



Medicaid Provider Manual July 2004 Updates



TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Overview	1 – Introduction	Language added: "The following documents comprise the Michigan Medicaid Provider Manual, and address healthcare programs administered by the Michigan Department of Community Health (MDCH). MDCH also issues periodic bulletins as changes are implemented to the policies and/or processes described in the manual. An inventory of these bulletins is maintained in the Supplemental Bulletin List located on the MDCH website. Bulletins are incorporated into the online version of the manual on a quarterly basis. (Refer to the Directory Appendix for website information.)"	Added for clarification.
General Information for Providers	11 – Third Party Liability	Last sentence of the second paragraph changed to read: "The Eligibility Verification System (EVS) shows Level of Care 32 for these individuals."	Updated to reflect current coding.
Beneficiary Eligibility	2.3 Level of Care Codes	Description of LOC 32 was changed to: "Beneficiary is incarcerated. Medicaid coverage limited to inpatient hospital related services only."	Updated to reflect current use of code.
Coordination of Benefits	2.6.E. Medicaid Liability	The following clarification was added after the third paragraph: "The MDCH payment liability for beneficiaries with Medicare coverage is the lesser of: <ul style="list-style-type: none"> • The beneficiary's liability for coinsurance, copayments, and/or deductibles minus any applicable Medicaid copayment, patient pay, or spenddown amounts. • The Medicaid fee screen/allowable amount minus any Medicare payments, contractual adjustments, and any applicable Medicaid copayment, patient pay, or spenddown amounts. • The provider's charge minus any Medicare payments, contractual adjustments, and any applicable Medicaid copayment, patient pay, or spenddown amounts." 	Added in response to provider inquiries.

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Billing & Reimbursement for Dental Providers	3.1 Electronic Claims	The following sentence was added to the first paragraph: "The payroll cut-off for electronic claims submission to MDCH is Wednesday of each week."	Added in response to provider inquiries.
Billing & Reimbursement for Dental Providers	3.2 Paper Claims	The following paragraph was added: "Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period."	Added in response to provider inquiries.
Billing & Reimbursement for Dental Providers	6.1 Replacement Claims General Information	The following information in bold was added: <ul style="list-style-type: none"> To return an overpayment (report "returning money" in Remarks section); To correct information submitted on the original claim (other than to correct the Provider ID number and/or the beneficiary ID number). Refer to the Void/Cancel subsection below; To report payment from another source after MDCH paid the claim (report "returning money" in Remarks section); and/or To correct information that the scanner may have misread (state reason in Remarks section). 	Clarification added to facilitate processing of replacement claims.
Billing & Reimbursement for Dental Providers	8.1 Payments/Claim Status	The following information was added as the third paragraph of this subsection: "If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider ID number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment."	Added in response to provider inquiries.
Billing & Reimbursement for Institutional Providers	2.1 Electronic Claims	The following sentence was added to the first paragraph: "The payroll cut-off for electronic claims submission to MDCH is Wednesday of each week."	Added in response to provider inquiries.

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Billing & Reimbursement for Institutional Providers	2.2 Paper Claims	The following paragraph was added: "Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period."	Added in response to provider inquiries.
Billing & Reimbursement for Institutional Providers	3.1 Replacement Claims	The following information in bold was added: <ul style="list-style-type: none"> To return an overpayment (report "returning money" in Remarks section); To correct information submitted on the original claim (other than to correct the Provider ID number and/or the beneficiary ID number). Refer to the Void/Cancel subsection below; To report payment from another source after MDCH paid the claim (report "returning money" in Remarks section); and/or To correct information that the scanner may have misread (state reason in Remarks section). Refer to the Void/Cancel subsection for additional information.	Clarification added to facilitate processing of replacement claims.
Billing & Reimbursement for Institutional Providers	5.10 Pre-Admission and Certification Evaluation Review	The following clarification was added to the "Readmission within 15 days to the Same Hospital (Unrelated Readmission)" portion of the table: <ul style="list-style-type: none"> The provider must submit two separate claims to assure appropriate processing. A claim for the first admission must be submitted and paid prior to submission of the readmission claim. 	Added in response to provider inquiries.
Billing & Reimbursement for Institutional Providers	6.1 Hospital Claim Completion – Outpatient General Information	The subsection was reformatted and information added as follows: 6.1.A. Multiple Visits – Same Revenue Center Multiple medical visits on the same day with the same revenue center, but the visits were distinct and constituted independent visits, must be submitted on separate claim lines when billed on the same claim. An example is a beneficiary going to the emergency room twice on the same day; in the morning for a broken foot and later for chest pain.	Instructions modified to facilitate processing of claims.

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		<ul style="list-style-type: none"> Condition Code G0 must be reported. The reason for each visit must be indicated in the Remarks section (e.g., seen twice on the same day, in the morning for a broken foot and in the afternoon for chest pain). <p>6.1.B. Multiple Visits – Different Revenue Center Modifier 22 must be used following the relevant CPT/HCPCS procedure code when reporting multiple visits in different revenue cost centers on the same date of service. Indicate in the Remarks section the reason for the multiple unrelated services on the claim.</p> <p>6.1.C. Late Charges Late charges do not apply for outpatient hospital (Type of Bill 135). A claim replacement must be submitted to report correct charges. (Refer to the Replacement and Void/Cancel Claims Section of this chapter.)</p> <p>6.1.D. Series Billing Certain services (listed below) of the same type (i.e., same procedure code) rendered to one beneficiary in a single calendar month may be billed on one claim line (i.e., billed by calendar month). The following services may be series billed monthly:</p> <table data-bbox="667 1122 1465 1206"> <tr> <td>Chemotherapy</td> <td>Peritoneal Dialysis</td> <td>Speech Pathology</td> </tr> <tr> <td>Hemodialysis</td> <td>Physical Therapy</td> <td></td> </tr> <tr> <td>Occupational Therapy</td> <td>Radiation Treatment Delivery</td> <td></td> </tr> </table> <ul style="list-style-type: none"> Enter the first treatment date of the month as the "from" date and the last treatment date as the "through" date for a single calendar month. The quantity should reflect the total number of treatments in the series for that month. The combined charges for the services for that month should be used. 	Chemotherapy	Peritoneal Dialysis	Speech Pathology	Hemodialysis	Physical Therapy		Occupational Therapy	Radiation Treatment Delivery		
Chemotherapy	Peritoneal Dialysis	Speech Pathology										
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		<ul style="list-style-type: none"> • Occupational, physical and speech-language therapy revenue codes should be billed using the appropriate therapy HCPCS code that describes the service provided. • For appropriate reimbursement, report facility charges on a separate claim line for each date of service (e.g., 0270, 0636). • Refer to the Chemotherapy Treatment Section of this chapter for additional information. • The appropriate modifier must be used when billing a dual-use supporting CPT/HCPCS code for OT and PT services. The modifier must follow the dual-use CPT/HCPCS code on the claim line. • Refer to the Therapies subsection of this chapter for more details about billing for dual-use CPT/HCPCS codes. • Enter a quantity of "1" for every 15 minutes of therapy provided if the CPT/HCPCS code indicates 15-minute intervals of service. • Enter the actual dates of service for that month in the Remarks section for each revenue code billed. <p>6.1.E. Individual Consideration For requesting individual consideration, report modifier 22 following the relevant CPT/HCPCS code. Do not use modifier 22 unless it is indicated.</p> <p>Indications for use of modifier 22 include:</p> <ul style="list-style-type: none"> • Reporting dose-specific description (report modifier 22 following the CPT/HCPCS code) • Reporting a quantity greater than six in the operating room (OR) (report why additional OR time requested in the Remarks section) • Reporting multiple visits in different revenue cost centers on the same date of service (indicate reason for the multiple unrelated services on the claim in Remarks section) 	

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		<ul style="list-style-type: none"> Use modifier 22 only when the code description is exceeding the allowable quantity. Do not use modifier 22 when reporting multiple J-codes. (Report the actual dosage given in the Remarks section.) 	
Billing & Reimbursement for Institutional Providers	6.7 Chemotherapy Treatment	<p>The following bullets were added:</p> <ul style="list-style-type: none"> Chemotherapy 33x series may be series billed monthly. Facility charges must be reported on a separate claim line for each date of service (e.g., 0270, 0636) for appropriate reimbursement. 	Added in response to provider inquiries.
Billing & Reimbursement for Institutional Providers	6.8 Childbirth Education	<p>The billing instructions were modified as follows to reflect current coding requirements:</p> <ul style="list-style-type: none"> Use revenue code 0942 (Education/Training) Use S9442 as the support code Report the quantity as "1" Enter the last date the beneficiary was seen for childbirth education in "statement covers period" The "from" and "through" dates must be the same 	Updated billing instructions.
Billing & Reimbursement for Institutional Providers	6.14 Diagnostic Testing (NEW SUBSECTION) Subsequent subsections renumbered.	<p>The following subsection was added to clarify current policy:</p> <ul style="list-style-type: none"> Do not bill for routine screening tests (e.g., to establish baseline values, etc.). Use revenue code 0920 and the appropriate supporting CPT/HCPCS code for a test recognized as relevant to the condition being investigated. Use revenue code 0740 or 0920 with the appropriate supporting CPT/HCPCS code to bill for diagnostic sleep studies. A fetal monitoring stress contraction test or fetal nonstress test may be billed as a diagnostic test on the same day as a medical visit. 	Information added in response to provider inquiries.

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Billing & Reimbursement for Institutional Providers	6.16 Drugs Administered on Premises (previously 6.15)	The following bullet was added to clarify existing policy. <ul style="list-style-type: none"> Medicaid does not cover revenue code 0637 (self-administered drugs). 	Clarification added in response to provider inquiries.
Billing & Reimbursement for Institutional Providers	6.17 Emergency Department Services (previously 6.16)	The following bullet was added to the bottom of the "Emergency Department Stabilization/Emergency Treatment Services" portion of the table: <ul style="list-style-type: none"> When an OPH service encounter spans two dates, use the date of service care was accessed (the first date) as the "from" and "through" date. 	Added in response to provider inquiries.
Billing & Reimbursement for Institutional Providers	6.21 Hysterectomy (previously 6.20)	The following bullet was added: <ul style="list-style-type: none"> When billing for a hysterectomy performed during a beneficiary's period of retroactive eligibility, indicate in the Remarks section "MSA-2218 not completed. Not eligible on date of service." Also indicate the beneficiary was informed prior to the hysterectomy that the service would render her incapable of reproducing. 	Instruction added to facilitate processing of claims.
Billing & Reimbursement for Institutional Providers	6.21 Individual Consideration	Section deleted. Information moved to 6.1.E. Individual Consideration	
Billing & Reimbursement for Institutional Providers	6.22 Injections	The following instructions were modified/added: <ul style="list-style-type: none"> For medications that do not have a specific code, document the National Drug Code (NDC), the dose administered, the drug name, and the cost in the Remarks section of the claim. Enter a quantity of "1". Do not recode injectable drugs from a national procedure code covered by Medicare or other payer to a not otherwise classified (NOC) code, unless MDCH does not cover that procedure code. If MDCH covers the procedure code, the same code must be submitted to MDCH that was submitted to the other payer. 	Clarification of claim completion requirements.

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Billing & Reimbursement for Institutional Providers	6.24 Labor and Delivery	<p>The following bullet was added:</p> <ul style="list-style-type: none"> Do not report a fetal monitoring stress contraction stress test, or a fetal nonstress test, in addition to a labor and delivery or false labor room charge. 	Information added to clarify current policy.															
Billing & Reimbursement for Institutional Providers	6.36 Therapies	<p>The following information was added:</p> <p>"The same CPT code may be used for OT and PT. They are referred to as dual-use codes. The appropriate modifier must be used following the dual-use code when billing both OT and PT services.</p> <ul style="list-style-type: none"> Dual-use CPT codes: 97110, 97112, 97116, 97124, 97139, 97530, and 97799 Occupational therapy modifier: GO Physical therapy modifier: GP" 	Added in response to provider inquiries.															
Billing & Reimbursement for Institutional Providers	7.4 Revenue Code and Reimbursement Groups	<p>The following was added to the first paragraph:</p> <p>"Each revenue code within the group represents the same service. Providers must report the appropriate charges (from a group) that support the service being performed."</p> <p>A text label was added for each group of codes.</p> <table border="0"> <tr> <td>Group A Pharmacy</td> <td>Group F Anesthesia Supplies</td> <td>Group L Delivery Room</td> </tr> <tr> <td>Group B IV Solutions</td> <td>Group G Blood Not Replaced</td> <td>Group M Hemodialysis/Peritoneal Dialysis</td> </tr> <tr> <td>Group C Procedure Room</td> <td>Group H Oxygen</td> <td>Group N Continuous Ambulatory Peritoneal Dialysis</td> </tr> <tr> <td>Group D Supplies</td> <td>Group J Clinic Room</td> <td></td> </tr> <tr> <td>Group E Operating Room</td> <td>Group K Recovery Room</td> <td></td> </tr> </table>	Group A Pharmacy	Group F Anesthesia Supplies	Group L Delivery Room	Group B IV Solutions	Group G Blood Not Replaced	Group M Hemodialysis/Peritoneal Dialysis	Group C Procedure Room	Group H Oxygen	Group N Continuous Ambulatory Peritoneal Dialysis	Group D Supplies	Group J Clinic Room		Group E Operating Room	Group K Recovery Room		Added for clarification.
Group A Pharmacy	Group F Anesthesia Supplies	Group L Delivery Room																
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Billing & Reimbursement for Institutional Providers	8.1.E. Billed Facility Days (NEW SUBSECTION)	8.1.E. Billed Facility Days	Added in response to provider inquiries.	
		Day of Admission		Medicaid reimburses the day of admission if the beneficiary is counted in the facility census (e.g. if they are in the facility at midnight).
		Day of Discharge		Medicaid does not reimburse the day of discharge unless the beneficiary died. When billing, the facility must use Patient Status Code 22 – Expired.
		Hospital Leave Days		<ul style="list-style-type: none"> • If the resident is expected to be in the hospital for ten days or fewer and dies while in the hospital, the nursing facility may bill for the hospital leave days up to the day before the resident died. • If the resident returns to the nursing facility under Medicare coverage, the facility may bill for the hospital leave days if the emergency hospitalization was for ten days or fewer. • A resident is counted in the facility census if he is in the facility at midnight. If the resident is out of the facility on hospital leave at midnight, that day must be counted as a hospital leave day. If the resident returns to the nursing facility from the hospital, then is readmitted to the hospital for the same condition that he was hospitalized for previously, the 10-day period of Medicaid reimbursed hospital leave days continues if the resident was not counted in the facility census for that day. If, given the circumstances above, the resident was counted in the facility census, a new 10-day period of Medicaid reimbursed hospital leave days may begin.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	8.8 Ancillary Physical and Occupational Therapy and Speech Pathology	<p>The following information was added for clarification:</p> <p>"The same CPT code may be used for OT and PT. They are referred to as dual-use codes. The appropriate modifier must be used following the dual-use code when billing both OT and PT services.</p> <ul style="list-style-type: none"> Dual-use CPT codes: 97110, 97112, 97116, 97124, 97139, 97530, and 97799 Occupational therapy modifier: GO Physical therapy modifier: GP" 	Added in response to provider inquiries.
Billing & Reimbursement for Institutional Providers	9.1 Intermittent Nursing Visits/Aide Visits/Therapies	<p>The following information was added:</p> <p>"The same CPT code may be used for OT and PT. They are referred to as dual-use codes. The appropriate modifier must be used following the dual-use code when billing both OT and PT services.</p> <ul style="list-style-type: none"> Dual-use CPT codes: 97110, 97112, 97116, 97124, 97139, 97530, and 97799 Occupational therapy modifier: GO Physical therapy modifier: GP" 	Added in response to provider inquiries.
Billing & Reimbursement for Institutional Providers	12.1 Payments/Claim Status	<p>The following information was added as the third paragraph of this subsection:</p> <p>"If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider ID number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment."</p>	Added in response to provider inquiries.
Billing & Reimbursement for Professionals	Section 2.1 Electronic Claims	<p>The following sentence was added to the first paragraph:</p> <p>"The payroll cut-off for submission of electronic claims to MDCH is Wednesday of each week."</p>	Added in response to provider inquiries.

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Billing & Reimbursement for Professionals	Section 2.2 Paper Claims	The following paragraph was added: "Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period."	Added in response to provider inquiries.
Billing & Reimbursement for Professionals	Section 4.1 Replacement Claims	The following information in bold was added: <ul style="list-style-type: none"> To return an overpayment (report "returning money" in Remarks section); To correct information submitted on the original claim (other than to correct the provider ID number and/or the beneficiary ID number). Refer to the Void/Cancel subsection below; To report payment from another source after MDCH paid the claim (report "returning money" in Remarks section); and To correct information that the scanner misread (except a provider ID number or beneficiary ID number). State reason in the Remarks section. 	Clarification added to facilitate processing of replacement claims.
Billing & Reimbursement for Professionals	Section 8.1 Payments/Claim Status	The following information was added as the third paragraph of this subsection: "If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider ID number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment."	Added in response to provider inquiries.

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Adult Benefits Waiver	1.3 Admission and Retrospective Review	<p>The following clarification was added after the first paragraph of the subsection:</p> <p>"In addition to the PACER number, a letter of prior authorization is required in order for hospitals to bill for some inpatient services. The attending physician must request prior authorization for the following surgeries from the MDCH Office of Medical Affairs (OMA) for FFS beneficiaries, or the respective CHP for CHP beneficiaries. (Refer to the Directory Appendix for contact information.)</p> <ul style="list-style-type: none"> • Cosmetic surgery • Weight reduction • Transplants" 	Added in response to provider inquiries.
Adult Benefits Waiver I	1.4 Reimbursement	<p>The following clarification was added after the second paragraph of the subsection:</p> <p>"Hospitals must obtain all authorizations prior to rendering services. A copy of the physician's prior authorization letter from the OMA or the CHP must be submitted with inpatient facility claims. The claim should indicate "PA letter submitted" in the Remarks section."</p>	Added in response to provider inquiries.
Hospital	Hospital Reimbursement Appendix 7.3.C.	The phrase "Concern Prevention" was corrected to "Cancer Prevention".	Error corrected.
Pharmacy	6 – General Noncovered Services	<p>Language was added to the 11th bullet as indicated in bold below:</p> <ul style="list-style-type: none"> • Proposed less-than-effective (LTE) drugs identified by the Drug Efficacy Study Implementation (DESI) program. 	Added for clarification.
Private Duty Nursing	2.3 Determining Intensity of Care and Maximum Amount of PDN	Information in the Factor III portion of the Decide Guide Table was corrected to reflect "Beneficiary attends school 25 or more hours per week, on average."	Error corrected.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
All Provider 04-08	6/1/04	Adult Benefits Waiver I	Chapter Header	Note indicating there is a temporary enrollment freeze for the ABW.
All Provider 04-06	6/1/04	General Information for Providers	6.2 Nonenrolled Michigan and Borderland Providers	Requires all nonenrolled Michigan and borderland providers receiving payments from MDCH to have a Trading Partner Agreement (TPA) on file.
			6.3 Beyond Borderland Area	Clarifies services that may be reimbursed to out of state (beyond borderland) providers. Requires all out of state providers to have a TPA on file.
			10.3 Billing Limitation	Claim submission instructions for providers with approved MSA-1038.
		Billing & Reimbursement for Dental Providers	6.3 Payment Refunds	Requires return of overpayments to be made through the claim replacement or void/cancel process unless being submitted by an inactive provider, or due to a settlement or lawsuit.
		Billing & Reimbursement for Institutional Providers	3.3 Refund of Payment	
Billing & Reimbursement for Professionals	4.3 Refund of Payment			
MHP 04-04	6/1/04	Medicaid Health Plan, Acronym Appendix	New Chapter/Sections	Newly promulgated chapter added to manual. New acronyms added to the Acronym Appendix.
Medical Supplier 04-05	6/1/04	Medical Supplier	2.14 External Infusion (Insulin) Pump and Related Supplies	Added diabetes mellitus without complications to the list of diagnoses that negate the need to obtain PA for an external infusion (insulin) pump and supplies.
			2.16 Home Intravenous Infusion Therapy	Adds bullet under PA Requirements portion of the table "beneficiaries age five and older (for factor products, beneficiaries of all ages)." Additional billing instructions included in the Payment Rules portion of the table.

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)



Michigan Department of Community Health

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 04-08	6/1/04	Medical Supplier	2.19 Incontinent Supplies	Information regarding participation of Medicare/Medicaid dual eligibles added to the Payment Rules portion of the table.
MSA 04-07	6/1/04	Practitioner	4.13.A. Coverage of the Injectables	Medicare applicable payment limits are used when establishing fee screens.
MSA 04-06	4/1/04	Medical Supplier	2.19 Incontinent Supplies	Transition of the MDCH Volume Purchase Contract for Select Incontinence Supplies to J & B Medical.
		Directory Appendix	Provider Resources	Updated contact information for Diaper & Incontinence Supply Contract.
AP 00-07	7/1/00	Beneficiary Eligibility	Section 9.3 Medical Exceptions to Mandatory Enrollment	Created new subsection (9.3) that incorporates policy and procedures related to medical exceptions to mandatory enrollment in a Medicaid Health Plan. Subsequent subsections were renumbered.

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