SERVICE DESCRIPTION
Psychiatric Services: Medication Administration, Medication Review, Telemedicine

This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as updated. The manual is available at:
http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

1. **Definition or Description of Service**
   a. **Medication Administration** is the process of giving a physician-prescribed oral medication, injection, intravenous (IV) or topical medication treatment to an individual. This should not be used as a separate coverage when other health services are utilized, such as Private Duty Nursing or Health Services, which already include these activities. A physician, physician's assistant, nurse practitioner, clinical nurse specialist, or registered nurse may perform medication administration under the direction of the physician. A licensed practical nurse who is assisting a physician may perform medication administration as long as the physician is on-site. For injections administered through the CMHSP clinic, refer to the Injectable Drugs and Biologicals subsection of the Practitioner Chapter of the Medical Provider Manual.
   b. **Medication Review** is evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. A physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, licensed pharmacist, or a licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications.
   c. **Telemedicine** - Behavioral health services may be delivered via telemedicine in accordance with current Medicaid policy. In compliance with the Michigan Insurance Code of 1956 (Act 218 of 1956), telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located. Refer to the Practitioner Chapter of the Medicaid Provider Manual for additional information regarding telemedicine services.
      i. Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location. MDHHS requires a real time interactive system at both the originating and distant site, allowing instantaneous interaction between the patient and health care professional via the telecommunication system.
      ii. Telemedicine should be used primarily when travel is prohibitive for the beneficiary or there is an imminent health risk justifying immediate medical need for services. Providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine. The technology used must meet the needs for audio and visual compliance in accordance with current regulations and industry standards.
      iii. A CMHSP/PIHP can be either an originating or distant site for telemedicine services. Practitioners must meet the provider qualifications for the covered service provided via telemedicine. No additional reimbursement will be made for the site facility fee.

2. **Practice Principles**
   a. Providers are encouraged to offer evidence-based and promising practices as part of the Medicaid covered specialty services where applicable. Providers shall assure that these practices are provided by staff who have been appropriately trained in the model(s) and are provided to the population for which the model was intended.
   b. Provider will comply with the principles of person-centered planning as outlined in the MDHHS BHDDA Person-Centered Planning Policy.

c. MDHHS encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. The use of natural supports must be documented in the individual's plan of service.
d. Determination of medical necessity and appropriateness of services is the responsibility of the physician within the scope of currently accepted medical practice and Medicaid limitations. The physician is held responsible if he orders excessive or unnecessary services (e.g., diagnostic tests, prescriptions) regardless of who actually renders or who receives payment for the service. The physician may also be subject to any corrective action related to these services, including recovery of funds.
e. The standards and scope of telemedicine services should be consistent with related in-person services.
f. The delivery of psychiatric services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.

3. Credentialing Requirements *Refer to current Medicaid Provider Manual for updated requirements and provider qualifications*

a. Provider will assure that licensed professional staff are licensed and/or registered in the State of Michigan to provide services at the level authorized by the Payor. Licensed professionals shall act within the scope of practice defined by their license.
b. Provider shall assure that all staff providing services are qualified and trained to provide services at the level authorized by the Payor.
c. Provider shall maintain a copy of training records for each staff person for review if requested by the Payor, the LRE, or an external review team.
d. Providers of services must:
    i. Be at least 18 years of age.
    ii. Be able to prevent transmission of any communicable disease from self to others in the environment where they are providing supports.
    iii. Be able to communicate expressively and receptively in order to follow individual plan requirements and Individual-specific emergency procedures, and report on activities performed. Understanding and skill must be documented.
    iv. Be in good standing with the law as outlined in the MDHHS/PIHP contract.
e. Professional staff shall each have an individual National Provider Identifier (NPI) Number
f. Telemedicine behavioral health services may be delivered via telemedicine in accordance with current Medicaid policy. In compliance with the Michigan Insurance Code of 1956 (Act 218 of 1956), telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state of Michigan.
g. Determination of medical necessity and appropriateness of services is the responsibility of the physician within the scope of currently accepted medical practice and Medicaid limitations. The physician is held responsible if he orders excessive or unnecessary services (e.g., diagnostic tests, prescriptions) regardless of who actually renders or who receives payment for the service. The physician may also be subject to any corrective action related to these services, including recovery of funds.
h. All physician services covered by Medicaid must be performed by the physician personally, the physician's employee, or an employee of the same legal entity that employs the physician, under the physician's delegation and supervision. Only persons currently licensed/certified in an appropriate health occupation/profession (e.g., physician's assistant, NP, CNM) as authorized by P 1978 PA 368, as amended, may provide direct patient care under the delegation and supervision of a physician when the physician is not physically present on the premises. The delegating/ supervising physician must be continuously available through direct communication such as telephone, radio, or telecommunication when not on the premises. Delegated and supervised

services rendered by non-physician practitioners (e.g., physician assistants and nurse practitioners) must be billed under the non-physician practitioner's NPI and include the NPI of the supervising physician as applicable.

4. Service Requirements

a. Provider's supports and services will be based upon the individual's plan of service, and in coordination with any additional plans of the Individual (e.g. nursing, occupational therapy, physical therapy, behavior support plans). Said documents are to be present (hard copy or electronically) at the service site, and accessible to the Provider's staff responsible for delivering the supports and services
b. Provider shall notify the individual's care manager when the individual's plan of service is in need of revision or modification.
c. Provider shall provide services in the least restrictive and most integrated settings, unless the less restrictive levels of treatment, service or support have been unsuccessful or cannot be safely provided for that Individual
d. Provider shall ensure coordination of care occurs between the individual(s) primary health care physician and Medicaid Health Plan (as appropriate). Coordination of care shall include the full array of primary and acute physical health services, behavioral health care, natural or community supports to provide effective treatment, and as specified in an Individual's plan of service.
e. Provider shall ensure language interpretation, translation services, and hearing interpreter services are provided as needed, and at no cost to the individual. Provider shall be responsive to the particular needs of individuals with sensory or mobility impairments, and provide necessary accommodations.
f. Provider shall complete service documentation and records that meet the PIHP/CMHSP's requirements for reimbursement. Provider's services and documentation/records shall comply with the standards of the PIHP, CMHSP, accreditation bodies, MDHHS, any applicable licensing Department or Agency of the State of Michigan, Medicaid and Medicare regulations and/or any third-party payers.
g. The individual's record must contain sufficient information to document the provision of services, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of contacts must take into consideration the health and safety needs of the individual.
h. Coordinate pharmacy needs and psychotropic medication for 30 days after discharge unless a subsequent service Provider assumes this responsibility.

5. Training Requirements

a. See Attachment I: Training Requirements for specific training requirements and frequency of trainings.
b. Provider will ensure and document that each staff is trained on the Individual's IPOS and ancillary plans, prior to delivery of service.

6. Eligibility Criteria/Access Requirements/ Authorization Procedures

a. Individuals presenting for mental health services will be engaged in a person-centered planning process through which diagnostic information and service eligibility will be determined. Eligibility tools may be used in conjunction with the person-centered planning process to determine and document medical/clinical necessity for the requested service.
b. Waiver eligibility requires verification of no change in waiver status.
c. Provider will complete ongoing assessment of readiness to transition Individuals with Medicaid to providers within their Medicaid Health Plan when the Individual no longer meets eligibility criteria

for CMHSP services. Provider will be responsible for referring Individuals to health plan providers and ensuring a smooth care transition.

d. When providing services via telemedicine, providers can only bill for services listed on the Telemedicine Services database. Procedure code and modifier information is contained in the MDHHS Telemedicine Services Database available on the MDHHS website. (Refer to the Medicaid Manual Directory Appendix for website information.)
e. The PIHP Guide to Services provides a summary of service eligibility, access to services, and service authorization. Additional information related to policies, procedures and Provider Manuals may be found by accessing the specific CMHSP websites.