other vaccines for Medicare patients should be billed through Medicare Part D.

***Infertility (ARM 37.85.207)***

Medicaid does not cover treatment services for infertility, including sterilization reversals.

***Prescriptions (ARM 37.86.1102)***

For detailed information about prescription drugs, refer to the *Prescription Drug Program* manual on the Pharmacy page of the [website](#).

The DUR Board has set monthly limits on certain drugs. Use over these amounts requires prior authorization. Refer to the Prior Authorization chapter of the *Prescription Drug Program* manual for limits.

### ***Routine Podiatric Care***

Medicaid pays for routine podiatric care when a medical condition affecting the legs or feet (such as diabetes or arteriosclerosis obliterans) requires treatment by a physician or podiatrist. Routine podiatric care includes the following:

- Cutting or removing of corns and calluses
- Trimming of nails
- Application of skin creams
- Debridement of nails
- Other hygienic or preventive maintenance care

### ***Sterilization (ARM 37.86.104)***

#### **Elective Sterilization**

Elective sterilizations are sterilizations done for the purpose of becoming sterile. Medicaid covers elective sterilization for men and women when all of the following requirements are met:

1. Member must complete and sign the Informed Consent to Sterilization (MA-38) form at least 30 days, but not more than 180 days, prior to the sterilization procedure. This form is the **only** form Medicaid accepts for elective sterilizations. If this form is not properly completed, payment will be denied. See the Forms page on the Provider Information [website](#) for the form and instructions for completing.

The 30-day waiting period may be waived for either of the following reasons:

- **Premature Delivery.** The Informed Consent to Sterilization must be completed and signed by the member at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
  - **Emergency Abdominal Surgery.** The Informed Consent to Sterilization form must be completed and signed by the member at least 72 hours prior to the sterilization procedure.
2. Member must be at least 21 years of age when signing the form.
  3. Member must not have been declared mentally incompetent by a federal, state, or local court, unless the member has been declared competent to specifically consent to sterilization.
  4. Member must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.



All forms required for sterilizations can be downloaded from the Provider Information [website](#),

Before performing a sterilization, the following requirements must be met:

- The member must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The member must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The member must be made aware of available alternatives of birth control and family planning.
- The member must understand the sterilization procedure being considered is irreversible.
- The member must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The member must be informed of the benefits and advantages of the sterilization procedure.
- The member must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present to translate or sign for those members who are blind, deaf, or do not understand the language to assure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the member is in labor or childbirth.
- If the member is seeking or obtaining an abortion.
- If the member is under the influence of alcohol or other substance which affects his/her awareness.

### **Medically Necessary Sterilization**

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies, and orchiectomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:

- A completed Medicaid Hysterectomy Acknowledgement form (MA-39) for each provider submitting a claim. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the member (or representative, if any) and physician must sign and date Section A of this form prior to the procedure. (See 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations.) Also, for Section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the member (and representative, if any) was informed



Medicaid covers hysterectomies only when they are a result of a procedure performed to address another medical problem, not when the primary purpose is to render the member sterile.



A notation *Not a Sterilization* on a claim is not sufficient to fulfill these certification requirements.

- orally and in writing, prior to the surgery, that the procedure would render the member permanently incapable of reproducing. The member does not need to sign this form when Sections B or C are used. Refer to the Forms page on the Provider Information [website](#) for instructions on completing the form.
- For members who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
    - The individual was informed prior to the hysterectomy that the operation would render the member permanently incapable of reproducing.
    - The reason for the hysterectomy was a life-threatening emergency.
    - The member was already sterile at the time of the hysterectomy and the reason for prior sterility.

When submitting claims for retroactively eligible members, attach a copy of the Notice of Retroactive Eligibility (Form 160-M) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

### ***Surgical Services***

- The fee schedule shows Medicaid policies code by code on global periods, bilateral procedures, assistants at surgery, co-surgeons, and team surgery. These policies are almost always identical to Medicare policies but in cases of discrepancy, the Medicaid policy applies.
- Medicaid only covers assistant at surgery services when provided by physicians or mid-level practitioners who are Medicaid providers.
- Medicaid does not cover surgical technician services.
- See the Billing Procedures chapter regarding the appropriate use of modifiers for surgical services.

### ***Telemedicine Services***

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

### ***Transplants***

- All Medicaid transplant services must be prior authorized. (See the Prior Authorization Information page on the [website](#).)
- All transplants must be medically necessary.
- Each case receives individualized review and is evaluated for medical suitability.

***Weight Reduction***

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