From: INTEGRATEDCARE
Sent: Thursday, May 23, 2013 1:04 PM
To: INTEGRATEDCARE
Subject: Michigan Plan Guidance for PBP Entry into HPMS

Dear Potential Integrated Care Bidder:

The Michigan Department of Community Health (MDCH) is providing guidance on the Plan Benefit Package to organizations seeking to participate as integrated care organizations (ICOs) in Michigan's integrated care demonstration program. This guidance may be used to prepare entries into the Centers for Medicare and Medicaid Services (CMS) Health Plan Management System (HPMS) for Michigan's state specific benefit requirements due June 3, 2013.

Guidance for the Plan Benefit Package (PBP) entry is subject to revision as CMS and MDCH continue discussion around the demonstration PBP and finalization of the Memorandum of Understanding (MOU) between CMS and MDCH. CMS has indicated that organizations bidding in Michigan will be able to make changes to the PBP up until the point the MOU is final. Potential bidders will be notified by MDCH of changes to the PBP requirements.

Please share this communication with the appropriate members of your organization. This information will be posted on the MDCH website.

If you have questions regarding this notice, you may contact us via our email box at IntegratedCare@michigan.gov.

Sincerely,

Susan Yontz, Director
Integrated Care Division
Michigan Dept. of Community Health

Michigan Plan Guidance for PBP Entry into HPMS

PBP Section	Service Category Description	Supplemental Benefit	Required by the State?	Proposed HPMS Instruction	Required Language in HPMS Notes Field 3,000 character maximum (B-14C has a 1,000 character maximum)
1A	Inpatient Hospital - Acute	Additional Days	Yes	Supplemental Y, Additional Days Y, Mandatory Y, Unlimited Days Y, Coinsurance? N, -Copayment? N Authorization, N Referral, N	Covered services are the same as Medicare Part A with the exception that transportation is paid separately to a transportation provider.
		Non-Medicare Covered Stay	No		
		Upgrades	No		
1B	Inpatient Hospital Psychiatric	Additional Days	No		
		Non-Medicare Covered Stay	No		
2	Skilled Nursing Facility	Additional Days beyond Medicare-covered	Yes	Supplemental? Y, Additional days? Y, Mandatory, Unlimited? Y, Out of Pocket cost? N, Coinsurance? N, Authorization: Y, Other describe Referral required? Y, PCP	**Authorization:** Must meet Michigan Medicaid Nursing Facility Level of Care standard
		Non-Medicare Covered Stay	Yes	Supplemental? Y Non-Medicare? Y, Mandatory, Unlimited? YOut of Pocket cost? N Coinsurance Structure for Non-medicare days same? Y, Deductible? Y Copayment? N, Authorization from: Other describe, Referral required? Y, PCP	Deductible: Patient pay amount (PPA) is established by the local Department of Human Services (DHS) office. **Authorization:** Participant must meet Michigan Medicaid Nursing Facility Level of Care standard.

Michigan Plan Guidance for PBP Entry into HPMS

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		Less than 3 day inpatient hospital stay prior to SNF admission	No		
3	Cardiac and Pulmonary Rehabilitation Services	Additional Cardiac Rehabilitation Services	No		
		Additional Intensive Cardiac Rehabilitation Services	No		
		Additional Pulmonary Rehabilitation Services	No		
4A	Emergency Care	Worldwide Coverage	No		
6	Home Health Services	Additional Hours of Care	No		
		Personal Care Services	No		
		Other 1: Non-Medicare Covered Home Health Services	Yes	Supplemental? Y, Maximum Amount? N, Coinsurance? N, Copayment? N, Authorization required? Primary Care Physisican, Physician Specialist, Referral required? N	Covered services include home health services intended for participants who are unable to access services (nursing, OT, PT, speech and language pathology therapy [ST]) in an outpatient setting. However, it is not required that participants be totally restricted to their home. A determination and documentation is required by the Home Health Agency that the home is the most appropriate setting in which to provide the service(s). Home health services are **not** provided solely on the basis of convenience.

Michigan Plan Guidance for PBP Entry into HPMS

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		Other 2: Plan to provide label	No		
7B	Chiropractic Services	Routine Care	No		
7C	Occupational Therapy Services	Non-Medicare Occupational Therapy Service: Plan to provide label	No		
7F	Podiatry Services	Routine Foot Care	No		
7I	Physical Therapy and Speech Language Pathology Services	Other 1: Plan to provide label	No		
		Other 2: Plan to provide label	No		
9D	Outpatient Blood Services	Three-pint deductible waived	Yes	Co-insurance? N, Co-payment? N, Authorization? Y, PCP, Physician Specialist	

Michigan Plan Guidance for PBP Entry into HPMS

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10B	Transportation Services	Plan-approved location	Yes	Supplemental? Y, Plan-approved location, mandatory, Unlimited? Y, Type of Transportation for Plan-approved Trip? Round Trip, Select Mode of Transportation for plan-approved location: taxi, bus, van, medical transport, Other, Describe, Max. Plan benefit Coverage? N, Out of pocket cost? N, Coinsurance? N, Deductible? N, Copayment? N.	Covered services include medically necessary transportation at no-cost to the participant. Other Covered Modes of transportation: Wheelchair Van/Ambulette
		Any location	No		
11A	Durable Medical Equipment	Durable Medical Equipment for Use Outside the Home	No		

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		Other 1: Adaptive Medical Equipment and Supplies	Yes	Supplemental? Y, Maximum? N, Co-insurance? N, Co-payment? N, Authorization? N Referral? N	**Other 1 Adaptive Medical Equipment and Supplies:** Covered services include devices, controls, or appliances specified in the plan of care (POC) that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available under the Medicaid state plan and Medicare that are necessary to address participant functional limitations. All items shall meet applicable standards of manufacture, design, and installation. This will also cover the costs of maintenance and upkeep of equipment. The coverage includes training the participant or caregivers in the operation and/or maintenance of the equipment or the use of a supply when initially purchased. Some examples (not an exhaustive list) of these items would be shower chairs/benches, lift chairs, raised toilet seats, reachers, jar openers, transfer seats, bath lifts/room lifts, swivel discs, bath aids such as long handle scrubbers, telephone aids, automated/telephone or watches that assist with medication reminders, button hooks or zipper pulls, modified eating utensils, modified dental aids, modified grooming tools, heating pads, sharps containers, exercise items and other therapy items, voice output blood pressure monitor, and nutritional supplements such as Ensure. This would also include rubber/vinyl gloves, reusable or disposable incontinence pads, and incontinence briefs.

Michigan Plan Guidance for PBP Entry into HPMS

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		Other 2: Assistive Technology	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? Y, Other, Describe, Referral? N	**Other 2 Assistive Technology:** Covered services include technology items used to increase, maintain, or improve n participant's functioning and promote independence. The service may include assisting the participant in the selection, designing, purchasing, leasing, acquisition, application, or use of the technology item. This service includes repairs and maintenance of assistive technology devices. This service also includes vehicle modifications to a vehicle that is the participant's primary method of transporation. Vehicle modifications must be of direct medical or remedial benefit to the participant and be specified under the plan of service. This does not include paying for or leasing vehicles, vehicle insurance and vehicle repairs. **Authorization:** Participant must meet the Michigan Medicaid Nursing Facility Level of Care standard.
11B	Prosthetics/Medical Supplies	Non-Medicare Service: Medical Supplies	No		
13A	Acupuncture		No		
13B	Over-the-Counter Items	Note that plans should not enter OTC drugs / items included in integrated formulary and captured in section Rx of the PBP	No		
13C	Meal Benefit		No		

Michigan Plan Guidance for PBP Entry into HPMS

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13D	Blank "Other" Category	Environmental Modifications	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Enrollee Deductible: N, Authorization? None, Referral? N	Covered services include physical adaptations to the home, required by the participant's service plan, that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant.
13E	Blank "Other" Category		No		
13F	Blank "Other" Category		No		
13H	Additional Services	EPSDT Services	No		
		Tobacco Cessation Counseling for Pregnant Women	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? None, Referral? N	
		Freestanding Birth Center Services	No		
		Respiratory Care Services	No		
		Family Planning Services	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? None, Referral? N	

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		Nursing Home Services	No		
		Home and Community Based Services	No		
		Personal Care Services	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? None, Referral? N	**Personal Care Services:** Provided to assist participants with ADLs and IADLs.
		Self-Directed Personal Assistance Services	No		
		Private Duty Nursing Services	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? Y, PCP, Other, Describe, Referral? N	**Private Duty Nursing Services:** Skilled nursing interventions provided on an individual and continuous basis to meet health needs directly related to the participant's physical disorder provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the participant's plan of service. **Authorization:** Participant must meet the Michigan Medicaid Nursing Facility Level of Care (MMNFLOC) standard.
		Case Management (Long Term Care)	No		
		Institution for Mental Disease Services for Individuals 65 or Older	No		

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		Services in an Intermediate Care Facility for the Mentally Retarded	No		
		Case Management	No		
		Other 1: Fiscal Intermediary	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? None, Referral? N	**Other 1 Fiscal Intermediary:**The FI helps the individual to manage and distribute funds to purchase services authorized in the POC.
		Other 2: Community Living Supports	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? Y, Other, Describe, Referral? N	**Other 2 Community Living Supports:** In-person, hands-on assistance or prompting to perform tasks through cuing, teaching, or reminding. CLS services are also provided on a short-term intermittent basis to relieve the participant's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. **Authorization:** Participant must meet the MMNFLOC standard.
		Other 3: Chore Services	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? None, Referral? N	**Other 3 Chore Services:** Tasks needed to maintain the home in a clean, sanitary, and safe environment.
		Other 4: Community Transition Services	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? None, Referral? N	**Other 4 Community Transition Services:** Non-reoccurring expenses for participants transitioning from a nursing facility to another residence.

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		Other 5: Preventive Nursing Services	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? None, Referral? N	**Other 5 Preventive Nursing Services:** Provided on an intermittent basis for the management of a chronic illness or physical disorder and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a RN.
		Other 6: Extensive Environmental Modifications	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? None, Referral? N	**Other 6 Extensive Environmental Modifications:** Accessibility modifications in excess of what is covered outside the c-waiver. Examples would include omplex kitchen or bathroom modifications.
		Other 7: Training and Counseling	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? None, Referral? N	**Other 7 Training and Counseling:** Instruction provided to a p[articipant or caregiver to teach a independent living skills, including the use of specialized or adaptive equipment or medically related procedures. Professional level counseling services to improve the beneficiary's emotional and social well-being through the resolution of personal problems or a change in an individual's social situation.
		Other 8: Personal Emergency Response System	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? None, Referral? N	
		Other 9: Medication Reconciliation	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? None, Referral? N	
		Other 10: Adult Day Program	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? Y, Other, Describe, Referral? N	**Other 10 Adult Day Program: Authorization:** Participant must meet the MMNFLOC standard.

Michigan Plan Guidance for PBP Entry into HPMS

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		Other 11: Home Delievered Meals	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? Y, Other, Describe, Referral? N	**Other 11 Home Delivered Meals: Authorization:** Participant must meet the MMNFLOC standard.
		Other 12: Respite	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? Y Other, Describe, Referral? N	**Other 12 Respite:** Provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. **Authorization:** Participant must meet the MMNFLOC standard.
		Other 13: Non-Medical Transportation	Yes	Maximum? N, Co-insurance? N, Co-payment? N, Authorization? Y, Other, Describe, Referral? N	**Other 13 Non-Medical Transportation: Authorization:** Participant must meet the MMNFLOC standard.
14C	Supplemental Education / Wellness Programs	Health Education	No		
		Nutrition Education	No		
		Additional Smoking and Tobacco Use Cessation	No		
		Membership in Health Club / Fitness Classes	No		
		Nursing Hotline	No		
15	Home Infusion Bundled Services	Does plan bundle Part D drug costs with admin/supplies as a supplemental benefits?	Yes		

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		Does Medicaid pay for Part D home infusion drug admin/supplies?	No		
16A	Preventive Dental	Oral Exams	Yes	Supplemental? Y, Mandatory? Y, Unlimited? N, Number of visits? 2, Frequency? Every six months, Maximum? N, EOOP? N, Coinsurance? N, Deductible? N, Copayment? N	
		Prophylaxis (Cleaning)	Yes	Supplemental? Y, Mandatory? Y, Unlimited? N, Number of visits? 2, Frequency? Every six months, Maximum? N, EOOP? N, Coinsurance? N, Deductible? N, Copayment? N	
		Fluoride Treatment	No		

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		Dental X-Rays	Yes	Supplemental? Y, Mandatory? Y, Unlimited? N, Number of visits? 1, Frequency? Every year, Maximum? N, EOOP? N, Coinsurance? N, Deductible? N, Copayment? N	Coverage includes radiographs limited to the number medically necessary to make a diagnosis. Bitewing radiographs are a covered benefit only once in a 12-month period. A panoramic radiograph is a covered benefit once every five years. A full mouth or complete series is a covered benefit once every five years consisting of a minimum of 10 periapical radiographs in conjunction with a minimum of two bitewing radiographs or an intraoral/extraoral combination of a panoramic radiograph in conjunction with a minimum of two bitewing radiographs.
16B	Restorative Dental	Non-routine Services	No		
		Diagnostic Services	No		
		Restorative Services	Yes	Supplemental? Y, Mandatory? Y, Unlimited? Y, Frequency? Maximum? N, EOOP? N, Coinsurance? N, Deductible? N, Copayment? N, Authorization?, N Referral? N	**Restorative Services:** Covered services include restorative treatment, using Amalgam or Direct Resin-Based Composite materials to restore carious lesions or fractured teeth. Restorative treatment is limited to those services necessary to restore and maintain adequate dental health. Replacement or repair of a restoration is the provider's responsibility for the first two years following placement of all restorations.

Michigan Plan Guidance for PBP Entry into HPMS

PBP Section	Service Category Description	Supplemental Benefit	Required by the State?	Proposed HPMS Instruction	Required Language in HPMS Notes Field 3,000 character maximum (B-14C has a 1,000 character maximum)
		Endodontics / Periodontics / Extractions	Yes	Supplemental? Y, Mandatory? Y, Unlimited? N, Number of visits? 1, Frequency? Every year, Maximum? N, EOOP? N, Coinsurance? N, Deductible? N, Copayment? N, Authorization?, N Referral? N	**Periondontics:** Covered services include full mouth debridement when performed as a therapeutic, not preventive, treatment for beneficiaries to aid in the evaluation and diagnosis of their oral condition. It is the removal of subgingival and/or supragingival plaque and calculus. Full mouth debridement is a benefit over once every 365 days. It is not covered when a prophylaxis is completed on the same day. **Endodontics** is not a covered service. **Extractions:** Coveraged Services include surgical extraction only when the removal of bone and the elevation of mucoperiosteal flap and/or sectioning of a tooth is required to facilitate the extraction. Surgical extractions are not a covered benefit in cases of multiple extractions in the same quadrant for preparation of complete dentures. The extraction of an impacted tooth is a benefit only when conditions arising from such an impaction warrant its removal. The prophylactic removal of asymptomatic teeth exhibiting no overt pathology and symptoms is not covered. An extraction is not a covered benefit if exfoliation is imminent. No other periodontal procedures are considered to be covered benefits.

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PBP Section	Service Category Description	Supplemental Benefit	Required by the State?	Proposed HPMS Instruction	Required Language in HPMS Notes Field 3,000 character maximum (B-14C has a 1,000 character maximum)
		Prosthodontics, Oral, Oral / Maxillofacial Surgery, Other Services	Yes	Supplemental? Y, Mandatory? Y, Unlimited? N, Number of visits? 1, Frequency? Other, Prosthodontics every 5 years, Maximum? N, EOOP? N, Coinsurance? N, Deductible? N, Copayment? N, Authorization?, N Referral? N	**Prosthodontics:** Covered services include complete and partial dentures. Providers must assess the beneficiary's general oral health and provide a five-year prognosis for the prosthesis requested. An upper partial denture assessment must also include the prognosis of six sound teeth. Complete or partial dentures are covered: there is one or more anterior teeth missing; there are less than eight posterior teeth in occlusion (fixed bridges and dentures are to be considered occluding teeth); or an existing complete or partial denture cannot be made serviceable through repair, relining, adjustment, or duplicating (rebasing) procedures. If a partial denture can be made serviceable, the dentist should provide the needed restorations to maintain use of the existing partial, extract teeth, add teeth to an existing partial, and remove hyperplastic tissue.
17A	Eye Exams	Routine Eye Exams	Yes	Supplemental? Y, Mandatory? Y, Unlimited? N, one exam, every two years, Maximum? N, EOOP? Y, Zero, Co-insurance? N, Deductible? N, Co-payment? N, Physician/Professional Service Cost Share? N	Covered services includes examinations including, but are not limited to, case history, determination of visual acuity (each eye), ophthalmoscopy, biomicroscopy, ocular motility, tonometry, refraction, diagnosis, treatment program and disposition. Nonroutine eye examinations are a benefit for the purpose of evaluation and treatment of chronic, acute, and/or sudden onset of abnormal ocular conditions.

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PBP Section	Service Category Description	Supplemental Benefit	Required by the State?	Proposed HPMS Instruction	Required Language in HPMS Notes Field 3,000 character maximum (B-14C has a 1,000 character maximum)
17B	Eye Wear	Contact Lenses	Yes	Supplemental? Y, Mandatory? Y, Unlimited? N, Contact Lenses? 1, Periodicity? Every year Maximum? N, EOOP? Y, Zero, Co-insurance? N, Deductible? N, Co-payment? N	**Contact Lenses:** Coverage includes a comprehensive contact lens evaluation as a benefit when the beneficiary presents with one of the following conditions, and visual performance is expected to be significantly improved with the application of a contact lens(es): Aphakia (congenital or surgical); Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses); Anisometropia or Antimetropia (of two diopters or greater that results in aniseikonia); or, other conditions which have no alternative treatment. The prescription for contact lenses requires the complete description of contact lens specifications. Fitting includes the supply of contact lenses, verification of lens characteristics, carrying case, solutions, instructions, training, and incidental modification of the lenses during the three-month adaptation period. One contact lens replacement in a year for each eye is allowed. (One year is defined as 365 days from the date the first pair of contact lenses [initial or subsequent] was ordered.) Except as indicated previously, contact lens supplies (e.g., wetting and cleaning solutions, carrying cases) are not Medicaid benefits.

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PBP Section	Service Category Description	Supplemental Benefit	Required by the State?	Proposed HPMS Instruction	Required Language in HPMS Notes Field 3,000 character maximum (B-14C has a 1,000 character maximum)
		Eye Glasses (Lenses and Frames)	Yes	Supplemental? Y, Mandatory? Y, Unlimited? N, One, Every year, Maximum? N, EOOP? Y, Zero, Co-insurance? N, Deductible? N, Co-payment? N	**Eye Glassses (lenses and frames):** Coverage includes a complete pair of eyeglasses as benefit and does not require PA when 1.) the eyeglasses being prescribed are the participant's first pair of eyeglasses ever worn. These eyeglasses are considered to be initial eyeglasses and must meet minimum diopter criteria for initial lenses. 2.) The participant's correction meets diopter criteria for subsequent lenses and the frames are unusable. 3) A previously used frame requires oversized lenses. (Oversized lenses are not a covered benefit, therefore, a complete pair of eyeglasses must be ordered.) 4.) Prescription lenses remain usable, but the original frame is broken beyond repair and the original frame is not a covered benefit. 5.) The participant's correction meets diopter criteria for subsequent lenses and the frames remain usable, but the vision provider feels that the previously used frames will break or otherwise be damaged during lens insertion or, 6.) The participant's eyeglasses have been lost, stolen, or broken beyond repair and the number of replacements have not exceeded coverage limits which are one pair of replacement eyeglasses per year. One year is defined as 365 days from the date the first pair of eyeglasses (initial or subsequent) was ordered.

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PBP Section	Service Category Description	Supplemental Benefit	Required by the State?	Proposed HPMS Instruction	Required Language in HPMS Notes Field 3,000 character maximum (B-14C has a 1,000 character maximum)
		Eye Glass Lenses	Yes	Supplemental? Y, Mandatory? Y, Unlimited? N, One, Every year, Maximum? N, EOOP? Y, Zero, Co-insurance? N, Deductible? N, Co-payment? N	**Eye Glass Lenses:** Coverage includes lenses that must conform to the latest edition of the American National Standard Recommendations for Prescription Ophthalmic Lenses. Plastic and glass lenses are a covered benefit. Lenses requiring PA are indicated in the MDCH Vision Services Database on the MDCH website. Plastic and glass bifocals are available in Round 22, FT-28, FT-35, and Executive style. Plastic and glass trifocals are available in FT-7x28 segments. Oversized lenses, no-line, progressive style multi-focals, or transitions are not covered benefits. Replacement of a corrective lens(es), without frames, for one that is damaged or broken is a benefit if that lens(es) is covered and the replacement limits have not been exceeded. A replacement lens(es) must be an identical copy of the damaged or broken lens.
		Eye Glass Frames	Yes	Supplemental? Y, Mandatory? Y, Unlimited? N, One, Every year, Maximum? N, EOOP? Y, Zero, Co-insurance? N, Deductible? N, Co-payment? N	**Eye Glass Fames:** Coverage includes frames that must conform to the latest edition of the American National Standard Requirements for the Dress Ophthalmic Frames. Safety frames are a covered benefit. These frames conform to ANSI Z87.1-2003 standards. Only polycarbonate lenses of 2 millimeter minimum thickness shall be used in frames marked "Z 87" or "Z 87-2". Frame repairs (e.g., aligning temples, insertion of screws, adjusting frames) are not a separately reimbursable service and cannot be billed.
		Upgrades	No		
18A	Hearing Exams	Routine Hearing Exams	No		
		Fitting / Evaluation for Hearing Aid	No		

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18B	Hearing Aids	Hearing Aids (All Types)	No		
		Hearing Aids - Inner Ear	No		
		Hearing Aids - Outer Ear	No		
		Hearing Aids - Over the Ear	No		

Note: This PBP guidance is subject to change during finalization of the MOU between CMS and MDCH.