12. Prescribed Drugs, Dentures and Prosthetic Devices and Eyeglass

A. Prescribed Drugs

1) Prescribed drugs are limited to legend drugs approved as safe and effective by the Federal Food and Drug Administration and those over-the-counter medications which fall into the following categories:

a. Oral Analgesics;
b. Ferrous sulfate;
c. Antacids;
d. Diabetic preparations;
e. Family planning drugs and supplies;
f. Pediatric, prenatal and geriatric vitamin formulations; and
g. Senna extract, single dose preparations when required for diagnostic radiological procedures performed under the supervision of a physician.
h. Prescribed drugs for purposes of nursing homes pharmacy reimbursement shall **not** include over-the-counter medications, syringes for diabetic preparations, geriatric vitamin formulations and senna extract (except as described above in item g).

2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

3) The Medicaid agency provides coverage to the same extent that it provides coverage for all Medicaid recipients for the following excluded or otherwise restricted drugs or classes of drugs to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.

a. Select agents when used for weight gain:
Megesterol

b. Select prescription vitamins and mineral products, except prenatal vitamins and fluoride:
Folic Acid, Vitamin B12

c. Select non-prescription drugs:
Analgesics, Antacids, Diabetic Therapy, Bowel diagnostic preparation kits

d. All barbiturates

e. All benzodiazepines

4) The District of Columbia will provide reimbursement for covered outpatient drugs when prescribed by an enrolled licensed provider within the scope of their license and practice as allowed by District law and in accordance with Section 1927 of the Social Security Act. This will apply to drugs of any manufacturer that has entered into a rebate agreement with the Center for Medicare and Medicaid Services. All drugs covered by the National Drug Rebate Agreements remain available to Medicaid beneficiaries, although some may require prior authorization. The District has established a preferred drug list with prior authorization for drugs not included on the preferred drug list. The Prior authorization process complies with the requirements of Section 1927 of the Social Security Act and provides for a 24-hour turnaround by either telephone or other telecommunications device from

receipt of request and provides for a 72 hour supply of drugs in emergency circumstances. The preferred drug list meets the formulary requirements that are specified in Section 1927(d)(4) of the Act.

5) The drugs or classes of drugs listed in 42 USC 1396r-8(d)(2) are excluded from coverage unless specifically placed, either individually or by drug class, on the Medicaid Drug List or prior authorized based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature. The following drugs are excluded from coverage through the Outpatient Pharmacy Program:

   a. A drug for which the FDA has issued a "less than effective (LTE) rating or a drug "identical, related, or similar" to an LTE drug;

   b. A drug that has reached the termination date established by the drug manufacturer;

   c. A drug for which the drug manufacturer has not entered into or has not complied with a rebate agreement in accordance with 42 USC 1396r-8(a) unless there has been a review and determination by the department that it shall be in the best interest of Medicaid recipients for the department to make payment for the non-rebated drug; and

6) Supplemental Rebate Program:
   The District is in compliance with Section 1927 of the Social Security Act. The District has the following policies for the Supplemental Rebate Program for the Medicaid population.

   a. The "Supplemental Drug-Rebate Agreement" between the participating states, First Health Services Corporation and the participating manufacturers, has been submitted to CMS and has been authorized. CMS has authorized the District of Columbia to enter into the Michigan multi-state pooling agreement (MMSPA)

   b. CMS has authorized the District of Columbia to enter into the National Multistate Pooling Initiative. This Supplemental Drug Rebate Agreement was submitted to CMS on November 8, 2006 and has been authorized by CMS.

   c. Supplemental rebates received by the District in excess of those required under the national drug rebate agreement will be shared with the Federal Government on the same percentage basis as applied under the national drug rebate agreement.

   d. Manufacturers who do not participate in the supplemental rebate program will continue to have their drugs made available to Medicaid participants through either the preferred drug list or the prior authorization process

depending on the results of the Pharmacy and Therapeutics Committee recommendations and Departmental review.

e. As specified in Section 1927(b)(3)(D) of the Act, not withstanding any other provisions of law, rebate information disclosed by a manufacturer shall not be disclosed by the District for purposes other than rebate invoicing and verification.

7) All anorexic drugs (amphetamine and amphetamine-like) are eliminated as reimbursable pharmaceuticals except for diagnosed conditions of narcolepsy and minimal brain dysfunction in children.

8) Prior authorization (PA) is required for the dispensing of the following prescribed drugs:

a. All prescriptions for Oxycodone HCL and Aspirin (more commonly known as Percodan), and Flurazepam (more commonly known as Dalmane);

b. Anorexic drugs (amphetamine and amphetamine-like) may be dispensed with prior authorization for the diagnosed conditions of narcolepsy and minimal brain dysfunction in children; and

c. Any injectable drugs on an ambulatory basis.

9) Pharmacy Lock-In Program

a. The Department of Health Care Finance (DHCF), along with the District of Columbia Drug Utilization Review (DUR) Board, will implement a Pharmacy Lock-In Program to safeguard the appropriate use of medications when an individual enrolled in the District of Columbia Medicaid Fee-for-Service Program misuses drugs in excess of the customary dosage for the proper treatment of the given diagnosis, or misuses multiple drugs in a manner that can be medically harmful. Beneficiaries listed in section 9(k) are exempt from the Pharmacy Lock-In Program.

b. DHCF will use the drug utilization guidelines established by the District of Columbia Drug Utilization Review (DUR) Board in support of the restriction. DUR Board Guidelines require a monthly report from the Medicaid MMIS to determine when a beneficiary may be at risk of exceeding the customarily prescribed dosages or utilization. The report will identify beneficiaries who meet criteria, such as:

1. > 3 controlled substance prescriptions per month;

2. >3 prescribers for controlled substances within the last 90 days;

3. >10 prescriptions per month; or

4. 3 or more pharmacies used per month

c. The Department of Health Care Finance (DHCF) will notify the Medicaid beneficiary in writing of the following at least fifteen (15) days prior to the effective date of the restriction:

1. DHCF proposes to designate him or her as a restricted Medicaid beneficiary;

2. The reason for the restriction; and

3. The beneficiary's right to a hearing if he or she disagrees with the designation.

d. The Medicaid beneficiary shall have fifteen (15) days from the date of the notice to file a request for a hearing with the Office of Administrative Hearings (OAH).

e. If the Medicaid recipient requests a hearing, no further action shall be taken on the restriction designation until the hearing is dismissed or a final decision has been rendered by OAH.

f. A restriction may be required for a reasonable amount of time, not to exceed twelve (12) months, without a review by the Drug Utilization Review Board. Subsequent restrictions will not be imposed until after the review has concluded.

g. DHCF will ensure that when a lock-in has been imposed, the beneficiary will continue to have reasonable access to Medicaid services of adequate quality.

h. When a restriction is imposed upon a beneficiary, the beneficiary may choose the pharmacy of his or her choice, based upon a list of three (3) pharmacy providers identified by DHCF.

i. When a beneficiary fails to request a hearing with OAH or fails to select a designated pharmacy after a decision has been rendered by OAH upholding the restriction within the specified time period, the DHCF, on behalf of that beneficiary, will designate a pharmacy for pharmacy services.

j. Restrictions will not apply in situations where emergency services are furnished to a beneficiary.

k. Beneficiaries in skilled nursing facilities, long term care facilities, and intermediate care facilities for the mentally retarded are not eligible for the Pharmacy Lock-In Program.

l. If a beneficiary, who is enrolled in the Medicaid Managed Care Organization (MCO) and is also required to participate in its Pharmacy Lock-In Program, subsequently becomes enrolled in the Medicaid Fee-For-Service Program, that beneficiary will be automatically enrolled in the Medicaid Fee-For-Service Pharmacy Lock-In Program. The lock-in will remain in force for a period not to exceed the length of the initial lock-in period first imposed by the MCO, or twelve (12) months, whichever is less.

(10) Medication Assisted Treatment (MAT) under Adult Substance Abuse Rehabilitative Services (described in Supplement 6 to Attachment 3.1-A)

a. MAT is the use of pharmacotherapies (e.g., methadone) as long-term treatment for opiate or other forms of dependence. MAT includes medication dosing used in conjunction with Substance Abuse Counseling.

b. Unit of Service: One unit consists of one (1) dose of medication per day.

c. Limitations: Prior approval from the Department of Health Addiction Prevention and Recovery Administration (APRA) or its designee is required prior to enrollment in MAT. The maximum number of MAT services available over a twelve (12) month period is three hundred sixty-five (365) units.

Beneficiaries receiving MAT will require two (2) prior authorizations from APRA or its designee before long-term maintenance can be authorized. A new patient shall have an initial authorization of up to ninety (90) units of daily medications. The provider must then request authorization for an additional ninety (90) units, if appropriate, after which the patient may receive authorization for long-term MAT up to one hundred eighty (180) units.

d. Location/Setting:
Substance abuse treatment facility or program certified by APRA or community-based setting otherwise approved or designated by APRA.

Buprenorphine Only: Private practice offices of individuals authorized to prescribe buprenorphine according to their licensure pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*).

e. Qualified Practitioners: Licensed practitioners, including: Qualified Physicians or APRNs and PAs who are supervised by qualified Physicians

Dentures

1. Dentures are limited to eligible EPSDT recipients.

2. Initial placement or replacement of a removable prosthesis (any dental device or appliance replacing one or more missing teeth, including associated structures, if required, that is designed to be removed and reinserted) once every five (5) years per recipient, unless the prosthesis:

   a. was misplaced, stolen, or damaged due to circumstances beyond the recipient's control;

   b. cannot be modified or altered to meet the recipient's dental needs.

3. Relines are limited to two (2) in five (5) years unless prior authorized.

C. Prosthetic Devices

1. Prosthetic devices are limited to items on the Durable Medical Equipment/ Medical Supplies Procedure Codes and Price List except where prior authorized by the State Agency.

2. Medical supplies and equipment in excess of specific limitations, i.e., cost, rental or lease equipment, or certain procedure codes must be prior authorized by the State Agency.

D. Eyeglasses

This item includes lenses required to aid or improve vision with frame when necessary that are prescribed by a physician skilled in diseases of the eye or by an optometrist at the discretion of the patient.

1. Eyeglasses are limited to one complete pair in a twenty-four (24) month period. Exceptions to this policy are:

   a. Recipients under twenty-one (21) years of age;

   b. Whenever there is a change in the prescription of more than plus or minus .5 (one half) diopter, and

   c. Broken or lost eyeglasses.

(3) Special glasses such as sunglasses and tints must be justified in writing by the ophthalmologist or optometrist. Special tints and sunglasses are not allowed in addition to untinted eyewear.

(4) Contact lenses must be prior authorized by the State Agency.

13. Other Diagnostic, Screening, Preventive and Rehabilitative Services, i.e., Other Than Those Provided Elsewhere in This Plan

a. Diagnostic services must be prior authorized.

b. Screening services are limited to eligible EPSDT recipients.

c. Preventive services must be prior authorized.

d. Rehabilitative services must be prior authorized and are covered for eligible Medicaid beneficiaries who are in need of mental health or substance abuse treatment, due to mental illness, serious emotional disturbance, or substance use disorder. Covered services include: 1) Mental Health Rehabilitation Services (MHRS); and 2) Adult Substance Abuse Rehabilitative Services (ASARS).

These services are described in Supplement 6 to Attachment 3.1-A.

d. Preventive services must be prior authorized.

14. Services for individuals age 65 or older in institutions for Mental Diseases.

a. Inpatient hospital services are limited to services certified as medically necessary by the Peer Review Organization.

b. Skilled nursing facility services are limited to services certified as medically necessary by the Peer Review Organization.

c. Intermediate care facility services are limited to services certified as medically necessary by the Peer Review Organization.

15.a. Intermediate Care Facility Services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care are provided with no limitations.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions are provided with no limitations.

16. Inpatient Psychiatric Facility Services for individuals under 22 years of age are provided with no limitations.

17. Nurse midwife services are provided in accordance with D.C. Law 10-247.

18. Hospice Care (in accordance with section 1905(c) of the Act).

A. Hospice programs provide palliative care and counseling services to terminally ill individuals in accordance with a written plan of care for each individual. The initial Hospice election period shall be for ninety (90) days, followed by a second ninety (90) day period, a third period of thirty (30) days, and then one or more thirty (30) day extended election periods as long as the provider obtains a written certification statement that the recipient's medical prognosis is for a life expectancy of six months or less. This certification shall be obtained no later than two (2) calendar days after the beginning of each period.

B. An election to receive hospice care is considered to continue through the initial election period and through any subsequent election periods without a break in care as long as the recipient remains in the care of the hospice and does not revoke the election.

C. If a recipient has both Medicare and Medicaid coverage, the hospice benefit shall be elected simultaneously as well as revoked simultaneously under both programs.

D. If the recipient revokes the hospice election, his or her waiver of other Medicaid coverage expires.

E. The recipient may revoke the hospice selection during any period.

F. The recipient may designate a new provider of hospice care no more than once during an election period.

G. The recipient shall waive all rights to Medicaid coverage for the duration of the election of hospice care for services which are equivalent to the services covered under the Medicare Program. After Hospice election, Medicaid payment shall be made for services that are covered under the state plan if those services are not covered by Medicare.

1. Services provided by the designated hospice (either directly or under arrangement);

2. Services provided by the recipients' attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services; and

3. Quality of life prescription drugs.

H. Covered hospice services include:

1. Nursing care provided by or under the supervision of a registered nurse;

2. Medical social services provided by a licensed social worker under the direction of a physician;

3. Services performed by a doctor of medicine, of dental surgery or dental medicine (for persons under 21 years of age), of podiatric medicine, or of optometry, except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine;

4. Counseling services, including bereavement, and if appropriate, spiritual and dietary;

5. Short-term inpatient care provided in a Medicaid certified hospice inpatient unit, or a Medicaid certified hospital or nursing home that provides supervision and management of the hospice team;

6. Durable medical equipment and supplies;

7. Prescription drugs which are used primarily for relief of pain and symptom control related to the recipient's terminal illness;

8. Physical, occupational and speech therapy services;

9. Home health aide, personal care aide, and homemaker services; and

10. Chemotherapy and radiation therapy to provide pain control or symptom relief.

I. Continuous Home Care - care to maintain a recipient at home during a brief period of crisis is covered for:

1. Nursing care, provided by either a registered nurse or a licensed practical nurse, and accounting for more than half of the period of care;

2. A minimum of eight (8) hours of care, not necessarily consecutive, provided during a twenty-four (24) hour day which begins and ends at midnight; and

3. Homemaker, home health, and personal care aide services if needed, to supplement nursing care.

19. Case management services and Tuberculosis related services

A. Services as Defined in and to The Group Specified in Supplement 2 to Attachments 3.1A and 3.1B (in accordance with section 1905(a)(19) or section 1915(g) of the Act) are provided with limitation.

B. Tuberculosis-Related Services

1. Covered services shall be defined as those services listed in Section 13603 of the Omnibus Reconciliation Act of 1993 as being related to the treatment of those persons with a diagnosis of tuberculosis disease. In accordance with Section 13603, room and board are not a covered service for patients completing treatment under observation.

These services shall be prescribed by a physician and shall be part of a written plan of care approved by the Bureau of Tuberculosis Control of the Department of Health.

Only tuberculosis-related services meeting all the following requirements shall be reimbursed by the program:

a. Covered services shall be directly and specifically related to a plan of care written by a physician and approved by the Bureau of Tuberculosis Control;

b. The services shall be of reasonable amount, duration and frequency and shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice;

b. Case management services for tuberculosis patients shall be prior authorized by the Bureau of Tuberculosis Control.

2. Documentation Requirements

Documentation of tuberculosis-related services shall at a minimum:

a. Include the diagnosis and describe the clinical signs and symptoms of the patient's condition;

Include a complete and accurate description of the patient's clinical course and treatments;

b. Document that a plan of care based specifically on a comprehensive assessment of the patient's needs has been developed for the patient and reviewed and approved by the Bureau of Tuberculosis Control of the Commission of Public Health;

c. Include a copy of the plan of care and the physician's orders;

d. Include all treatment rendered to the patient in accordance with the plan of care, providing information on the frequency, duration, modality, and response, and identify who provided the care by full name and title;

e. Describe changes in the patient's condition in response to the services provided through the plan of care; and

f. Include the time frames necessary to complete the treatment and the patient's discharge destination.

Services provided to patients without an approved plan of care shall not be reimbursed.

3. Service limitations. The following general requirements shall apply to all reimbursable tuberculosis-related services:

a. Patients must be under the care of a physician who is legally authorized to practice and who is acting under the scope of his/her license.

b. Services shall be furnished under a written plan of care that is established and reviewed periodically by a physician. The services or items for which reimbursement is sought must be necessary to carry out the plan of care and must be related to the patient's condition.

c. A physician's recertification of a plan shall be required periodically; shall be signed and dated by the physician who reviews the plan of care; shall indicate the continuing need for service and estimate how long services will be needed; and, must be available when the plan of care is reviewed by the Medicaid program or its agent.

d. The physician's orders for services shall include the specific treatment to be provided and shall indicate the frequency and duration of services.

e. Utilization review shall be conducted by the Medicaid program or its agent to determine whether services are appropriately provided and to ensure that the services are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and shall not be reimbursed, and services found not to be medically necessary as a result of utilization review shall not be reimbursed.

20. Extended Services for Pregnant Women

A. Pregnancy-related and postpartum services for 60 days after the pregnancy ends are provided with no limitations. The Department of Health will provide the full range of services available under the District of Columbia Medicaid State Plan, as long as the required medical service is pregnancy related.

B. Services for any other medical condition that may complicate pregnancy are provided with no limitations. The Department of Health will provide the full range of services available under the District of Columbia Medicaid State Plan, as long as the required medical service is pregnancy related.

21. Ambulatory Prenatal Care for Pregnant Women Furnished During A Presumptive Eligibility Period by a Qualified Provider (in accordance with section 1920 of the Act) is provided (see Item 25).

22. Respiratory Care Services are not provided for ventilator dependent individuals in accordance with section 1902(e)(9)(A) through (C) of the Act.

23. Nurse practitioner services are provided in accordance with D.C. Law 10-247 (see Item 27).

A. The services of the nurse practitioner are subsumed under the broad category, Advanced Practice Registered Nursing which includes, but is not limited to, nurse midwife, nurse anesthetist, nurse practitioner and clinical nurse specialist.

B. The services of the advanced practice registered nurse are to be carried out in general collaboration with a licensed health care provider.

24. Any Other Medical Care and Any Other Type of Remedial Care Recognized under State Law, Specified by the Secretary

A. Transportation services are not discussed under this section of the state plan. See Attachment 3.1D.

B. Services of Christian Science Nurses are not provided.

C. Care and Services Provided in Christian Science Sanitaria are not provided.

D. Nursing Facility Services provided for Patients under 21 Years of Age are provided with no limitations.

E. Emergency Hospital Services

1. The emergency room clinic physician encounter must be authenticated in the medical record by the signature of a licensed physician to be considered for reimbursement by the program.

2. Reimbursement by the State Agency is restricted to one encounter when the same patient is seen in both the emergency room and/or outpatient clinic department on the same day.

3. Reimbursement for induced abortions is provided only in cases where the life of the mother would be endangered if the fetus were carried to term, or the pregnancy occurred as a result of rape or incest, and when the claim is accompanied by the following documentation:

   a. Documentation that services were performed by a provider licensed to provide such services; and

   b. Written documentation from the treating physician that the life of the mother would be endangered if the fetus were carried to term; or

   c. Documentation that the pregnancy occurred as a result of rape or incest. For purposes of this requirement, documentation may consist of official reports; a written certification from the patient that the pregnancy occurred as a result of rape or incest; certification from the physician that the patient declared the pregnancy occurred as a result of rape or incest; or certification from the physician that in his or her professional opinion, the pregnancy resulted from rape or incest.

   Reimbursement shall be made according to the fee schedule amount and shall cover all services related to the procedure including physician fee(s), laboratory fee(s) and counseling fee(s).

24. (continued) Any other Medical Care and Any Other Type of Remedial Care Recognized Under State Law, Specified by the Secretary

f. Personal Care Services, Prescribed in Accordance with a Plan of Treatment and Furnished by Qualified Person Under Supervision of a Registered Nurse are covered with limitations.

1. Personal care aide (PCA) services must not exceed eight (8) hours per day, or one thousand and forty (1040) hours in any twelve (12) month period, unless prior authorization is given by the State Agency.

2. When the cost of PCA services, in addition to other home care services, exceeds the cost of institutional care over a six (6) month period, the State Medicaid Agency may limit or deny PCA services on a prospective basis.

3. A family member other than a spouse, parent of a minor recipient or any other legally responsible relative may provide personal care services. Family members must be certified according to CFR 484.36 (e) (1,2).

4. Covered Services

   a. Section 1905(a)(24) of the Act and Title 42, Code of Federal Regulations, section 440.167(a)(3) authorizes the provision of personal care aide services "in a home, and at the state's option, in another location". Such services must be authorized by a physician in accordance with a plan of treatment, and be provided by an individual who is:

      (1) Qualified to provide the services; and
      (2) Supervised by a registered nurse.

   b. Definitions

      (1) "Personal Care Aide (PCA)" is an individual who provides services through a Provider Agency to assist the patient in activities of daily living including bathing dressing, toileting, ambulation, and eating.

(2) "Provider Agency" is a certified Home Health Agency or Homemaker Agency, which holds a valid provider agreement with the District of Columbia Medicaid Agency to provide Personal Care Aide services.

c. Scope of Personal Care Aide Services

(1) In order to receive reimbursement from Medicaid, Personal Care Aide Services must be:

(a) Ordered by a physician as part of the patient's plan of care,
(b) Certified by the physician initially and every six months,
(c) Recertified after any interruption of service, including hospital admission,
(d) Be part of a total plan of care prepared by a registered nurse, which is developed at the initiation of Personal Care Aide services. The Plan must be reviewed at least every six months, and specify the expected outcome of the services provided.

(2) Examples of Personal Care Aide services include:

(a) Basic personal care such as bathing, grooming and assistance with toileting or bed pan use.
(b) Assistance with prescribed, self-administered medication.
(c) Meal preparation and assistance with eating.
(d) Household tasks related to keeping the patient's living areas in a condition that promotes patient health and comfort.
(e) Accompanying the patient to medically related appointments.
(f) Shopping for items related to promoting the patient's nutritional status and other health needs.

(3) Personal Care Aide services may not include services that require the skills of a licensed professional, including catheter insertion, procedures requiring sterile techniques, and medication administration.

(4) Personal Care Aide services may not include tasks usually performed by chore workers, including cleaning of areas not occupied by the patient, cleaning laundry for family members of the patient, and shopping for items not used by the patient.

25(i). Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: No limitations X Provided With limitations None licensed or approved

Please describe any limitations: See below

(A) Facilities must:

(1) Be licensed by the Department of Health (DOH) under Chapter 26 of Title 22 of the District of Columbia Municipal Regulations (DCMR);

(2) Be specifically approved by DOH to provider birth center/maternity center services; and

(3) Maintain standards of care required by DOH for licensure.

(B) Birth Centers shall cover services relating to three main components of care:

(1) Routine ante-partum care in any trimester shall include the following:

(a) Initial and subsequent history;

(b) Physical Examination;

(c) Recording of weight and blood pressure;

(d) Recording of fetal heart tones;

(e) Routine chemical urinalysis;

(f) Maternity counseling, such as risk factor assessment and referrals;

(g) Limitations on services for billing related to a normal, uncomplicated pregnancy (approximately fourteen (14) ante-partum visits include:

(i) Monthly visits up to 28 weeks gestation;

(ii) Thereafter, biweekly visits up to 36 weeks gestation;

(iii) Thereafter, weekly visits until delivery; and

(iv) Additional visits for increased monitoring during the ante-partum period beyond the fourteen (14) routine visits must be medically necessary to qualify for payments.

(2) Delivery services shall include:

(a) Admission history and physical examination;

(b) Management of uncomplicated labor;

(c) Vaginal delivery.

(3) Postpartum care

(a) Mother's Postpartum check within six (6) weeks of birth

(b) Newborn screening test. Screening panel includes but is not limited to the following:

(i) PKU;

(ii) CAH;

(iii) Congenital hypothyroidism;

(iv) Hemogobinopathies;

(v) Biotinidase deficiency;

(vi) MSUD;

(vii) MCAD deficiency;

(viii) Homocystinuria; and

(ix) Galactosemisa.

(c) Limitations of services for a Well Baby Check (newborn assessment) include:

(i) One postpartum check per beneficiary;

(ii) Two tests per new born for screening on two separate dates of service; and

(iii) Two Well Baby Checks/assessments per newborn.

(ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: No limitations X Provided with limitations (please describe below)
Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations: Professionals will be reimbursed for those services included under Birth Center Services under 25 (i).

Please check all that apply:

X (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

The following practitioners may provide birth center services and must be licensed in the District of Columbia as a:

(a) Physician under Chapter 46 of Title 17 of the DCMR
(b) Pediatric nurse practitioner under Chapter 56 of Title 17 of the DCMR
(c) Family nurse practitioner under Chapter 56 of Title 17 of the DCMR
(d) Nurse midwife under Chapter 56 of Title 17 of the DCMR

X (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

(i) Licensed certified professional midwives

(c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*
N/A

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: (see b (i) above).